Plan Document and Summary Plan Description
For
ARUP Laboratories
Employee Dental Plan
Dental Plus Platinum Indemnity Co-Insurance

TABLE OF CONTENTS

INTRODUCTION

This document is a description of ARUP Laboratories Employee Dental Plan Dental Plus Platinum Indemnity Co-insurance (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Employee or Dependents against certain other expenses.

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

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

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

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

Dental care has become an increasingly common and expensive medical cost in recent years. Yet, dental health can be maintained easily through regular, routine care. Therefore, in addition to reimbursement for much of the cost of major procedures, the Plan encourages preventive and restorative dental care in order to avoid future, more costly major dental expenses.

If the Plan is terminated, the rights of Covered Persons are limited to covered charges incurred before termination.

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

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

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

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

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

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

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

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

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

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

Eligible Classes of Employees.
All Active Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage on date of hire.

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

(1) A covered Employee's Spouse or Domestic Partner and unmarried children from birth to the limiting age of 26 years. The Dependent children must be primarily Dependent upon the covered Employee for support and maintenance. When a child reaches the limiting age, coverage will end on the child's birthday.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term “Domestic Partner” shall mean a person whom Employee has a domestic partnership or similar civil union which is registered with or certified by any governmental body pursuant to state or local law authorizing such registration or certification, documentation of which registration or certification has been provided to the Employer where allowed by law; the person with whom Employee has entered into a same-sex marriage valid in the jurisdiction where entered, but not recognized by the state of residence, documentation of which marriage has been provided to the Employer where allowed by law; or the person whom Employee has registered with the Employer as a domestic partner, pursuant to applicable human resources policies and procedure of the Employer as attested to in writing to the Employer.

The term "children" shall include natural children living in the same household as the Employee, Domestic Partner’s children, living with and financially dependent upon the Employee, adopted children or children placed with a covered Employee in anticipation of adoption. Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household.

If a covered Employee is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as covered Dependents.

(2) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily Dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

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

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

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

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

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

FUNDING

Cost of the Plan.
Company Name pays a portion of the cost of Employee and Dependent coverage under this Plan.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application. The covered Employee is required to enroll for Dependent coverage also.

Timely Enrollment - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage.

Late Enrollment – Failure to enroll within 31 days after the person becomes eligible for the coverage results in late enrollment. Late enrollees will not be able to enroll in the plan until Open Enrollment.

EFFECTIVE DATE

Effective Date of Employee Coverage. Eligible Employees are effective for coverage on the date of hire of Full-time employment provided the Employer has received a properly completed application for enrollment.

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

TERMINATION OF COVERAGE
Covered Persons may terminate coverage during the employer's open enrollment period or, within 31 days of a Qualifying Event.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

(1) The date the Plan is terminated.

(2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes termination or death of Active Employment of the covered Employee.

Termination of coverage will not prejudice any existing claim. If Covered Persons terminate insurance and wish to re-enroll at a later date, the Plan reserves the right to require a two-year waiting period. The two-year waiting period will begin on the date the Covered Person first terminated coverage.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance.

For leave of absence or layoff only: the date the Employer ends the continuance.

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.

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

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates:

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

(2) The date that the Employee's coverage under the Plan terminates for any reason including death.

(3) The date a covered Spouse or Domestic Partner loses coverage due to loss of dependency status.

(4) On the first date that a Dependent child ceases to be a Dependent as defined by the Plan.

OPEN ENROLLMENT

OPEN ENROLLMENT

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

Benefit choices for Late Enrollees made during the open enrollment period will become effective January 1st.

Employee or Dependents will receive detailed information regarding open enrollment from their Employer.

SCHEDULE OF BENEFITS
(Preferred Network)

DENTAL BENEFITS

Calendar Year deductible,
per person..... $50
per Family Unit $150

The deductible applies to these Classes of Service:
Class B Services - Basic
Class C Services - Major

Dental Percentage Payable

Class A Services-
Preventive 100%

Class B Services-
Basic 80%

Class C Services-
Major..... 50%

Class D Services -
Orthodontia *(Dependents under age 19)*..... 50%
Orthodontia (*Adults & Children*) ……..20% Discount

Maximum Benefit Amount

For other than Class D-Orthodontia:
Per person per Calendar Year $1500

For Class D-Orthodontia:
Annual Maximum per person…….. $750
Lifetime maximum per person $1500

Preferred Network Specialist Services
A Specialist is a licensed dentist who is board certified in one or more of the following specialties: Endodontics, Periodontics, Pedodontics, Prosthodontics, Oral Surgery, Orthodontics, and any other board certified specialty outside of general dentistry.

Services rendered by a Preferred Network Specialist are reimbursed as follows:
- The Employee or Dependent receives a negotiated discount off of billed charges for covered services.
- After the deductible, the Plan pays Preferred Network Specialists according to the reasonable and customary fees..
- The Employee or Dependent is responsible for the difference between the discounted fee and the Plan's payment.

SCHEDULE OF BENEFITS
(Non-Preferred Network)

DENTAL BENEFITS

Calendar Year deductible,
per person..... $50
per Family Unit $150

The deductible applies to these Classes of Service:
Class B Services - Basic
Class C Services - Major

Dental Percentage Payable

Class A Services-
Preventive ..... 100% of R&C

Class B Services-
Basic ..... 80% of R&C

Class C Services-
Major..... 50% of R&C

Class D Services - *(Dependents under age 19)*
Orthodontia 50%

Maximum Benefit Amount

For other than Class D-Orthodontia:
Per person per Calendar Year $1500

For Class D-Orthodontia:
Annual Maximum per person…….. $750
Lifetime maximum per person $1500

Non-Preferred General Dentist & Specialist Services
After the deductible, the Plan will allow up to the reasonable and customary charge for covered services rendered by a Non-Preferred General Dentist or Specialist. Charges above the reasonable and customary rate are the Employee or Dependent's responsibility.

DEFINED TERMS

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

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

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

Cosmetic Dentistry means dentally unnecessary procedures.

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

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

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

Employer is ARUP Laboratories.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Full-Time Employee is an Active Employee of the Employer, working the required hours for Full-Time designation..

Late Enrollee means an Employee or Dependent who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

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

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations while covered by this Plan.

Medically Necessary care and treatment is recommended or approved by a Dentist; is consistent with the patient's condition or **accepted standards of good dental practice**; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

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

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

Plan means ARUP Laboratories Employee Dental Plan Dental Plus Platinum Indemnity Co-insurance, which is a benefits plan for certain Employees of ARUP Laboratories and is described in this document.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Total Disability (Totally Disabled) means: In the case of a Dependent Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before Basic and/or Major benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

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

BENEFIT PAYMENT
Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT
The Maximum Dental Benefit Amount is shown in the Schedule of Benefits.

DENTAL CHARGES
Dental charges are the contracted fees or Reasonable and Customary Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

Preferred Network General Dentist Services
The Claims Administrator has negotiated discounted fees with Preferred Network General Dentists. After the deductible, your Plan pays for covered services rendered by a Preferred Network General Dentist at the coverage level indicated on the Schedule of Benefits.

Preferred Network Specialist Services
A Specialist is a licensed dentist who is board certified in one or more of the following specialties: Endodontics, Periodontics, Pedodontics, Prosthodontics, Oral Surgery, Orthodontics, and any other board certified specialty outside of general dentistry.

Services rendered by a Preferred Network Specialist are reimbursed as follows:

- The Employee or Dependent receives a negotiated discount off of billed charges for covered services.
- After the deductible, the Plan pays Preferred Network Specialists according to the reasonable and customary fees.
- The Employee or Dependent is responsible for the difference between the discounted fee and the Plan's payment.

Non-Preferred General Dentist & Specialist Services
After the deductible, the Plan will allow up to the reasonable and customary charge for covered services rendered by a Non-Preferred General Dentist or Specialist. Charges above the reasonable and customary rate are the Employee or Dependent's responsibility.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Class A Services:
Preventive and Diagnostic Dental Procedures

(1) Examinations and cleanings, topical fluoride (age 23 & under) - 2 per calendar year.
(2) Panoramic or full mouth series x-rays - 1 per 36 months.
(3) Bitewings x-rays - 4 twice per 12 months.
(4) Periapical x-rays - 6 per 12 months.
(5) Occlusal x-ray - 1 per 24 months.
(6) Space maintainers (age 13 & under) to preserve space between teeth for premature loss of a primary baby tooth. This does not include use for orthodontic treatment.
(7) Sealants on permanent molars - age 15 & under every 36 months.

Class B Services:
Basic Dental Procedures

(1) Oral surgery - simple extraction of teeth; frenectomy, incision and drainage of intraoral abcess; extraction of impacted tooth; surgical exposure of tooth; alveolectomy; alveoplasty; excision of pericoronal gingiva, exostosis, hyperplastic tissue; reimplantation and repositioning of natural tooth.
(2) Fillings of amalgam, silicate, acrylic, synthetic porcelain and composite filling materials; benefit for gold foil will be reduced to that of an amalgam filling.
(3) Pin retention of fillings.
(4) Endodontic treatment: root canal therapy; pulpotomy; pulpal therapy; apicoectomy, apexification/recalcification; root amputation; hemisection; intentional reimplantation; retrograde fillings.
(5) Periodontic services: one perio maintenance (2 per calendar year in lieu of preventive cleaning); root scaling and planing (once per quadrant of mouth in any 24 month period); gingivectomy, gingival curettage; osseous surgery including flap entry and closure; pedical or free soft tissue grafts; full mouth debridement (1 per 60 months).
(6) Repair of dentures or bridges.
(7) General anesthesia, including intravenous sedation.

Class C Services:
Major Dental Procedures

(1) Crown build-up; post and core.
(2) Recementing inlays, onlays and crowns and bridges.
(3) Crowns, bridges, inlays, onlays, dentures and gold fillings - every 60 months. Benefit for gold inlays, onlays and crowns will be reduced to that of a plastic restoration unless special need is demonstrated for use of gold, (Additional lab fee may be charged by provider for higher metals and porcelain that is not covered by the plan.)
(4) Addition of teeth to existing partial denture.
(5) Relining or rebasing of existing removable dentures - 1 per year.
(6) Occlusal guards for bruxism only - 1 every 2 years.
(7) Implants.
(8) Vestibuloplasty.

Class D Services:
Orthodontic Treatment and Appliances

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

These services are available for covered Dependent Children under age 19 and include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and retention appliance.

Payments for comprehensive full-banded orthodontic treatments are made in installments.

**Note: No coverage or limited coverage for orthodontic treatment which began prior to the effective date of coverage.

PREDETERMINATION OF BENEFITS
Before starting a dental treatment for which the charge is expected to be $300 or more, a predetermination of benefits form is highly suggested but not required to be submitted.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form.

The Dentist should send the form to the Claims Administrator at this address:

Dental Select
5373 S Green Street, 4th Floor
Salt Lake City, UT 84123
800-999-9789

Dental Select will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

ALTERNATE TREATMENT
Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

EXCLUSIONS
A charge for the following is not covered:

(1) Services and supplies not listed in Covered Services, not necessary or not recognized as essential for the treatment of the condition according to accepted standards of practice or considered experimental.
(2) Cosmetic procedures including but not limited to veneers and bleaching of teeth and procedures performed primarily for cosmetic reasons.
(3) Charges for services related to, performed in conjunction with, or resulting from a non-covered procedure.
(4) Charges in excess of the contracted Fee-for-Service schedule or the Reasonable and Customary rate, whichever applies.
(5) Any treatment program which began before the Employee or Dependent enrolled under the plan.
(6) Crowns, inlays or onlays on teeth that can be restored by direct placement materials.
(7) Replacement of crowns, bridges, dentures, inlays or onlays that can be repaired or restored to normal function.
(8) Replacement of crowns, bridges, inlays, onlays or prosthetic appliance within 5 years from the date of last placement.
(9) Charges for services and supplies payable under any medical expense, auto or no-fault plan.
(10) Any condition covered any Worker's Compensation Act or similar law.
(11) Services provided without cost by any municipality, county or other political subdivision or for which there would be no charge in the absence of insurance.
(12) Expenses incurred during any waiting period required by the Plan. When Employee or Dependent voluntarily ends coverage without a qualifying event and re-enroll at a later date, the waiting period is 2 years and begins on the date the Employee or Dependent's coverage first ended.
(13) Services that are applied toward the satisfaction of a Deductible, if any.
(14) Services subject to a waiting period that were incurred during the waiting period.
(15) Charges resulting from changing from one provider to another while receiving treatment, or from receiving treatment from more than one provider for one dental procedure to the extent that the total charges billed exceed the amount incurred if one provider had performed all services.
(16) Hospital facility charges for any dental procedure, including but not limited to: emergency room charges, surgical facility charges, hospital confinement.
(17) Drugs or the dispensing of drugs.
(18) Oral hygiene instruction; plaque control; nitrous oxide; acid etch; prescription or take home fluoride; broken appointments; completion of a claim form; OSHA/Sterilization fees (Occupational Safety & Health Agency); or diagnostic photographs (except for orthodontic purposes).
(19) Myofunctional therapy, athletic mouth guards, precision or semi-precision attachments, treatment of fractures, cysts, tumors, or lesions, maxillofacial prosthesis, orthognathic surgery, TMJ dysfunction, cleft palate, or anadontia.
(20) Orthodontia, unless included within Covered Services.

(21) Composite, resin, gold or white fillings on posterior primary teeth. Benefit will be reduced to that of an amalgam or silver filling.
(22) Replacement of a filling within 24 months of placement unless for specific health reasons.
(23) Replacement of retainers.
(24) Sealants not applied to a permanent bicuspid or molar; applied at age 15 or older; applied within 3 years from a previous sealant

application; applied to a decayed tooth.

(25) Lab fees for higher metals or porcelain crowns, bridges, inlays, or onlays.

HOW TO SUBMIT A CLAIM

When a Covered Person has a claim to submit for payment that person must:

Have the dentist complete an ADA approved claim form.

Send the above to the Claims Administrator at this address:

Dental Select
5373 S Green Street, 4th Floor
Salt Lake City, UT 84123
800-999-9789

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 7 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

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

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Employee or Dependent with a written notice of this denial. This written notice will be provided within 90 days after receipt of the claim. The written notice will contain the following information:

(a) the specific reason or reasons for the denial;

(b) specific reference to those Plan provisions on which the denial is based;

(c) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

(d) appropriate information as to the steps to be taken if an Employee or Dependent wishes to submit the claim for review.

Payment of Benefits

After a claim has been submitted to the Claims Administrator, if additional information is needed for payment of the claim, the claims processor will request the same. The claims processor will approve, partially approve, or deny the claim within thirty (30) days after all necessary information is received by the claims processor to determine the validity of the claim. This time period may be extended for fifteen (15) days if it necessary because of matters beyond the Plan's control, and if the Plan notifies the covered person of those circumstances and the expected date of decision before the end of the thirty (30) day period. This Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. The Employee will be allowed up to forty-five (45) calendar days from receipt of the Notice of Extension to provide the additional information. The Plan will then make a claim determination within a reasonable period but not later than fifteen (15) calendar days from the date the Plan receives the additional information.

If the services of preferred provider are used, Plan benefits are payable directly to the provider of service. If the services of a non-preferred provider are used, benefits are payable to the covered person whose illness or injury, or whose Dependent's illness or injury, is the basis of claim under this Plan, unless the covered person has made an assignment of benefits to the provider of service.

In the event a claim for benefits under the Plan is denied in whole or in part, the covered person will receive written notification stating the required information including the review procedure, in the same fashion as reimbursement for a claim, in a manner calculated to be understood by the covered person. A claim worksheet will be provided by the claims processor showing the calculation of the total amount payable, charges not payable, and the reason.

CLAIMS REVIEW PROCEDURE

In cases where a claim for benefits payment is denied in whole or in part, the Employee or Dependent may appeal the denial. This appeal provision will allow the Employee or Dependent to:

(a) Request from the Plan Administrator a review of any claim for benefits. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.

(b) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Plan Administrator or Claims Administrator within 180 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Employee or Dependent with a written response within 60 days of the date the Plan Administrator receives the Employee or Dependent's written request for review and if not notified, the Employee or Dependent may deem the claim denied. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the Employee or Dependent of the delay within the 60 day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator

received the Employee or Dependent's written request for review.

The Plan Administrator's written response to the Employee or Dependent shall cite the specific Plan provision(s) upon which the denial is based.

An Employee or Dependent must exhaust the claims appeal procedure before filing a suit for benefits.

COORDINATION OF BENEFITS

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

The plan that pays first according to the rules will pay as if there were no other plan involved. When it is determined that the plan is a secondary plan, benefits may be reduced as follows:

- when one of the plans has contracted for discounted provider fees, the secondary plan may limit payment to any co-payments and deductibles owed by the Employee or Dependent after payment by the primary plan; or

- if none of the plans have contracted for discounted provider fees, the secondary plan may reduce its benefits so that the total benefits paid or provided by all plans for a covered service are not more than the highest allowable expense of any of the plans for that service.

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

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

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

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

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

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

- **(a)** The benefits of the plan which covers the person directly (that is, as an Employee, member or subscriber) are determined before those of the plan which covers the person as a Dependent.
- **(b)** The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
- **(c)** The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
- **(d)** When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
  - **(i)** The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
  - **(ii)** If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
- **(e)** When a child's parents are divorced or legally separated, these rules will apply:
  - **(i)** This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
  - **(ii)** This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
  - **(iii)** This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
  - **(iv)** If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
- **(f)** If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this

Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

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

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

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

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

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

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

CONTINUATION OF COVERAGE

In order to comply with federal regulations, this Plan includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended.

The coverage which may be continued under this provision consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes dental benefits as provided under the Plan.

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a Covered Person to lose coverage under this Plan, even if such coverage is not lost immediately, and allow such person to continue coverage beyond the date described in Termination of Coverage:

1. Death of the Employee.
2. The Employee's termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the Plan.
3. Divorce or legal separation from the Employee.
4. The Employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan.
5. A Dependent child no longer meets the eligibility requirements of the Plan.
6. The last day of leave under the Family Medical Leave Act of 1993.
7. The call-up of an Employee reservist to active duty.
8. A covered Retiree and their covered Dependents whose benefits were substantially reduced within one (1) year of the employer filing for Chapter 11 bankruptcy.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a Spouse being divorced or legally separated from a covered Employee, an individual no longer qualifying as a Domestic Partner as defined herein, or a child's loss of Dependent status, the Employee or Dependent must notify the Employer of that event within sixty (60) days of the event. Failure to provide such notice to the Employer will result in the person forfeiting their rights to continuation of coverage under this provision.
2. Within fourteen (14) days of a qualifying event, or within fourteen (14) days of receiving notice of a qualifying event, the Employee or Dependent will be notified of his rights to continuation of coverage, and what process is required to elect continuation of coverage.
3. After receiving notice, the Employee or Dependent has sixty (60) days to decide whether to elect continued coverage. Each person who was covered under the Plan prior to the qualifying event, has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the Employee or Dependent chooses to have continued coverage, he must advise the Employer in writing of this choice. The Employer must receive this written notice no later than the last day of the sixty (60) day period. If the election is mailed, the election must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the latter of the following:
   A. The date coverage under the Plan would otherwise end; or
   B. The date the person receives the notice from the Employer of his or her rights to continuation of coverage.
4. Within forty-five (45) days after the date the person notifies the Employer that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continued coverage are to be made monthly, and are due in advance, on the first day each month.
5. The Employee or Dependent must make payments for the continued coverage.

WHEN CONTINUATION COVERAGE BEGINS

When continuation coverage is elected and the contributions paid within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for Dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A Spouse, Domestic Partner or Dependent child newly acquired during continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A Dependent acquired and enrolled after the original qualifying event, other than a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

SUBSEQUENT QUALIFYING EVENTS
Once covered under continuation coverage, it is possible for a second qualifying event to occur, including:

1. Death of an Employee.
2. Divorce or legal separation from an Employee.
3. Employee's entitlement to Medicare.
4. The child's loss of Dependent status.

If one of these subsequent qualifying events occurs, a Dependent may be entitled to a second continuation period. This period will in no event continue beyond thirty-six (36) months from the date of the first qualifying event.

Only a person covered prior to the original qualifying event or a child born to or placed for adoption with a covered Employee during a period of COBRA continuation is eligible to continue coverage again as the result of a subsequent qualifying event. Any other Dependent acquired during continuation coverage is not eligible to continue coverage as the result of a subsequent qualifying event.

END OF CONTINUATION
Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen (18) months from the date continuation began because of a reduction of hours or termination of employment of the Employee.
2. Thirty-six (36) months from the date continuation began for Dependents whose coverage ended because of the death of the Employee, divorce or legal separation from the Employee, or the child's loss of Dependent status.
3. The end of the period for which contributions are paid if the covered person fails to make a payment on the date specified by the Employer.
4. The date coverage under this Plan ends and the Employer offers no other group health benefit plan.
5. The date the Covered Person first becomes entitled to Medicare after the original date of the Covered Person's election of continuation coverage.
6. The date the Covered Person first becomes covered under any other group health plan after the original date of the Covered Person's election of continuation coverage, with exception of the pre-existing provision below.
7. Retirees, and widows or widowers of Retirees who died before bankruptcy are entitled to lifetime continuation coverage. However, if a Retiree dies after bankruptcy, the surviving Spouse or Domestic Partner and Dependent children may only elect an additional thirty-six (36) months of continuation coverage after the death.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND
When this provision applies. The Covered Person may incur dental charges due to injuries which may be caused by the act or omission of a third party or a third party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that third party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to recover payments from any third party or insurer. This subrogation right allows the Plan to pursue any claim which the Covered Person has against any third party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the third party or insurer, but in any event, the Plan has a lien on any amount recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any third party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the recovery made from the third party or insurer.

Amount subject to subrogation or refund. The Covered Person agrees to recognize the Plan's right to subrogation and reimbursement. These rights provide the Plan with a priority over any funds paid by a third party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses.

Notwithstanding its priority to funds, the Plan's subrogation and refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. However, the Plan's right to subrogation still applies if the recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to subrogate.

Defined terms: "Recovery" means monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injuries or Sickness whether or not said losses reflect medical or dental charges covered by the Plan.

"Subrogation" means the Plan's right to pursue the Covered Person's claims for medical or dental charges against the other person.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

Recovery from another plan under which the Covered Person is covered. This right of refund also applies when a Covered Person recovers under an uninsured or under an underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan or any

liability plan.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. ARUP Laboratories Employee Dental Plan Dental Plus Platinum Indemnity Co-insurance is the benefit plan of ARUP Laboratories, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by ARUP Laboratories to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, ARUP Laboratories shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to an Employee or Dependent's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.
(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
(3) To decide disputes which may arise relative to an Employee or Dependent's rights.
(4) To prescribe procedures for filing a claim for benefits and to review claim denials.
(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
(6) To appoint a Claims Administrator to pay claims.
(7) To perform all necessary reporting as required by ERISA.
(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan.

These are duties which must be carried out:
(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
(3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT
The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR
Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.
If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of an Employee or Dependent, if it is requested, the amount of overpayment will be deducted from future benefits payable.

GENERAL PLAN INFORMATION

Name of Plan:
ARUP Laboratories Employee Dental Plan Dental Plus Platinum Indemnity Co-insurance

Name, Address and Phone Number of Employer/Plan Sponsor:
ARUP Laboratories
500 Chipeta Way
Salt Lake City, UT 84108

Employer Identification Number:
870403206

Plan Number:
12002105

Type of Plan:
Group Health Plan providing coverage for dental benefits.

Type of Administration:
Contract administration: The processing of claims for benefits under the terms of the Plan is provided through Dental Select and shall hereinafter be referred to as the Claims Administrator.

Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent For Service of Legal Process:
ARUP Laboratories
500 Chipeta Way
Salt Lake City, UT 84108

Eligibility Requirements:
For detailed information regarding a person's eligibility to participate in the Plan***,*** refer to the following sections:
Eligibility, Enrollment, Effective Date

Schedule of Benefits:
Eligible, enrolled Employees and Dependents are covered for the benefits under this Plan. Refer to the section entitled, Schedule of Benefits. The Schedule of Benefits will list all applicable maximum benefits; the extent to which preventive services are covered under the Plan; whether, and under what circumstances, coverage is provided for dental services and procedures.

Employee/ Dependent Contributions:
Employee and Dependent coverage is 100% paid by the Employer***.***

Employee/Dependent Cost Sharing:
All covered expenses are subject to applicable Plan provisions including, but not limited to: deductible, coinsurance and maximum benefit provisions as shown in the Schedule of Benefits, unless otherwise indicated. Any expenses incurred by the covered person for services, supplies or treatment provided will not be considered covered expenses by this Plan if they are greater than the customary and reasonable amount for nonpreferred providers.

Provider Network:
The Plan uses a Preferred Provider Organization. A preferred provider is a provider which has an agreement in effect with the Preferred Provider Organization (PPO) to accept a reduced rate for services rendered to covered persons. This is known as the negotiated rate. The preferred provider cannot bill the covered person for any amount in excess of the negotiated rate. Covered persons should contact the Employer for a current listing of preferred providers. This PPO listing is provided at no charge.

Under the Plan, covered persons have the choice of using either a preferred provider or a non-preferred provider. Because the covered person and the Plan save money when services, supplies or treatment are obtained from providers participating in the Preferred Provider Organization, benefits are usually greater than those available when using the services of a non-preferred provider. Refer to the section entitled, *Schedule of Benefits.*

Loss of Benefits:
For detailed information regarding a person being ineligible for benefits through reaching maximum benefit levels, reduction in benefits, or termination of coverage, refer to the following sections:
Schedule of Benefits, Termination of Coverage, Exclusions

Third Party Liability Reimbursement/Subrogation:
The Covered Person may incur dental charges due to injuries which may be caused by the act or omission of a third party or a third party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that third party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to recover payments from any third party or insurer. This subrogation right allows the Plan to pursue any claim which the Covered Person has against any third party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the third party or insurer, but in any event, the Plan has a lien on any amount recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:
(1) automatically assigns to the Plan his or her rights against any third party or insurer when this provision applies; and
(2) must repay to the Plan the benefits paid on his or her behalf out of the recovery made from the third party or insurer.

Plan Termination:
The Employer reserves the right to terminate the Plan, in whole or in part, at any time. Upon termination, the rights of the Covered Persons to benefits are limited to claims incurred up to the date of termination. Any termination of the Plan will be communicated to the Covered Persons.

Upon termination of this Plan, all claims incurred prior to termination, but not submitted to either the employer or Claims Administrator within three (3) months of the effective date of termination of this Plan, will be excluded from any benefit consideration.

The allocation and disposition of any assets of the Plan upon termination of the Plan shall include appropriate payment of Plan expenditures including administrative fees and covered expenses for covered persons.

Plan Modification/Amendment:
The Employer may modify or amend the Plan from time to time at its sole discretion, and such amendments or modifications which affect Covered Persons will be communicated to the Covered Persons within sixty (60) days after the adoption of the amendment. Any such amendments shall be in writing, setting forth the modified provisions of the Plan, the effective date of the modifications, and shall be signed by the Employer's designee. Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan on file with the Employer, or a written copy thereof shall be deposited with such master copy of the Plan.

Continuation of Coverage (COBRA) Information:
Once coverage under the Plan becomes effective for Employees and their Dependents, those individuals have the right to continue coverage under the Plan should loss of coverage occur due to specified reasons. This period of continuation of coverage has specified time limitations, depending upon the reason for loss of coverage. Employees and Dependents who elect continuation of coverage under this provision are responsible for payment of the full costs of the Plan, including a two percent (2%) administration charge. For detailed information concerning continuation of coverage, refer to the section entitled, Continuation of Coverage.

Source of Plan Contributions:
Contributions for the Plan expenses are derived solely from the employer.

Funding Method:
The employer pays Plan benefits and administration expenses directly from general assets. Contributions received from covered persons are used to cover Plan costs and are expended immediately.

Ending Date of Plan Year:
December 31

Procedures for Filing Claims:
The following is intended to provide a general overview of the procedures for filing a claim, providing notice of benefit determinations, and appealing denied claims. For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled, *Claim Filing Procedures.* The designated Claims Administrator is:

Dental Select
5373 S Green Street, 4th Floor
Salt Lake City, UT 84123
800-999-9789

General Requirements:
(1) The Plan may not have any provision that unduly inhibits or hampers claims filing or processing.
(2) The Plan may not prohibit an authorized representative from acting on behalf of a Covered Person.
(3) The Plan must have administrative processes and safeguards to ensure that claim decisions are made based upon plan documents and have been consistently applied for similarly situated individuals.
(4) Upon a Covered Person's request after a claim denial, the Plan must provide any relevant information verifying that it compiled with its procedures.

Specific Requirements:

(1) Timing of Notification of Benefit Determination The covered person shall be notified of the Plan's benefit determination on review as follows:

   a. Pre-service Claims: The Plan must make a benefit determination within fifteen (15) days after receipt of request from a covered person. This time period maybe extended for another fifteen (15) days if it is necessary because of matters beyond the Plan's control, and if the Plan notifies the covered person of those circumstances and the expected date of the decision before the end of the first fifteen (15) day period.
   b. Concurrent Care Claims: When a covered person requests extension of an on-going course of treatment beyond that which the Plan has approved, the Plan must make a decision regarding the extension within twenty-four (24) hours after receipt of the request and notify the covered person of the decision, provided the request for the extension was made at least twenty-four (24) hours before the end of the treatment which was already approved.
   c. Post-service Claims: The Plan shall notify the covered person of an adverse benefit determination not more than thirty (30) days after receipt of the claim by the Plan. This time period may be extended for fifteen (15) days if it necessary because of matters beyond the Plan's control, and if the Plan notifies the covered person of those circumstances and the expected date of decision before the end of the thirty (30) day period. This Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. The Employee will be allowed up to forty-five (45) calendar days from receipt of the Notice of Extension to provide the additional information. The Plan will then make a claim determination within a reasonable period but not later than fifteen (15) calendar days from the date the Plan receives the additional information.

(2) Appeals. The Plan may not require a covered person to file more than two (2) appeals before he is able to file a lawsuit under ERISA.

a. Pre-service Claims (precertification): If certification of medical necessity is denied and the Covered Person appeals the denial, the Plan must render a review decision within thirty (30) days after receiving the appeal. If the Plan provided for two (2) levels of review, both appeals must be decided within that thirty (30) day time period, and one must be decided within fifteen (15) days after receipt of the appeal. The Covered Person has 180 days to appeal a denial.
b. Concurrent Care Claims: If the Plan has approved an on-going course of treatment, and then determines that such treatment should be reduced or terminated, the Plan must notify the Covered Person of this decision far enough in advance of the reduction or termination to allow the Covered Person to appeal the decision and obtain a review before the reduction or termination takes effect. This does not apply to an amendment or termination of the Plan.
c. Post-service Claims: If a claim for benefits is denied by the Plan and the Covered Person appeals the denial, the Plan must render a review decision within sixty (60) days after receiving the appeal. If the Plan provide for two levels of review, both appeals must be decided within the sixty (60) day time period, and one must be decided within thirty (30) days following receipt of the appeal. The Covered Person has 180 days to appeal a claim denial.

PLAN EFFECTIVE DATE: 01/01/2011
OPEN ENROLLMENT: November

Statement of ERISA Rights:
Participants in the Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

1. 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, 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.
2. 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 summary plan description. The Plan Administrator may make a reasonable charge for the copies.
3. 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.
4. Continue health care coverage for the participant, the participant's Spouse, Domestic Partner or Dependents if there is a loss of coverage under the Plan as the result of a qualifying event. The participant or Dependent may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.
5. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan**,** if the participant or Dependent has creditable coverage from another plan. The participant or Dependent should be provided a certificate of creditable coverage, free of charge, from the group health plan or health insurance issuer when coverage under the plan is lost, when the participant or Dependent becomes entitled to elect COBRA continuation coverage; when COBRA continuation coverage ceases; if a certificate is requested before losing coverage; or if a certificate is requested within twenty-four (24) months after losing coverage. Without evidence of creditable coverage, the participant or Dependent may be subject to a preexisting condition exclusion for twelve (12) months (eighteen (18) months for a late enrollee) after the enrollment date for coverage.

In addition to creating rights for Employee or Dependents, 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 all Employee or Dependents. No one, including the employer**,** a union, or any other person, may fire an Employee or discriminate against an Employee to prevent the Employee from obtaining any benefit under the Plan or exercising the participants' rights under ERISA.

If claims for benefits under the Plan are denied or ignored, in whole or in part, the participant has 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 participants can take to enforce the rights. For instance, if material is requested from the Plan and the material is not received within thirty (30) days, the participant may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay the participant up to $110 a day until the materials are received, unless the materials were not provided for reasons beyond the control of the Plan Administrator**.** If a claim for benefits is denied or ignored, in whole or in part, the participant may file suit in a state or federal court. In addition, if the participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if participants are discriminated against for asserting these rights, participants may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court. The court will decide who will pay the costs and legal fees. If the participant is successful, the court may order the person who is sued to pay these costs and fees. If the participant loses, the court may order the participant to pay the costs and fees; for example, if it finds the participant's claim frivolous.

Participants should contact the Plan Administrator for questions about the Plan**.** For questions about this statement or about rights under ERISA, or if the participant needs assistance in obtaining documents from the Plan Administrator, participants should contact the nearest office of the Pension and Welfare Benefits 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. Participants may also obtain certain publications about these rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

BY THIS AGREEMENT, ARUP Laboratories Employee Dental Plan Dental Plus Platinum Indemnity Co-insurance is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for ARUP Laboratories on or as of the day and year first below written.

_____
Signature of Company Official

_____
Printed Name and Title

_____
Date

_____
Witness

_____
Printed Name and Title

_____
Date