



INDIVIDUAL EPO PLANS

PLAN DOCUMENT

University of Utah Health Plans

PO Box 45180 www.uhealthplan.utah.edu

Salt Lake City, UT 84145

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(833) 981-0214

Care Management (801) 213-4111, Option 2 or
(833) 981-0214, Option 2

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SECTION 1 – INTRODUCTION AND OVERVIEW

Introduction

As You read this Policy, 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 terms “We,” “Us” and “Our” refer to University of Utah Health Plans and the term “Policyholder” means a person who is enrolled for coverage under a University of Utah Health Plans health insurance Policy, and whose name appears on the records of University of Utah Health Plans as the individual to whom this Policy was issued. Policyholder does not mean a dependent under this Policy. Other terms are defined in the Definitions Section at the back of this Policy or where they are first used.

Policy

This Policy describes benefits effective January 1, 2019, for the Policyholder and Enrolled Dependents. This Policy provides the evidence and a description of the terms and benefits of coverage.

University of Utah Health Plans agrees to provide benefits for Medically Necessary services as described in this Policy, subject to all of the terms, conditions, exclusions and limitations in this Policy, including endorsements affixed hereto. This agreement is in consideration of the premium payments hereinafter stipulated and in further consideration of the application and statements currently on file with Us and signed by the Policyholder for and on behalf of the Policyholder and/or any Enrolled Dependents listed in this Policy, which are hereby referred to and made a part of this Policy.

Guaranteed Issue and Renewability of Policy

This Policy is issued on a guaranteed basis and is renewable at the option of the Policyholder upon payment of the monthly premium when due or within the grace period, except in cases of intentional misrepresentation of material fact or fraud in connection with the coverage, Our decision to cease offering this Policy to individual Policyholders, or Our decision to cease offering coverage in the individual market. No modification or amendment will be effective until 30 days (or longer, as required by law) after written notice has been given to the Policyholder (except for modification of premium, which shall not be effective until 45 days after written notice has been given to the Policyholder), and modification must be uniform within the product line and at the time of renewal. .

Examination of Policy

If, after examination of this Policy, the Policyholder is not satisfied for any reason with this Policy, the Policyholder will be entitled to return this Policy within 10 days after its delivery date. If the Policyholder returns this Policy to Us within the stipulated 10-day period, such Policy will be considered void as of the original Effective Date and the Policyholder generally will receive a refund of premiums paid, if any. (If benefits already paid under this Policy exceed the premiums paid by the Policyholder, We will be entitled to retain the premiums paid and the Policyholder will be required to repay Us for the amount of benefits paid in excess of premiums).

Open Enrollment Period

The open enrollment period is the period of time, as designated by law, during which You and/or Your eligible dependents may enroll.

Using Your Policy

The University of Utah Health Plan offers the medical plan described in this Policy. 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 Health Plans Customer Service Department or visit Our website at www.uhealthplan.utah.edu.

You Select Your Provider

University of Utah Health Plans allows You to select your own providers. You are not required to have a referral to see any provider, including a specialist.

- **In-Network Provider.** When You choose to see an In-Network Provider, You will receive the highest level of benefits and will not be billed for balances on Covered Services beyond any Copayment, Deductible, and/or Coinsurance.
- **Out-of-Network Provider.** Services obtained from an Out-of-Network Provider are not covered by your plan unless they are associated with a medical emergency. When You see an Out-of-Network Provider, You are responsible to pay 100% of the charges. Medical emergencies will be paid at the In-Network rate, the out of network provider may bill you the remaining balance. Any services, except emergencies, provided outside of the United States are not covered. Any services outside of the State, except emergencies, are not covered. (Out-of-Network Residential Treatment Centers (RTC) must meet Accreditation requirements as outlined in the UUHP Provider Manual.)
- **Rural Health Care Providers.** You may be entitled to coverage for health care services from non-contracted providers if you live or reside within 30 paved road miles of an independent hospital, federally qualified health center, or a credentialed staff member at an independent hospital, federally qualified health center, or at his/her local practice location. If you have questions concerning your rights to see one of these providers, you may contact University of Utah Health Plans at (801) 587-6480 or (888) 271-5870. If we do not resolve your problem, you may contact the Office of Consumer Health Assistance in the Insurance Department, toll free.

For each benefit in this Policy, Your payment amount for In-Network and Out-of-Network Providers is indicated. You can go to www.uhealthplan.utah.edu for additional Provider network information and to find In-Network Providers. All claims submitted by both In-Network and Out-of-Network Providers must be submitted in a format approved by UUHP. Submitted claims must meet UUHP's claims editing requirements (including National Correct Coding Initiative guidelines/edits adopted by UUHP) in order to be processed for payment.

Guidance and service along the way

This Policy 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 Our 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.
- **Primary Care Physician (PCP).** You are not required to select a PCP, but we highly recommend it. A PCP will work to treat your overall health and make sure you get the care you need. The following types of doctors may be selected as your PCP:
 - Family Practice (for all ages)
 - Internal Medicine (for adults)
 - Pediatrics (for children)
 - Obstetrics and Gynecology (OB/GYN – for women)

A PCP will:

- See you for routine check-ups
- Treat you when you are sick or injured
- Refer you to a specialist, if needed (you are not required to have a referral from your PCP to see a specialist)
- Approve all non-emergency hospital stays
- Be your contact if you need care after office hours (except emergencies)
- Work with our Care Management team to help you manage your health care in the best way possible.

If you would like help finding a PCP in your area, call Member Services at (801) 587-6480 or (888) 271-5870, Option 1.

- **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.
- **Prior Authorization.** The Plan requires prior authorization for inpatient services and select outpatient services excluding emergencies and maternity services. U of U Health Plans will notify you of the benefit decision related to the prior authorization request within 15 days of receipt of request for care. If we are unable to make a decision within that time frame we will notify you of a request for an additional 15 days. In case of urgent care, we will notify you no later than 72 hours. All services, not limited to only inpatient services, must meet standards of medical necessity, and we reserve the right to review any and all services to ensure these standards are met. Providers are encouraged to submit a pre-service review if they are unsure whether the service meets the standards of medical necessity. As outlined in the Prescription Drug Benefits section of this policy some prescription drugs also require prior authorization. In addition, any prescription drug \$1,000 or more requires prior authorization. Please refer to the Rx Information web page for more information.
- **Claims Processing.** The plan will process your claims and notify you of the benefit determination within 30 days of receipt of the claim.

SECTION 2 – 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.

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

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.

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).

SECTION 3 – DEFINITIONS

The following are key words used in this Policy. When they are used, they are capitalized. Also, some terms are capitalized and described within the Summary of Benefits and Coverage (SBC), or the provisions in which they appear in this Policy.

Accident means an unexpected traumatic incident or unusual strain which: (1) is identified by time and place or occurrence; (2) is identifiable by part of the body affected; (3) results in a bodily Injury Accident and does not mean an unintentional accident caused by or during medical treatment or surgery for an Illness or Injury.

Allowed Amount is the maximum amount the Plan will pay for a covered health service. For Participating or In-Network Providers, the Allowed Amount is based on the contract the provider has with the Plan. For Out-of-Network Providers, the Allowed Amount is based on UCR (Usual, Reasonable and Customary) rates.

Annual Out-of-Pocket Maximum means the maximum amount that the Covered Person must pay every Calendar Year for Covered Medical Expenses incurred for Covered Benefits. The Annual Out-of-Pocket Maximum, if any, is shown in the SBC. Unless otherwise specified, it applies to all Covered Benefits except the Preventive Health Care Services Benefit.

The Annual Out-of-Pocket Maximum includes the following:

1. Calendar Year Deductible
2. Copayments
3. Coinsurance
4. Prescription deductible, copayments or coinsurance

When the Annual Out-of-Pocket Maximum is satisfied in the Calendar Year, We will then pay 100% of Covered Medical Expenses incurred for Covered Benefits for the remainder of that Calendar Year. The Annual Out-of-Pocket Maximum must be satisfied each Calendar Year. Prescription drug brand-generic fees do not apply to the Out-of-Pocket Maximum.

Family Limit for the Annual Out-of-Pocket Maximum

The Family Annual Out-of-Pocket Maximum will be satisfied in the Calendar Year when the total out-of-pocket expenses incurred by one or more insured family members equal the Family Annual Out-of-Pocket Maximum. The Family Annual Out-of-Pocket Maximum has to be met each Calendar Year.

Behavioral Health: Services provided by a psychiatrist, psychologist, licensed clinical social worker and/or therapist for mental health related conditions. Outpatient therapy and treatment does not require prior-authorization. Inpatient admissions for a behavioral health diagnosis requires prior authorization for determination of medical necessity.

Coinsurance means the percentage of the Maximum Allowable Fee payable by the Covered Person for Covered Medical Expenses incurred for Covered Benefits. After the Covered Person satisfies the Annual Out-of-Pocket Maximum during the Calendar Year, We will then pay 100% of Covered Medical Expenses incurred for Covered Benefits for the remainder of that Calendar Year. The Coinsurance amount is shown in the SBC.

Complications of Pregnancy means diseases or conditions which are distinct from pregnancy but are adversely affected or caused by pregnancy. These complications include acute nephritis, nephrosis, cardiac decompensation, ectopic pregnancy which is terminated, a spontaneous termination of pregnancy when a viable birth is not possible, puerperal infection, eclampsia, pre-eclampsia and toxemia. This definition does not include false labor, occasional spotting, doctor prescribed rest during the period of

pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy.

Copay or Copayment means a fixed dollar amount the Covered Person is required to pay for specifically listed Covered Benefits as shown in the SBC. The required Copayment must be paid before benefits are payable under this Policy. Copayments are generally paid to the Provider at time of service.

Convalescent Home means an institution, or distinct part of such institution, other than a Hospital, which is licensed pursuant to state or local law. A Convalescent Home is: (1) a Skilled Nursing Facility; (b) an Extended Care Facility; (3) an Extended Care Unit; or (4) a Transitional Care Unit. A Convalescent Home is primarily engaged in providing:

1. Continuous nursing care services;
2. Health-related services; and
3. Social services.

Such Convalescent Home services must be provided by or under the direction and supervision of a licensed registered nurse, on a 24-hour basis, for Ill or Injured persons during the convalescent state of their Illness or Injuries. A Convalescent Home is not, other than incidentally: (1) a rest home; (2) a home for custodial care; or (3) a home for the aged.

Cosmetic Surgery means any surgical procedure performed primarily to improve physical appearance.

Covered Benefits means all services covered under this Policy. Covered Benefits are payable as shown in the SBC.

Covered Dependent means the Policyowner's spouse or Domestic Partner and any Dependent Children (as defined in this Policy) who are insured under this Policy. A Covered Dependent must be listed on the application for this Policy and approved by Us. The required premium for the Covered Dependent's coverage under this Policy must be paid to Us.

Covered Medical Expense means expenses incurred for Medically Necessary services, supplies, and medications that are:

1. Based on the Maximum Allowable Fee;
2. Covered under this Policy;
3. Provided to the Covered Person for the diagnosis or treatment of an active Illness or Injury or maternity care. In the event We do cancel or do not renew this policy, there will be an extension of pregnancy benefits for a pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force, unless (a) You do not pay the required premiums, or (b) You perform an act or practice that constitutes fraud or make an intentional misrepresentation of material fact under the terms of coverage of this policy.
4. Preventive Care

The Covered Person must be charged for such services, supplies and medications.

Covered Person means the Policyowner and/or his or her Covered Dependents.

Custodial Care Services provided primarily to maintain rather than improve a Member's condition or for the purpose of controlling or changing the Member's environment. Services requested for the convenience of the Member or the Member's family that do not require the training and technical skills of a licensed Nurse or other licensed Provider, such as convalescent care, rest cures, nursing home services, etc. Services that are provided principally for personal hygiene or for assistance in daily activities.

Deductible means the fixed dollar amount of Covered Medical Expenses that the Covered Person must incur for certain Covered Benefits before We begin paying benefits for them. The Deductible must be satisfied each Calendar Year by each Covered Person, except as provided under “*Family Deductible Limit*” provision. The Deductible is shown in the SBC. Only the Maximum Allowable Fee for Covered Medical Expenses is applied to the Deductible. Prescription drug brand-generic fees do not apply to the Deductible.

Family Deductible

Each individual deductible of the insured family members is embedded in the Family Deductible. The Family Deductible will be satisfied during the Calendar Year when the total expenses paid by one or more toward each Individual Deductible equals the Family Deductible.

Dependent means Your:

1. Lawful spouse or Domestic Partner; and
2. Dependent Child as defined in this Policy.

Dependent Child or Dependent Children means Your children who are:

1. Under the age of 26, regardless of their place of residence, or student status; including: (a) newborn children; (b) stepchildren; (c) legally adopted children; (d) children with a court or administrative order indicating the Policyowner must provide coverage; (e) children placed for adoption with the Policyowner in accordance with applicable state or federal law; and
2. Unmarried dependent Handicap Children age 26 and over. Refer to the definition of *Handicapped Child*.

A Dependent Child does not include a child who is enrolled for Medicare.

Domestic Partner means a person with whom You have entered into a Civil Union in accordance with state law where You reside, or into a Domestic Partnership.

Domestic Partnership or Civil Union means a long-term committed relationship of indefinite duration with a person which meets the following criteria:

1. You and Your Domestic Partner have lived together for at least 12 months;
2. Neither You nor Your Domestic Partner is married to anyone else or has another domestic partner;
3. Your Domestic Partner is at least 18 years of age;
4. Your Domestic Partner resides with You and intends to do so indefinitely;
5. You and Your Domestic Partner have an exclusive mutual commitment that is intended to be permanent;
6. You and Your Domestic Partner are jointly responsible for each other’s common welfare and share financial obligations; and
7. You and Your Domestic Partner meet the requirements for a Domestic Partnership or Civil Union in the state where You reside, if any.

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

1. Placing the Covered Person’s health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Care Services means health care items or services furnished or required to evaluate and treat an Emergency Medical Condition. Such emergency care services must be provided by or ordered by a licensed health care provider in a Hospital's emergency room.

If you are in a Nonparticipating Facility, once the Emergency Condition has been stabilized, you may be asked to transfer to a Participating Facility in order to continue receiving Participating Benefits.

Essential Health Benefits or EHB means a standardized set of essential health benefits that are required to be offered by University Health Plans to You and/or Your Dependents, as determined by the Affordable Care Act. Essential Health Benefits have no lifetime limits and cover at least the following 10 categories of benefits:

- Ambulatory patient care
- Emergency services
- Hospitalization
- Maternity and newborn care, including pediatric vaccinations and dietary products for inborn errors of amino acid or urea cycle metabolism
- Mental health and substance use disorder services, including behavioral health treatment and catastrophic coverage of mental health conditions
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including dental* and vision care for Members under the age of 19

*Pediatric dental services can be separately provided through a stand-alone dental plan that is certified by the Marketplace.

Experimental Treatment means medical treatment, services, supplies, medications, drugs, or other methods of therapy of medical practices, which are not accepted as a valid course of treatment by the Utah Medical Association, the U.S. Food and Drug Administration, the American Medical Association, or the Surgeon General.

Family Coverage means coverage for: (1) You; and (2) Your spouse or Domestic Partner; and/or (3) one or more Dependent Children.

Handicapped Child means a child who is 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 chiefly dependent upon You for support and maintenance since the child reached age 26 with a break in coverage of not more than 63 days.

Health Insurance Marketplace (Exchange) means: (1) a State-based Exchange; (2) a Federally-Facilitated Exchange; or (3) an Exchange in partnership with the federal Department of Health and Human Services through which qualified consumers can compare and purchase insurance from insurance companies.

Home Health Agency means a public agency or private organization or subdivision of the agency or organization that is engaged in providing home health services to individuals in the places where they live. Home health agencies must be licensed and operating in the scope of such license. Services may include additional support services.

Home Infusion Therapy Agency means a health care facility that provides home infusion therapy services.

Home Infusion Therapy Services means the preparation, administration, or furnishing of parenteral medications or parenteral or enteral nutritional services to an individual in that individual's residence. The

services include an educational component for the patient, the patient's caregiver, or the patient's family member.

Hospice means a program of care for the terminally ill and their families which occurs in a home or in a health care facility and which provides medical, palliative, psychological, spiritual, or supportive care and treatment and is licensed and operating within the scope of such license.

Hospital is a facility that is licensed by the state in which Services are provided that is legally operated for the medical care and treatment of sick or injured individuals.

A Facility that is licensed and operating within the scope of such license, which:

- a. Operates primarily for the admission, acute care, and treatment of injured or sick persons as inpatients;
- b. Has a 24-hour-a-day nursing service by or under the supervision of a graduate registered Nurse (R.N.) or a license practical Nurse (L.P.N.);
- c. Has a staff of one or more licensed Physicians available at all times; and
- d. Provides organized facilities for diagnosis and surgery either on its premises or in facilities available to the Hospital on a contractual prearranged basis.

Hospital Stay means the time period, in days, in which the Covered Person is hospitalized. Hospital stays must be ordered by the Physician and be Medically Necessary.

Illness means any sickness, infection, disease or any other abnormal physical condition which is not caused by an Injury. Illness includes pregnancy, childbirth and related medical conditions.

Indian has the same meaning as defined by Section 4 of the Indian Health Care Improvement Act.

Indian Services mean services for Covered Benefits that are provided directly by:

1. An Indian Health Service;
2. An Indian Tribe;
3. A Tribal Organization;
4. An Urban Indian Organization; or
5. Services provided through referral under contract health services;

YOU WILL BE RESPONSIBLE FOR COST SHARING UNDER THIS PLAN FOR ANY COVERED SERVICES NOT PROVIDED BY A PARTICIPATING TRIBAL HEALTH PROVIDER.

Indian Tribe means any Indian:

1. Tribe;
2. Band;
3. Nation; or
4. Other organized group or community, including:
 - a. Any Alaska Native village; or
 - b. Any regional or village corporation;

as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688; 43 U.S.C. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Injury means physical damage to the Covered Person's body, caused directly and independently of all other causes. An Injury is not caused by an Illness, disease or bodily infirmity.

Inpatient or Inpatient Care means care and treatment provided to a Covered Person who has been admitted to a facility as a registered patient and who is receiving services, supplies and medications under the direction of a Participating Provider with staff and privileges at the facility. Such facilities include:

1. Hospitals;
2. Transitional care units;
3. Skilled nursing facilities;
4. Convalescent homes; or
5. Freestanding inpatient facilities.

Such facilities must be licensed or certified by appropriate State and Federal authorities.

Investigational/Experimental Service means surgical procedures or medical procedures, supplies, devices, or drugs which at the time provided, or sought to be provided, are in Our judgment not recognized as conforming to accepted medical practice or the procedure, drug, or device:

1. Has not received the required final approval to market from appropriate government bodies;
Is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes;
2. Is not demonstrated to be as beneficial as established alternatives;
3. Has not been demonstrated to improve the net health outcomes; or
4. Is one in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

Major/Minor Diagnostic Tests means diagnostic testing used to establish or monitor a disease or condition in an individual based on several considerations such as the invasiveness and complexity of the test, the level of expertise required to interpret or perform the test, and where the test is commonly performed. Examples of common major diagnostic tests (not intended to be an inclusive list) are:

1. Cardiac nuclear studies or cardiovascular procedures such as coronary angiograms;
2. Gene-based testing and genetic testing;
3. Imaging studies such as MRIs, CT scans, and PET scans; and
4. Neurologic studies such as EEG's, EMG's, and nerve conduction studies

Anything not defined as major is considered a minor diagnostic

Major/Minor Surgery means Major surgery incorporates several aspects of the surgical procedures including the complexity of the surgery, the requirement for special training of the surgeon to adequately perform the procedure, the need for an assistant or co-surgeon, the requirement for use of general anesthesia or close monitoring by anesthesia specialist due to the nature of the procedure, invasiveness of the procedure including entry into a major body cavity such as abdomen chest or skull, the probability of the procedure requiring a period of inpatient hospitalization and the risk of the procedure to the member. Examples of major surgery include (not intended to be a complete list):

1. Open or closed intra-Abdominal surgery such as removal of the gallbladder or appendix, hysterectomy, c-section delivery
2. Any intracranial procedure either open or closed
3. Joint replacement surgery or arthroscopic surgery
4. Heart surgery including transcatheter valve replacements

5. Upper or Lower Endoscopic procedures
6. Cardiac catheterization procedures such as stent placement or ablations for heart rhythm disturbances

Maximum Allowable Fee means the maximum amount that a Participating Provider agrees contractually to accept as full payment for providing services for Covered Benefits under this Policy.

Medical Prescription Drugs means prescription drugs that are covered under the medical benefit. Medical Prescription drugs with anticipated costs over \$1,000 require prior authorization. For a list of medical drugs that require prior authorization or that are not covered, please refer to the Plan website at <http://uhealthplan.utah.edu/individual/pharmacy.php>.

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, injury, disease or its symptoms in a manner that is:

1. in accordance with generally accepted standards of medical practice in the United States;
2. clinically appropriate in terms of type, frequency, extent, site, and duration;
3. not primarily for the convenience of the patient, physician, or other health care provider; and covered under the contract;
5. not more costly than an alternative drug, service(s), or supply that is at least as likely to produce equivalent therapeutic or diagnostic results to the diagnosis, injury, disease, or symptoms.

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 known to be effective. For interventions not yet in widespread use, the effectiveness shall be based on scientific evidence. For established interventions, the effectiveness shall be based on:

1. scientific evidence;
2. professional standards; and
3. expert opinion.

Medical Policy means the utilization review management guidelines used for this Policy. The guidelines are used to determine if health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:

1. Final approval from the appropriate governmental regulatory agencies;
2. Scientific studies showing conclusive evidence of improved net health outcome; and
3. In accordance with any established standards of good medical practice.

Medicare means the "Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended."

Out-of-Network Provider means a Physician, Facility or Other Provider that does not have an active contract to provide services to Covered Persons under this Policy.

Out-of-Pocket Maximum is the maximum you pay for your pharmacy and medical costs out-of-pocket. Once you have met your Out-of-Pocket Maximum your prescriptions are covered at 100%. Refer to your Summary of Benefits and Coverage for more information.

Outpatient means treatment or services that are provided when the Covered Person is not confined as a bed patient in a Covered Facility. This includes outpatient treatment at a Covered Facility as well as visits to a Physician or other Participating Providers.

Participating or In-Network Provider means a Physician, Facility or Other Provider that has an active contract with the Network to provide services to Covered Persons under this Policy.

Pediatric Services

Means coverage will be provided for Pediatric services as mandated by the federal Affordable Care Act.

Physician means a person licensed to practice medicine in the state where the service is provided. A Physician is a Participating Provider if he or she has an active contract with the Network to provide services to Covered Persons under this Policy. A Physician is a Non-Participating Provider if he or she does not have an active contract with the Network to provide services to Covered Persons under this Policy. The Covered Person should check to make sure that the Physician is a Participating Provider when seeking medical services.

Physician Specialist means a Physician who: (1) has obtained advanced training in various areas of a medical specialty; and (2) is board-certified in that specialty. Physician Specialists include, but are not limited to: (1) Anesthesiologists; (2) Dermatologists; (3) Ophthalmologists; (4) Orthopedic Surgeons; (5) Psychiatrists; (6) Radiation Oncologists; and (7) Surgeons. Physician Specialist does not include: (1) a Family Practice Physician; (2) an Internal Medicine Physician; (3) an obstetrician; or (4) a gynecologist. Services by a Physician Specialist are covered under this Policy.

Policy Effective Date means the date on which this Policy becomes effective. The Policy Effective Date is shown in the Application which You completed.

Post-service Appeal means an appeal which has been submitted after medical services have been rendered.

Pre-service Appeal means an appeal which has been submitted before medical services have been rendered.

Primary Care Physician means a provider who is acting within the scope of his or her license. A Primary Care Physician includes the following providers: (1) Family Practice (FP); (2) Internal Medicine (IM); (3) Pediatrician (MD); Obstetrics and Gynecology (OBGYN); (4) Gynecologist (GYN); (5) Geriatrician (MD); (6) Osteopath (DO); and (7) other providers performing services for Covered Persons in connection with the services provided by preceding specified providers, listed in (1) through (6), including: (a) Registered Nurse (RN); (b) Advanced Practical Registered Nurse (APRN); (c) Nurse Practitioner (NP); (d) Certified Nurse Midwife (CNM); and (e) Physician's Assistant (PA).

Provider means a licensed practitioner of the healing arts acting within the scope of the Provider's practice for the treatment of any illness, injury, or condition by any licensed class of health care providers when the treatment is within the scope of the licensee's practice and the illness, injury, or condition which falls within the coverage of the contract.

The Provider is a Participating Provider only if the Provider is actively contracted as a Participating Provider with the Network.

Skilled Nursing Facility means an institution, or distinct part thereof, that is licensed pursuant to state law and is operated primarily for the purpose of providing skilled nursing care for individuals recovering from Illness or Injury as an Inpatient, and:

1. Has organized facilities for medical treatment and provides 24-hour nursing service under the full time supervision of a Physician or a graduate registered nurse;
2. Maintains daily clinical records on each patient and has available the services of a Physician under an established agreement;
3. Provides appropriate methods for dispensing and administering drugs and medicines; and
4. Has transfer arrangements with one or more Hospitals, a utilization review plan in effect, and operation policies developed in conjunction with the advice of a professional group including at least one Provider.

Any institution that is, other than incidentally, a rest home, or a home for the aged, is not considered a Skilled Nursing Facility. Limited to 30 days per year.

Substance Use Treatment: Services provided by trained specialists in Addiction or Behavioral Health Services to provide necessary guidance and treatment. Residential Treatment or inpatient admissions require prior authorization for review of medical necessity. Residential treatment centers must meet Accreditation requirements as outlined in the U of U Health Plans Provider Manual. Residential and Partial Day Programs have a limit of 30 days combined benefit per calendar year. Detox services must take place at an Acute Care Hospital ONLY. Detox care does not apply to the 30 day benefit limit.

Surgery or Surgical Procedure means manual procedures that: (a) involve cutting of body tissue; (b) debridement or permanent joining of body tissue for repair of wounds; (c) treatment of fractured bones or dislocated joints; (d) endoscopic procedures; (e) general anesthesia; (f) electrocauterizing; (g) tapping (paracentesis); (h) applying plaster casts; (i) administering pneumothorax; or (j) endoscopy; tapping and (e) other manual procedures when used in lieu of cutting for purposes of removal, destruction or repair of body tissue.

Treatment means medical care, services or treatment or course of treatment which is ordered, prescribed and/or provided by a Physician to diagnose or treat an Injury or Illness, including:

1. Confinement, Inpatient or Outpatient services or procedures; and
2. Drugs, supplies, equipment, or devices.

The fact that a Treatment was ordered or provided by a Physician does not, of itself, mean that the Treatment will be determined to be Medically Necessary.

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.

SECTION 4 - WHO CAN BE COVERED UNDER THIS POLICY

Who is the Covered Policyowner?

The person in whose name this Policy is issued is the Policyowner. The Policyowner is covered under this Policy unless the Policyowner elected Dependent Coverage Only for his or her eligible Dependent Children who are minors as defined by state law.

If, after coverage is effective under this Policy, the Policyowner is called to active duty in the military:

1. This Policy will terminate if only the Policyowner is covered under this Policy at the time the Policyowner is called to active duty. The Policyowner must reapply for coverage when his or her active duty ceases; or
2. This Policy will remain in force if the Policyowner has Covered Dependents and the Covered Dependents remain insured under this Policy. Upon the Policyowner's return to civilian status, his or her coverage under this Policy will be reinstated.

Are Dependents of the Policyowner Covered?

If You, as the Policyowner, are enrolled for Family Coverage, the following Dependents may also be covered under this Policy:

1. Your spouse or Domestic Partner; and
2. Your eligible Dependent Children as defined in this policy.

Are Dependents in the Military Eligible for Coverage?

Dependents in military service are not eligible for coverage under this Policy. If a Covered Dependent is called to active duty, his or her coverage under this Policy will terminate on the date he or she departs for active duty. Upon his or her return to civilian status, the Dependent will be reinstated effective on the date his or her active military status ceases if: (1) this Policy is still in effect; and (2) the Dependent still meets the eligibility for coverage under this Policy. You must notify Us of these changes.

Are Medicare Eligible People Eligible for Coverage?

People who are eligible for Medicare are not eligible for coverage.

SECTION 5 - WHEN COVERAGE BEGINS AND ENDS

When Coverage Begins

What is the Effective Date of Coverage?

1. You, the Policyowner, are covered under this Policy upon Our receipt of Your application and remittance of the required premium payment. Your effective date of coverage is the same as the Policy Effective Date shown in the Application which You filed.

2. Eligible Dependents are covered under this Policy as follows:

- a. On the date Your coverage is effective if they are included in Your application for this Policy;
- b. On the date the Dependent is eligible for coverage, meaning: (1) birth; (2) adoption (3) placement for adoption; (4) a marriage that results in the spouse or Domestic Partner and stepchildren being added to coverage; and (5) minor dependents required to be covered by court order or administrative order.

When May You Enroll for Coverage

You may enroll for coverage during the Enrollment Period set by CMS or the State, or during a special enrollment period, or outside of the open enrollment period because of a qualifying event as defined by the Health Insurance Portability and Accountability Act.

Coverage for Dependent Child Due to Court or Administrative Order

If a court or administrative order requires You to provide coverage for a Dependent Child, and the child is enrolled for coverage under this Policy on or after the Policy Effective Date, the following provisions will apply to the child's coverage.

We will not deny coverage for the child on the grounds that the child:

1. Was born out of wedlock and is entitled to coverage as a noncustodial parent;
2. Was born out of wedlock and the custodial parent seeks enrollment for the child under the custodial parent's policy;
3. Is not claimed as a dependent on the parent's federal tax return; or
4. Does not reside with the parent or within Our service area.

How do You Enroll Dependents After the Policy Effective Date?

If after the Policy Effective Date, You acquire a Dependent as a result of:

1. Marriage or the establishment of a Domestic Partnership;
2. Birth;
3. Placement for adoption; or
4. A court or administrative order;

The Dependent may be enrolled for coverage within the time period indicated below in the *Adding a Dependent Due to Marriage/Domestic Partnership*, *Adding a Dependent Child*, and *Adding a Dependent*

Due to Court or Administrative Order provisions or by Exchange Rules if this Policy is purchased on the Exchange.

Adding a Dependent Due to Marriage/Domestic Partnership:

If You have a new Dependent(s) due to marriage or the establishment of a Domestic Partnership, the effective date of coverage for the eligible Dependent(s) will be the first of the month following the event, provided We receive notification of the new Dependent(s) and approve the Dependent(s) for coverage under this Policy. You must notify Us within 60 days from the date of marriage or establishment of Domestic Partnership. If there is a change in premium, it will be included in the first billing date after the change, adjusted back to the effective month of the change.

Adding a Dependent Child Due to Birth or Placement for Adoption:

You must notify Us when You acquire a new Eligible Dependent Child due to:

1. Birth; or
2. Placement for adoption.

Provided you meet applicable premium payments and notification requirements described below, the effective date of coverage for the new Eligible Dependent will be:

1. The date of birth for a newborn natural child;
2. The date of birth for newborn adopted child if placement for adoption occurs within 30 days of birth; and
3. The date of Placement for an adopted child, if Placement for adoption occurs 30 days or more after the child's birth.

We must receive notification and payment of any required premium for the new Eligible Dependent Child within 30 days in order for coverage to be continued under this Policy.

With regard to an adopted child, coverage under this Policy will cease prior to end of the 30-day period if:

1. The Placement is disrupted prior to legal adoption; and
2. The child is removed from Placement.

"Placement for adoption" or "Placement" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child.

If your dependent has not been added to your plan during the special enrollment period you will receive a notice that claims will be denied. If no additional premium is due you have thirty (30) days from the date of this notice to add your dependent and have the claim denial reversed.

Adding a Dependent Child Due to Court or Administrative Order:

If a court or administrative order requires You to provide coverage for a Dependent Child, We must receive notification and any required premium for the child's coverage under this Policy within 30 days (or 60 days if purchased on the exchange) of the court or administrative order. Refer to "*Coverage for Dependent Child Due to Court or Administrative Order*" for an additional coverage details.

How Long Is Coverage Effective Under This Policy?

You may elect to continue this Policy or discontinue this Policy during an open enrollment period or due to a qualifying event. Coverage under this Policy will be continued if You elect to continue this Policy. If You elect to discontinue this Policy, provide a written notice 30 days in advance of the requested termination date.

When You are no longer eligible for coverage: This Policy will terminate on the first of the month following the date:

1. You enter active duty in the military service. However, if You retain coverage for Your Covered Dependents, this Policy will remain in force to insure Your Covered Dependents provided the required premiums continue to be paid;

2. Of Your death;
3. This Policy terminates for any other reason.

When Your Covered Dependents are no longer eligible for coverage under this Policy: The coverage for Your Covered Dependent will continue in force through the last day of the month in which he or she ceases to be a Covered Dependent. A Covered Dependent will cease to be a Covered Dependent upon the occurrence of any of the following events:

1. The Covered Dependent no longer meets the eligibility requirements specified in this Policy;
2. Your spouse is no longer an eligible Dependent as a result of a divorce decree or legal separation;
3. You and Your Domestic Partner are no longer in a Domestic Partnership relationship;
4. Your Dependent Child reaches his or her 26th birthday, except as provided for Handicapped Children;
5. Your Dependent enters active duty in the military;
6. Your death;
7. This Policy terminates.

No coverage will be available for a Covered Dependent upon attainment of the limiting age for a Covered Benefit specifying a limiting age for coverage under this Policy.

When May We Rescind this Policy?

If We find that You committed fraud or intentionally misrepresented material information on an application for this Policy within two (2) years from the Policy Effective Date, this Policy will be rescinded and will be considered as never having been in effect provided We give You 30 days prior notice. Any premiums paid for coverage for the ineligible person will be refunded minus any claims paid for that person. We are entitled to recover the claim amounts that exceed the amount of premium paid.

When Can We Terminate this Policy?

We will terminate this Policy at 12:01 a.m. local time at Your place of residence on the earliest of the following:

1. During any open enrollment period that the policy is not renewed;
2. If You fail to pay the required premium payment when due, subject to the Grace Period; or
3. If you obtained this Policy through fraudulent means;
4. For any other reason for termination of this Policy as specified in this Policy, provided We give You at least forty-five (45 days) prior written notice.

What Is Our Responsibility for Payment of Claims if this Policy Terminates?

We will only pay a claim for covered services which You received prior to the termination date of this Policy. We will not pay Covered Medical Expenses for Covered Benefits that are incurred after the date this Policy terminates for any reason.

SECTION 6 – PREMIUMS

When are Premiums Due?

All premium, any charges or fees for this Policy (hereinafter referred to as “premium”) must be paid to Us. The premium for this Policy is shown in the Application. If You do not pay premiums when due, this Policy will terminate subject to the *Grace Period*. The Premium Due Date is shown in the Application.

Grace Period

This Grace Period provision applies if you are NOT receiving any federal subsidies for this Policy.
After the first due premium payment, if a premium is not paid on or before the date it is due, it may be paid during the next thirty (30) days. These thirty (30) days are called the Grace Period. Coverage under this Policy will remain in force during the Grace Period. We may pend claims for services received during the grace period. If any premium is unpaid at the end of the Grace Period, this Policy will automatically terminate at the end of the Grace Period.

This Grace Period provision applies if you are receiving any federal subsidies for this Policy.

After the first due premium payment, if a premium is not paid on or before the date it is due, it may be paid during the next ninety (90) days. These ninety (90) days are called the Grace Period. Coverage under this Policy will remain in force during the Grace Period.

During the first month of a subsidy grace period, We will continue to pay claims incurred for Covered Medical and Prescription Expenses. During the second and third months of the Grace Period, We will suspend payment of any claims until We receive the past due premiums. Once the outstanding premium is paid We will automatically reprocess medical claims that may have been pended during the Grace Period. You will be responsible for contacting Your pharmacy to have Your pharmacy reverse and reprocess any claims for prescriptions filled during the second and third months of the Grace Period, If payment is not received for all outstanding premium by the end of the grace period, this Policy will be terminated effective at 12:01 a.m. on the first day of the second month of the three month grace period. You will be responsible for the cost of any health care services You receive after the last day of the first month of the grace period.

Can the Company Change the Premium Rates?

Subject to the rate requirements in the state of Utah, where this Policy is issued, We may change the rates for this Policy on any Policy Anniversary Date. Any rate change will be made only when We change the rates for all policies in the same rate class on the same form as this Policy that are issued in Utah. We will give You at least 45 days advance written notice prior to the effective date of any rate change.

When is a Premium Refund Applicable?

In the event the Policy is canceled for a reason other than a material misrepresentation any unearned amount of collected premium will be refunded. In the event of material misrepresentation on the application collected premium minus claims paid will be refunded.

If this Policy is Terminated, Can It be Reinstated?

If any renewal premium is not paid within the time granted to You for payment, a subsequent acceptance of premium by University Health Plans or by any agent duly authorized by University Health Plans to accept the premium, without also requiring an application for reinstatement, shall reinstate the policy. However, if University Health Plans or agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy shall be reinstated upon approval of this application from University Health Plans or, lacking this approval, upon the 45th day following the date of the conditional receipt, unless University Health Plans has previously notified You in writing of our disapproval of the application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after that date. In all other respects You and University Health Plans have the same rights under the reinstated policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to this policy in connection with the reinstatement. Any premium accepted in

connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

SECTION 7 – CARE MANAGEMENT PROGRAM

You have access to the following sponsored care management program. 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.

Our experienced nurse care managers and team can provide education, incentives, and resources on wellness programs, disease management services including diabetes, cardiac concerns, weight management, stress and other health related issues. We have specialized population health programs that understand the specific health issues so you can have a healthy outcome and quality lifestyle.

To learn more or to enlist the services of a care manager, please contact the Care Management team at (801) 587-6480 or (888)271-5870, Option 2.

SECTION 8 – DIABETES COVERAGE

University of Utah Health Plans will cover diabetes self-management training and patient management, including medical nutrition therapy, provided by an accredited or certified program and referred by an attending physician within the plan. The Plan also covers equipment, supplies, and appliances to treat diabetes when medically necessary.

SECTION 9 – AUTISM BENEFIT

University of Utah Health Plans will cover the diagnosis and treatment of Autism Spectrum Disorder, in accordance with Utah S.B. 57 (31A-22-642) and S.B. 95 (Autism Amendment). Behavioral health treatment must be authorized after a diagnosis of Autism Spectrum Disorder. Treatment will be reviewed every six months. To request authorization, please contact Care Management at (801) 587-6480 or (888) 271-5870, Option 2.

SECTION 10 – ADOPTION BENEFIT

University of Utah Health Plans will pay \$4,000 payable to the Policyholder in connection with an adoption of a child when an adopted child is placed for adoption with the Policyholder within 90 days of the child's birth. In the event a Policyholder adopts more than one newborn from a single pregnancy (for example, twins), only a single \$4,000 adoption benefit is available.

To receive this benefit, the Policyholder must submit eligible receipts to the Plan at the following address:

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

SECTION 11 – SMOKING CESSATION

University of Utah Health Plans has a comprehensive program in place to help you quit smoking. There is no prior authorization required to participate in this program, and the services are provided at no cost to you. Included in the program are individual, group and telephone cessation counseling, and all FDA-approved tobacco cessation medications (nicotine patch, lozenge, nasal spray and inhaler; approved oral medications). To enroll in this program, please contact Care Management at (801) 587-6480 or (888) 271-5870, Option 2.

SECTION 12 – 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 medical benefits provided under this Plan are subject to this Coordination of Benefits provision.

Definitions

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.

Birthdate 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.

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

- Individual and group accident and health insurance and subscriber contracts.
- Uninsured arrangements of group or Group-Type Coverage.
- Group-Type Coverage.
- Coverage through closed panel plans (a plan that provides coverage primarily in the form of services through a panel of Providers that have contracted with or are employed by a plan and that excludes benefits for services provided by other Providers, except in the cases of emergency or referral by a panel member).
- Medical care components of long-term care contracts, such as skilled nursing care.
- Medicare and other governmental coverages, as permitted by law.

Other Plan does not include:

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

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

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

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

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

Order of Benefit Determination

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

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

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

- When Your parents are married or living together (whether or not they have ever been married), the plan of the parent whose Birthday falls earlier in the Year is the Primary Plan. If both parents have the same Birthday, the plan that has covered a parent longer is the Primary Plan.

- When Your parents are divorced or separated or are not living together (if they have never been married) and a court decree states that one of Your parents is responsible for Your health care expenses or health care coverage, the plan of that parent is primary to the plan of Your other parent. If the parent with that responsibility has no health care coverage for Your health care expenses, but that parent's spouse does, the plan of the spouse shall be primary to the plan of Your other parent.
- If a court decree states that both parents are responsible for Your health care expenses or health care coverage, or if a court decree states that the parents have joint custody of You, without specifying that one of the parents is responsible for Your health care expenses or health care coverage, the provisions of the first bullet above (based on parental Birthdays) shall determine the order of benefits.
- If there is no court decree allocating responsibility for Your health care expenses or health care coverage, the order of benefits is as follows:
 - The plan of Your custodial parent shall be primary to the plan of Your custodial parent's spouse;
 - The plan of Your custodial parent's spouse shall be primary to the plan of Your noncustodial parent; and
 - The plan of Your noncustodial parent shall be primary to the plan of Your noncustodial parent's spouse.

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

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

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

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

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

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

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

Primary Health Plan Benefits

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

Secondary Health Plan Benefits

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

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

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

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

Right to Receive and Release Needed Information

Certain facts are needed to apply Coordination of Benefits provisions. We have the right to decide which facts they need. We 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 Us any information necessary or appropriate to administer this Coordination of Benefits provision. Receipt of such information by Us will be a condition precedent to this Plan's obligation to provide benefits.

Right of Recovery/Subrogation

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

- From You, if payment was made to You. Recovery would be by reversal of payments and be limited to a period within 12 months of the overpayment, or 24 months if related to a coordination of benefits error, or 36 months if related to a recovery by Medicare, Medicaid, or the Children's Health Insurance Program. If the reversal is necessitated by Your fraudulent act(s), fraudulent statement(s), or material misrepresentations there is no time limit. 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 10 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. We are 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). We are 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.

SECTION 13 – APPEALS PROCESS

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 a First-level Appeal and Voluntary External Appeal-IRO that 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.

The First-level appeal must be pursued within 180 days of your receipt of Our determination. 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.

Appeal decisions will be determined in the following time frame:

- **Pre-service Appeal:** within 30 calendar days of receipt of the request
- **Post-service Appeal:** within 45 calendar days of receipt of the request
- **Expedited Appeal:** within 72 hours of receipt of the request
- **Voluntary External Appeal:** within 45 days of the receipt of the request
- **Voluntary Expedited External Appeal:** within 72 hours of the receipt of the request

First-level Appeals

First-level 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, please use the Independent Review Request Form available at www.insurance.utah.gov. You may also contact the Utah Insurance Department, Office of Consumer Assistance, Suite 3110 State Office Building, Salt Lake City UT 84114.

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.

First-level Expedited Appeals

The first-level expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the Appeal decision. First-level 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.

SECTION 14 – GENERAL PROVISIONS

Choice of Forum

Any legal action arising out of this Policy must be filed in a court in the state of Utah.

Entire Contract; Changes

This Policy including the application, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. Pursuant to U.C.A. § 31A-21-106(2), a modification of contract must be in writing, and agreed upon by the party against whose interest the modification operates. No change in this Policy will be valid until approved by an executive officer of the Company and unless such approval be endorsed in or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Incontestability

After two (2) years from the Policy Effective Date of this Policy no statements, except fraudulent misrepresentations, made by the applicant in the application for this Policy will be used to void this Policy or to deny a claim for loss incurred or disability (as defined in this Policy) commencing after the expiration of such two-year period.

Representations

In the absence of fraud, any statement made by You will be deemed a representation and not a warranty. Such statement may not be used in defense of a claim, unless it is contained in a signed application.

What Are the Time Limits on Legal Actions?

Legal Actions: No action will be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action will be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished. Failure to give notice or file proof of loss as required does not bar recovery under the policy if the insurer fails to show it was prejudiced by the failure.

Improper payments: If We make improper payments to You or a provider, we may recover the correct amount within 24 months of the amount improperly paid for a coordination of benefits error, or within 12 months of the amount improperly paid for any other reason, and We may take action against a provider involved, if necessary.

Can this Policy be Assigned?

This Policy cannot be assigned.

SECTION 15 – 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 Policy. On a case-by-case basis, The Plan may in its sole discretion extend or add Benefits that are not otherwise expressly covered or are limited by the Plan. In making this decision, The Plan will consider the medical appropriateness and cost effectiveness of the proposed exception. When making such exceptions, The Plan reserves the right to specify the Providers, Facilities, and circumstances in which the additional care will be provided and to limit payment for additional Services to the amount The Plan would have paid had the Service been provided in accordance with the other provisions of the Plan. Benefits paid are subject to all other Member payment obligations of the Plan such as Copays, Coinsurance, and Deductibles.

Waiting Period For Preexisting Conditions

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

Specific Exclusions

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

Adoption Benefit

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

Allergy Services

Charges for office visits in connection with repetitive injections are not covered. Sublingual or colorimetric allergy testing are not covered.

Alternative Care

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

- acupuncture and acupressure and dry needling;
- holistic and homeopathic treatment;
- massage or massage therapy;
- naturopathy;
- faith healing;
- milieu therapy;
- hypnotherapy;

- 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, vision therapy.

Ambulance Services

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

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

Billing of Services

The following improper billing practices:

- unbundling or fragmentation of surgical codes; and
- unbundling of lab charges or panels.

Birthing Centers

Services and supplies related to birthing centers.

Cardiac Rehabilitation

Phases 3 and 4 associated with cardiac rehabilitation, which include individual and group exercise programs.

Certain Illegal Activities

- Services for an illness, condition, accident or injury arising from You or Your Dependent directly related to the participation in an activity where You or Your Dependent is found guilty of an illegal activity in a criminal proceeding; or is found liable for the activity in a civil proceeding. A guilty finding includes a plea of guilty, a no contest plea, and a plea in abeyance.

Chiropractic Treatment

Any services associated to chiropractic treatment.

Clinical Trials

Charges for unproven medical practices or care, treatment, devices or drugs that are Experimental or Investigational in nature or generally considered Experimental or Investigational by the medical profession as determined solely by UUHP.

UUHP does not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in approved clinical trials. Routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial. Patient costs do not include the investigational item, device, or service, itself; items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Cosmetic/Reconstructive Services and Supplies

Cosmetic and/or reconstructive services and supplies, 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. Services specifically excluded include, but are not limited to, the following:

- services not medically necessary;
- complications from cosmetic surgery, except in cases of reconstructive surgery following a trauma;
- breast reduction;
- mastectomy for gynecomastia;
- blepharoplasty;
- capsulotomy, replacement, removal or repair of breast implant originally placed for cosmetic purposes;
- rhinoplasty, except when related to an accident;
- rhytidectomy;
- injection of collagen;
- lipectomy, abdominoplasty, panniculectomy;
- repair of diastasis recti;
- hair transplants;
- treatment for spider or reticular veins;
- liposuction;
- chin implant, genioplasty or horizontal symphyseal osteotomy;
- otoplasty;
- chemical peels

Counseling

Charges for counseling a Claimant, including the following:

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

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

Court Ordered Treatment

Treatment ordered by a court unless both medically necessary and performed at a participating hospital.

Dental Services

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

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.

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; visits in conjunction with palliative care or metatarsalgia or bunions, etc; and subtalar implants.

Government Programs

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

Growth Hormone Therapy

Growth hormone therapy, once bone growth is complete.

Hearing Care

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

Home Health Care

Services including, but not limited to, the following:

- nursing or aide services, which are requested by, or are for the convenience of family member, which do not require the training, skill or judgment of a nurse;
- private duty nursing;
- home health aide;
- custodial care;
- respite care; and
- travel or transportation expenses, escort services to provider's offices or elsewhere, or food services

Infertility

The Plan will only cover the cost of tests to reach an initial diagnosis of infertility. Treatment to achieve pregnancy (including but not limited to ovulation-stimulating medication, tubal reconstructive surgery, intrauterine insemination, intrafallopian transfer, and in vitro fertilization) is not covered. Once the patient

has received a diagnosis of infertility or begins medication specific to promoting pregnancy (not including medication for co-occurring conditions such as hypothyroidism), tests to monitor effectiveness of treatment or select additional treatments are not covered. Additional exclusions are as follows:

- diagnostic testing after initial diagnosis of infertility has been reached;
- sexual dysfunction, treatment and surgery;
- assisted reproductive technologies;
- reversal of sterilization;
- sperm banking system, storage, treatment or other such services;

Investigational or Experimental Services

Investigational or experimental treatments or procedures (Health Interventions) and services, supplies, devices, drugs and accommodations provided in connection with Investigational or Experimental treatments or procedures (Health Interventions). Also excluded are any services or supplies provided under an Investigational protocol. Refer to the expanded definition in the Definitions Section of this Policy. Complications as a result of any of these services and procedures is also excluded. Traveling to another country to obtain medical care, also known as medical tourism, is not covered.

Home Birth

Home Birth is not covered. Services and supplies related to Home Births are also not covered.

Medical Prescription Drugs that require prior authorization or that are anticipated to cost over \$1,000 that have not received a prior authorization approval. Medical drugs listed as not covered. For a list of medical drugs that require prior authorization or that are not covered, please refer to the Plan website at <http://uhealthplan.utah.edu/individual/pharmacy.php>.

Mental Health

The following disorders and mental health-related treatment:

- conduct disorders;
- oppositional disorders;
- learning disabilities;
- situational disturbances;
- conditions without manifest psychiatric disorder or non-specific conditions;
- wilderness programs;
- therapeutic schools and academies
- inpatient treatment for behavior modification;
- psychological evaluations for testing or legal purposes;
- occupational or recreational therapy;
- hospital leave of absence charges;
- sodium amobarbital interview; and
- intensive outpatient programs (IOP)

Refer to Section 3 – Definitions for additional information regarding Behavioral Health and Substance Abuse.

Motor Vehicle Coverage and Other Insurance Liability

Expenses for services and supplies that are payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Claimant, whether or not the Claimant makes a claim under such coverage. Further, the Claimant is responsible for any cost-sharing required by the motor vehicle coverage, unless applicable state law requires otherwise. Once benefits under such

contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, Benefits will be provided according to the Policy.

Non-Covered Services in conjunction with a Covered Service

Non-Direct Patient Care

Services that are not direct patient care, including:

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

Nutritional Counseling for non-nutritional related disorders

This exclusion does not apply to services and supplies for Diabetic Education or as required under PPACA.

Organ and Tissue Donation

Organ and tissue donor charges, when a UUHP member is not the organ recipient.

Orthognathic Surgery

Services and supplies for orthognathic surgery, including, but not limited to, orthodontic treatment in conjunction with orthognathic surgery.

Other Specific Services

- Mole mapping;
- Virtual colonoscopy as a screening for colon cancer

Over-the-Counter Contraceptives

Over-the-counter contraceptive supplies and oral contraceptive.

Personal Comfort Items

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

Physical Exercise Programs and Equipment

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

Prenatal Services

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

- childbirth education classes;
- epidemiological and predictive genetic screening, except genetic evaluations for pregnancy at high risk of genetic disease;
- amniocentesis or chorionic villi sampling, except for high risk pregnancy;
- molecular diagnostic testing in the course of evaluation for a genetic or congenital disease; and
- medical services for surrogate mothers.

Prescription Drugs and Other Medications Covered under the Retail Pharmacy Benefit

Please refer to the section titled "**Prescription Drug Benefits**"

Prescription Drugs covered under a per diem for a Skilled Nursing, Long-term Care, or Acute Rehab facility contract.

Psychoanalysis/Psychotherapy

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

Pulmonary Rehabilitation

Phase 3 associated with pulmonary rehabilitation, which includes individual and group exercise programs.

Repatriation

Medical evacuation or transportation home from a foreign country for medical reasons.

Reversals of Sterilizations

Services and supplies related to reversals of sterilization.

Robot-Assisted Surgery

Robot-assisted surgery is limited to the procedures set forth in University of Utah Health Plans medical criteria. Direct costs for the use of the robot are not covered.

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

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

- diet and weight monitoring services;
- childbirth-related classes including infant care and breast feeding classes;
- instruction programs including those to learn how to stop smoking and programs that teach a person how to use Durable Medical Equipment or how to care for a family member;
- scholastic education;
- vocational training; and
- special training for learning disabilities.

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

Services and Supplies for which no charge is made or no charge is normally made

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

- services or supplies for which a Claimant cannot be held liable because of an agreement between the Provider rendering the service and another third party 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.

Services and Supplies Provided by a Member of Your Family

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

Services and Supplies Provided by a School or Halfway House

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

Services and Supplies that are not Medically Necessary

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

- any service or supply not specifically identified as a benefit;
- any surgery solely for snoring;
- hospital visits the same day as surgery except for treatment of a diagnosis unrelated to the surgery;
- evaluations not required for health reasons, such as employment or insurance examinations;
- autopsy procedures;
- charges for independent medical evaluations and testing for the purpose of legal defense, including court-ordered drug screenings;
- routine drug screening, except when ordered by a treating physician;
- autologous blood storage for future use;
- sodium amobarbital interviews;
- probability and predictive analysis and testing; and
- hair analysis, trace elements or dental filling toxicity.

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.

Skilled Care

Charges for skilled care provided in a nursing home, rest home, transitional living facility, community reintegration program, vocational rehabilitation, and services to retrain self-care or activities of daily living.

Sleep Studies

Sleep Studies are covered only when provided by:

- A board-certified sleep specialist or at a Participating Facility certified as a sleep center/lab by the American Board of Sleep Medicine; or
- In your home if you or your dependent are 18 years or over and the sleep study is ordered by a board certified sleep specialist who has performed a face:face encounter with the member.”

Termination of Pregnancy

Services and supplies in connection with the performance of any induced abortion services except in the following circumstances and in accordance with the Hyde Amendment: (a) in the professional judgment of the pregnant woman's attending physician, the abortion is necessary to save the pregnant woman's life; or (b) the pregnancy is the result of rape or incest if evidence of the rape or incest is appropriately documented in medical records, a police report, or filed charges.

Third Party Liability

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

Travel and Transportation Expenses

Travel and transportation expenses other than covered ambulance services provided under the Plan, including, but not limited to:

- commercial or private aviation services, meals, accommodations and car rental; and
- charges for mileage reimbursement, except for eligible ambulance service.

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.

Varicose Veins

Procedures to treat varicose veins except when associated with ulceration or bleeding with significant comorbid complications.

Vision Care

Vision hardware, except the first intraocular lenses following cataract surgery and as Medically Necessary for the treatment of keratoconus.

Vision services, except for routine Pediatric Vision services as required by PPACA and an annual routine adult eye exam and refraction, including, but not limited to, 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.

War or Insurrection

The treatment of any condition caused by or arising out of a Claimant's voluntary 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. Specifically excluded are:

- treatment of obesity by bariatric or other surgery, medical services or prescription drugs, regardless of associated condition, and
- complications related to gastric bypass or other weight loss procedures within the first year. Services related to complications outside of the first year require prior authorization.

Work-Related Conditions

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

Durable Medical Equipment**Limitations**

- one lens for affected eye following eligible corneal transplant surgery
- one pair of ear plugs within 60 days following ear surgery
- artificial eye prosthetic, when made necessary by loss from an injury or illness must be pre-authorized
- wheelchairs require pre-authorization
- knee braces limited to one per knee in a three year period
- additional limitations may be placed on specific providers and place of service per medical policy

General Exclusions

- training and testing in conjunction with DME and prosthetics
- more than one lens for each affected eye following surgery
- DME that is inappropriate for the patient's medical condition
- equipment purchased from non-licensed providers
- used DME
- TENS unit

- neuromuscular stimulator
- H-wave electronic device
- sympathetic therapy stimulator

Excluded Devices

- adaptive devices or aids to daily living
- air purifier
- air conditioners
- alarm systems
- allergy-free bedding
- arch supports, insoles, heel cushions
- auto-tilt chair
- bandages
- bar bell set, dumb bells
- barrel crawl
- bathtub seat/bench/chair
- bathtub/toilet rails
- battery charger
- bed, air-fluidized
- bed baths
- bed board
- bed cradle
- bedside rails
- bed wedges, foam slants
- bed, hospital, standard, semi-electric
- bed, non-hospital adjustable
- bed, oscillating
- bed, pressure therapy
- beeper
- biofeedback device
- blood pressure cuff
- booster chair
- braille teaching texts
- cane
- car seat
- car/van lift
- carafe
- cervical pillow
- chair, adjustable
- chest compression vest, system generator and hoses
- circle balance discs
- routine circumcision
- cleaning solutions
- coagulation Protime self-testing device
- communicative device, equipment or repair
- compression stockings
- computer systems or components
- computerized assistive devices
- contact lens
- continuous hypothermia machine
- contour chair
- cranial electro stimulation

- crawler, height adjustable
- crawler, prone
- crawling coordination training unit
- crutches-purchase
- crutches-rental
- crutch substitutes or alternatives
- cuff weights
- dehumidifiers
- deironizer
- diapers
- drionic machine
- dynasplint
- electrodes and accessories for stimulators
- electronic controlled thermal therapy devices
- electrostatic machine
- elevators
- emesis basins
- EMG machine
- enuresis alarm unit
- environmental control systems
- erectile aid system
- exercise equipment
- eyeglasses
- face masks
- grab bars
- gym mat
- hand controls for motor vehicle
- handgrip replacement
- head float
- health spa
- hearing aids, hearing devices
- heat lamps
- heating pads, hot water bottle
- home modifications
- home physical therapy kits
- hot tub
- humidifier
- humidifier, room or central heating
- hydrocollater unit
- hydrotherapy tanks
- incontinence supplies
- incontinence treatment system
- interferential nerve stimulator
- IPPB machine
- lift platform, wheelchair, van or home
- light box
- maclaren buggy, stroller
- maintenance, warranty or service contracts
- maintenance/repair, routine
- massage devices
- motor vehicle
- motor vehicle alterations, conversions
- motor vehicle devices, hand controls,

- mouth guard
- muscle stimulator
- myoelectric prosthetics
- neo-control chair
- neuromuscular stimulator
- orthopedic brace for sports
- orthosis, back brace (TLSO, LSO)
- orthotics, shoe inserts
- overbed tables
- pager
- paraffin bath units
- parallel bars
- pelvic floor stimulator
- percussor, chest³
- polarcare
- portable room heaters
- postural drainage board
- posture chair
- cushions and mattresses
- prosthetics, limb (covered on Bronze EPO w/3 Copays before Deductible plan only)
- prosthetic socks (covered on Bronze EPO w/3 Copays before Deductible plan only)
- protonics knee orthosis
- pulsed galvanic stimulator
- reflux board, infant
- repairs, non-routine performed by a skilled technician
- rocking bed
- roho air flotation system
- rollabout chair
- rowing machine
- safety grab bar, rail, bathroom, toilet, bed
- safety rollers, with walkers
- sauna baths
- scooter board
- shoes, orthopedic or corrective, modifications, lifts, heels, wedges, inserts, etc
- shower bench
- shower chair
- sitz bath
- spa membership
- speech augmentation communication device
- speech generating device
- speech teaching machines, language master
- sphygmomanometer with cuff
- spinal pelvic stabilizers
- stairglide
- stander
- standing table
- stethoscope
- sun glasses
- support hose
- swimming pool
- sympathetic therapy stimulator
- telephone
- telephone alert system

- telephone arms
- theraband
- therapy ball, roll, putty
- thermometer
- tips, replacement
- toddler walkabout
- toileting aids
- tool kits
- transcutaneous electrical nerve stimulator unit, including supplies (TENS unit)
- transfer board
- tray, desk, drafting table, easel, caddy tray, cup holder, etc
- tricycle, hip extensor
- upholstery, reinforcement or replacement
- urinals
- used equipment
- uterine activity monitor, with pregnancy
- vaporizer, room-type
- ventilator-purchase
- vibrating chair
- vibrators
- vision aid or device
- waterbed
- wheelchair, auto carrier
- wheelchair, backpacks, caddy, carrier, baskets, etc
- wheelchair, spoke protectors
- wheelchair, stand-up
- wheelchair, utility tray
- wheelchair ramp
- wheelmobile
- whirlpool bath equipment
- whirlpool pumps
- white cane
- wig, hair piece
- wrist alarm

SECTION 16 – PRESCRIPTION DRUG BENEFITS (Retail Pharmacy)

Prescription Drug Benefits are administered through University of Utah Health Plans. Pharmacy Customer Service is available 24 hours a day, 7 days a week at [866-236-5936] for information and assistance with your Prescription Drug coverage. To fill your prescription(s), use your Health Plan Identification Card at participating network pharmacies. You can obtain additional information regarding covered medications, limits, and over-the-counter drugs by going to the University of Utah Health Plans website at uhealthplan.utah.edu/individual/pharmacy.php.

Cost for Prescription Drugs

The amount you will pay for your prescription drugs is shown in your Outline of Coverage (OOC). Your responsibility will be based on the type of drug (generic, brand, or specialty) and what tier the drug is in.

A **Deductible** is the amount you need to pay first before any benefits on the Summary of Benefits apply. This does not apply to preventive drugs that are covered at 100% under the Affordable Care Act (Third

party payer assistance (manufacturer copay cards, coupons, , etc. cannot be used to meet your Deductible.) Prescription drug brand-generic fees do not apply to the Deductible.

Copays/Coinsurance are the amounts that you pay for prescriptions once you meet your deductible as outlined on the Summary of Benefits. A copay is a flat amount per 30-day prescription. Coinsurance is a percentage of the cost of the drug. (Third party payer assistance, manufacturer copay cards, etc. cannot be used to meet your copay or coinsurance responsibility.)

Out-of-Pocket Maximum is the maximum you pay for your pharmacy and medical costs out-of-pocket. Once you have met your Out-of-Pocket Maximum your prescriptions are covered at 100%. (Please note that brand penalty costs do not apply to the out-of-pocket maximum.) Refer to your Summary of Benefits and Coverage for more information. (Third party payer assistance, manufacturer copay cards, coupons, etc... cannot be used to meet your Out-of-Pocket Maximum.) Prescription drug brand-generic fees do not apply to the Out-of-Pocket Maximum.

How the Plan Works

When you incur expenses for prescription drugs purchased from a duly licensed pharmacy pursuant to a prescription order, prescription drug benefits will be provided, as follows:

- when you present your Prescription order and use your Health Plan Identification Card at a Participating Network Pharmacy, you will be required to pay at the time of purchase only the applicable Deductible, Copay, or Coinsurance amounts specified in the Summary of Benefits and Coverage (SBC); when you present your Prescription order, but do not use your Health Plan Identification Card, you will be required to pay the entire cost of the prescription drug. You can file a paper claim within 365 days of fill date for reimbursement of eligible expenses with University of Utah Health Plans Pharmacy Customer Service for the amount to be paid by the Plan less any Deductible, Copay, or Coinsurance, as specified in the Summary Of Prescription Drug Benefits, not to exceed the amount the Plan would have paid a Participating Pharmacy if you had used your Health Plan Identification Card. Claims are denied if submitted more than one year after the services were provided unless notice was given or proof of loss was filed as soon as reasonably possible. Adjustments or corrections to claims can be made only if the supporting information is submitted within one year after the claim was first processed unless the additional information relating to the claim was filed as soon as reasonably possible.
- if your premiums are delinquent, you will be required to pay the full price for your prescription. It will be the member's responsibility to contact the pharmacy after premiums are paid current to have the pharmacy reverse and reprocess the claim through the plan or file a paper claim for reimbursement as outlined above.

If you fill a prescription drug at an Out-of-Network Pharmacy you will be required to pay the entire cost of the prescription drug. There is no reimbursement for prescription claims processed by an Out-of-Network Pharmacy, unless it is related to a medical emergency.

You are able to fill a 30 day supply at any In-Network Pharmacy. The Plan uses a Nationwide Network of Pharmacies. You can locate a network pharmacy at <http://uhealthplan.utah.edu/individual/pharmacy.php>. You are also able to fill a 90 day supply on preferred generic (Tier 1) and preferred brand/non-preferred generic drugs (Tier 2) at a Designated Mail Order or Designated 90 day at Retail Pharmacy. Contact University of Utah Health Plans Pharmacy Customer Service at [866-236-5936] to see if your drug is eligible for the mail order or 90 day at Retail program. To be eligible for the mail order or 90 day at Retail program, you must have your premiums set up on auto-pay through University of Utah Health Plans.

The U of U Health Plans Pharmaceutical & Therapeutics Committee will make a reasonable effort to review each new FDA approved drug product (or new FDA approved indication) within 90 days of release onto the

market and will make a decision on each new FDA approved drug product (or new FDA approved indication) within 180 days of its release onto the market, or a clinical justification will be provided if this timeframe is not met. Additionally, each therapeutic class is updated as needed and reviewed at least annually.

The Plan has discretion to determine if a medication will be covered under medical pharmacy or retail pharmacy.

Generic Drug is a drug that has the same active ingredients compared to a brand name drug with regards to its dosage, strength, quality, performance, outcome, and intended use.

Brand Name Drug is a drug that has a trade name and is protected by patent; meaning it can only be manufactured and produced by the company holding the patent. Brand name drugs may require step therapy or prior authorization.

Specialty Drugs are high risk, high-cost drugs that are used to treat complex conditions requiring special handling and administration. Specialty drugs require prior authorization and are limited to a 30-day supply. All Specialty drugs must be filled through a University of Utah Specialty Pharmacy or other designated specialty pharmacy if not available through University of Utah Health. Please call University of Utah Health Plans Pharmacy Customer Service for additional information.

Step Therapy is required before some drugs can be approved. Step therapy is a process where a first-line medication is required before another drug can be considered.

Prior Authorization is required before some brand and generic drugs, as well as all specialty drugs that can be filled through the Plan. For drugs that require prior authorization, a provider must complete a prior authorization (PA) form through U of U Health Plans Pharmacy Customer Service or online at our website and submit for review along with clinical documentation to support the request. Once U of U Health Plans receives the PA form along with the appropriate clinical documentation, the prior authorization request will be reviewed for medical necessity within the Plan's established criteria and benefits for approval/denial.

Drug Tier is the way a formulary or list of drugs is organized. Tiers are groups of different drugs that are arranged based on classification, price, and patient responsibility. Drugs in different tiers can have different patient responsibility.

- Tier 1 – Preferred Generic Drugs
- Tier 2 – Preferred Brand Drugs and Non-Preferred Generic Drugs
- Tier 3 – Non-Preferred Brand Drugs
- Tier 4 – Specialty Drugs

In accordance with the Patient Protection and Affordable Care Act ("PPACA"), as amended by the Health Care and Education Reconciliation Act, certain generic contraceptives are covered for women at 100% 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"). When no generic contraceptive exists in that category of contraceptive, a brand is covered. Once a generic becomes available, the brand will no longer be covered at 100%. Insertion of a contraceptive device is covered under Preventive Care, but removal of the device is not. Over-the-counter medications required to be covered under PPACA will be covered by the Plan at 100% of the Allowable Amount with a Prescription for the item(s). Certain generic smoking cessation medications are also covered under the plan; quantity limits apply. Some smoking cessation medications require step therapy of a generic before they can be approved.

Brand Generic Drug Fee is applied if you receive a Brand name drug, regardless of reason or medical necessity, or if your provider prescribes a Brand name drug when a generic is available. A Brand-Generic Fee is the difference in cost from the Generic to the Brand name drug. This fee is added to the regular cost sharing outlined in your benefits summary. The Brand-Generic Fee does not apply towards your Deductible or Out-of-Pocket Maximum.

Third Party Payments

Third party service providers may not waive, rebate, give, pay, or offer to waive, rebate, give, or pay all or part of the Insured's deductible or other out of pocket costs for prescription drugs. The plan will only accept third party payments of cost sharing from:

- A Ryan White HIV/AIDS Program
- An Indian tribe or tribal organization
- Local, state or federal government programs, including grantees directed by a government program to make payments on its behalf

The Plan will also accept third party payments from individuals such as family and friends, religious institutions and other not-for-profit organizations when all of the following criteria are met:

- The assistance is provided on the basis of the insured's financial need
- The institution/organization is not a healthcare provider
- The institution/organization is not financially interested. Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a pecuniary interest in the payment of health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a pecuniary interest in the payment of health insurance claims.

Third party cost-sharing payments from the approved Third Parties identified above will accumulate towards Deductibles and/or Out-of-Pocket Maximum. All other Third Party payments are not allowed under The Plan and would not apply to a member's Deductible and/or Out-of-Pocket Maximum. If a financially interested third party payments of this type are identified after the fact, the Plan has the right to remove from the accumulation toward the Deductible and/or Out-of-Pocket Maximum.

Lost/Damaged/Stolen Prescription replacements are not covered by the plan. The member will have access to the network discounts, but the cost for replacement will be member responsibility. If a medication is stolen, the plan will review for replacement only when accompanied by a police report and if the provider is willing to write a new prescription. In the case, a stolen replacement is approved it will be limited to one incident per year.

The Plan has the discretion to require certain therapies be provided in the home versus in an infusion center.

The Plan will determine if a prescription drug is covered under medical or retail pharmacy.

Coordination of Benefits

The Plan does not coordinate pharmacy benefits with other insurance plans. If You are covered by another plan that is Your Primary Coverage, you must use that benefit and pay the copay or coinsurance applicable to that plan. In this situation, there is no pharmacy benefit available under this plan.

Covered Prescription Drug Benefits

Covered prescription drugs must be prescribed by a licensed provider and purchased at a network pharmacy, except in a medical emergency. Benefits are available for the following:

- Prescription Drugs, including drugs and approved biologicals prescriptions, used to treat an Illness or Injury and not specifically excluded herein;
- Insulin and prescribed oral agents for controlling blood glucose levels;
- FDA-approved tobacco cessation medications (nicotine patch, gum, lozenge, bupropion and Chantix);

- Diabetic supplies including test strips, lancets, alcohol swabs, and syringes; and
- Prescription contraceptives.

Prescription Drug Benefit Exclusions and Limitations

Specific medications may not be a covered benefit under The Plan. Some prescriptions drugs, though FDA approved, have failed to show meaningful efficacy toward treating any condition, may have a suitable over-the-counter alternative, may be solely used for conditions not covered by the plan, or have significant safety concerns which outweigh the benefit of the therapy. These may include drugs used to solely treat cosmetic conditions or for weight loss, as examples. This drug list is subject to change as it's updated due to new drugs becoming available and others removed from the market. For a complete list of covered and non-covered medications and plan limitations, refer to The Plan's website.

The following exclusions and limitations apply to your Prescription Drug Benefits:

- A Non-Legend Patent or Proprietary medication
- Anabolic Steroids
- Biological Sera, Blood, or Blood Plasma
- Charges for the Administration or Injection of any Drug
- Compounded Products; unless prior approval received for medical necessity. Compounded products are limited and cannot be considered if a commercial product is available.
- Diabetic infusion sets, which include: (a) a cassette; (b) needle and tubing; and (3) one insulin-pump during the warranty period. Diabetic-infusion sets, pumps and accessories for insulin pumps are covered under the Durable Medical Equipment Benefit.
- Emergency Contraceptives (e.g., Preven and Plan B) – except with a prescription and as defined by PPACA
- Experimental Trial medications
- Fluoride, except pediatric use as defined by PPACA
- Food Supplements, Special Formulas, and Special Diets
- Hair Loss, growth, or replacement medication or treatment
- Homeopathic Medications
- Infertility Medications to treat or enhance fertility
- Investigational, Experimental, or Unproven Drugs: Drugs labeled “Caution – limited by federal law to investigational use”, or experimental drugs, even though a charge is made to the individual
- Medications for Cosmetic purposes (e.g., cosmetic hair growth and removal Products)
- Medication Taken or Administered While a Patient: Medication which is taken by or administered to an individual, in whole or in part, while he or she is a patient in a doctor's office, hospital, rest home, sanatorium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals. (In some cases, this medication is covered under the Medical Benefits portion of the Plan.)
- Medications that cannot be self-administered
- Medications that are therapeutically the same as an over-the-counter medication
- Medications that are covered under a per diem for a Skilled Nursing, Long-term Care, or Acute Rehab facility contract No Charge Medications received under worker's compensation laws, federal, state, or local programs
- Medications to treat erectile dysfunction or impotence
- Off-label use of Medication; except as outlined in the Off-label Use Policy
- Over-the-Counter Medication (OTC) or other items purchased at a pharmacy other than Prescription Drugs whether or not there is a Prescription order for the item(s), except as required under PPACA
- Pigmenting/De-pigmenting Agents, except as required to treat photosensitive conditions, such as psoriasis

- Prescription Drugs for a Non-FDA Approved Purpose or Dosage (off-label): Any prescription drug prescribed for use other than its FDA-approved purpose or in a dosage other than the standard dosage for an FDA-approved purpose. If a prescription drug 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 prescription drug may be provided when so used, as determined by medical necessity by the Plan.
- Prescription Drugs in excess of a 90-day supply
- Prescription order is in excess of the day's supply or Plan's quantity limit
- Refills in excess of the number specified by the Physician or any refill dispensed after one year from the Physician's original Prescription order
- Testopel pellets
- Therapeutic devices or appliances, including hypodermic needles, syringes (excluding insulin syringes), support garments, and other non-medicinal substances, regardless of intended use. (In some cases, items may be covered under the Medical Benefits portion of the Plan.)
- Vitamins and Minerals, except prenatal vitamins or vitamins as required under PPACA. Please note vitamins may be limited to coverage by age and specific dosing requirements.
- Travel-related medications, including preventive medication for the purpose of travel to other countries. The following immunizations are not covered: anthrax, BCG (tuberculosis), cholera, plague, typhoid, and yellow fever.
- Weight-loss medications

Additional Definitions

In addition to the definitions in the Definitions Section of this Policy and the definitions above, the following definitions apply to this Covered Prescription Drug Benefits Section:

Out-of-Network Pharmacy means a pharmacy which has no network agreement with University of Utah Health Plans or its designee. There is no coverage if you are using an out-of-Network Pharmacy.

Participating Pharmacy means a duly licensed pharmacy with which University of Utah Health Plans or its designee has a network agreement. A list of Participating Pharmacies can be obtained online at <http://uhealthplan.utah.edu/individual/pharmacy.php>.

Designated pharmacy means you must use the pharmacy designated by the Health Plan for that particular pharmacy benefit to apply.

Prescription Drug means a drug or medicine which can only be obtained by a Prescription Order and approved by the US Food and Drug Administration. They typically bear the legend "Caution, Federal Law prohibits dispensing without a prescription". Prescription drugs can be restricted by State or Federal law and are considered self-administered.

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