INDIVIDUAL EPO PLANS

PLAN DOCUMENT

University of Utah Health Plans

PO Box 45180 www.uhealthplan.utah.edu

Salt Lake City, UT 84145

Customer Service 801-213-4111
833-981-0214

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

Appeals 801-213-4111 or
833-981-0214

TABLE OF CONTENTS

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, 2024, 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 except in the following circumstances listed below:

    - **Emergency Services**: If You have an emergency medical condition and get emergency services from an Out-of-Network Provider, the most the provider may bill You is Your in-network cost-sharing amount (such as copayments and coinsurance) associated with a medical emergency, including post-stabilization. You can't be balance billed for these emergency services. This includes services You may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post stabilization services.
    - **Certain services at an in-network facility by an out-of-network provider:** When you get services at an in-network facility by an Out-of-Network provider, the most the Out-of-Network provider may bill You is Your in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Out-of-Network providers can't balance bill You and may not ask You to give up Your protections not to be balanced billed. If You get other services at these in-network facilities, out-of-network providers can't balance bill You, unless you give written consent and give up Your protections.
    - Lack of availability of in-network services in on of the following circumstances:
        - Travel distance to in network provider exceeds plan distances thresholds for placing undue burden on the member.
        - Equivalent Services to meet member's clinical needs are not available with in network providers/facilities.
        - Medically Necessary Services are not available with an in network provider in a timely fashion to meet member's needs.

NOTE: Refer to the "Notice: Your Rights and Protections Against Surprise Medical Bills" for information regarding reimbursement and balance billing applicable to Out-of-Network Providers. This can be found by visiting https://uhealthplan.utah.edu/notices/pdf/balance-billing.pdf.

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 U of U Health Plans 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 the University of Utah Health Plans at 801-213-4111 or 833-981-0214. 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 U of U Health Plans Submitted claims must meet U of U Health Plans claims editing requirements (including National Correct Coding Initiative guidelines/edits adopted by (U of U Health Plans) 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 801-213-4111 or 833-981-0214 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 can treat many of your health concerns quicker and at a lower cost than seeking urgent or emergency care. They can also speed and smooth the process of seeking specialty care. Please see the **Definitions** section for the types of providers that may be selected as your PCP.

  A PCP will:
  - See you for routine health care needs and preventive check-ups.
  - Assist with acute health problems.
  - Smooth and speed the referral to a specialist if needed (you are not required to have a referral from your PCP to see a specialist).
  - Be your contact if you need care after office hours (except emergencies) so as to help you avoid unnecessary emergency room or urgent care visits.
  - 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 801-213-4111 or 833-981-0214, 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 801-213-4111 or 833-981-0214, 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. Claims for medical drugs anticipated to cost over $500 per dose may be subject to medical necessity review. As outlined in the Prescription Drug Benefits section of this policy some retail prescription drugs also require prior authorization. Please refer to the Prescription Drug (Rx) Information on University of Utah Health Plans website at uhealthplan.utah.edu/individual/pharmacy.php.
- **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 https://uhealthplan.utah.edu/pdf/npp_healthplans_8.2020.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) 587-9241 or visit our website at http://www.privacy.utah.edu to find the right form for your request.

If you have concerns or wish to file a complaint, contact:
University of Utah Health Plans
PO Box 45180
Salt Lake City, UT 84145
801-213-4111
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:
University of Utah Health Plans has a Notice of Privacy Practices that is available by calling Customer Service or visiting https://uhealthplan.uta.edu/pdf/npp_healthplans_9.2020.pdf. 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 https://uhealthplan.utah.edu/providers/policy-forms.php and submitting it to:

University of Utah Health Plans
PO Box 45180
Salt Lake City, UT 84145
801-213-4111 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) and achievement of reasonable symmetry and stability, 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) at a minimum. 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 accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause and that occurs while the insurance is in force.

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 Summary of Benefits and Coverage. 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 charges do not apply to the Out-of-Pocket Maximum.

Third-party assistance, copay cards, and coupons may not be used to satisfy your out-of-pocket maximum. Refer to your SBC for more information.

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.

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.

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 as defined by the Affordable Care Act.

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

Covered Person means the Policy owner 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 or Prescription 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 charges 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 Policy owner must provide coverage; (e) children placed for adoption with the Policy owner in accordance with applicable state or federal law; and
2. Unmarried dependent Disabled Children age 26 and over. Refer to the definition of Disabled *Child.*

A Dependent Child does not include a child who is receiving Medicare benefits.

Disabled 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.

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 such requirements exist.

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 qualified health care provider in a licensed 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 Services meeting ANY of the following criteria are considered experimental/investigational:

- The intervention does not have the Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s); or
- Available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or
- The intervention is not proven to be as safe or effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or
- The intervention does not improve health outcomes; or
- The intervention is not proven to be applicable outside the research setting.

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

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 licensed health care facility that provides home infusion therapy services.

Home Infusion Therapy Services means the preparation, administration, or furnishing of parenteral medications or parenteral medications 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 resides in a hospital from the day of admission to the day or discharge.

Illness means any sickness, infection, disease or any other abnormal physical condition which is not caused by an Injury. Pregnancy, childbirth, and related medical conditions are considered illnesses for the sake of this document.

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

Indian Services mean services for Covered Health 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. Common examples of minor diagnostic testing include (not intended to be an inclusive list):

1. An electrocardiogram (EKG);
2. A urinalysis to look for infection; and
3. Simple, common blood tests such as a complete blood count (CBC), lipid panel/cholesterol test, diabetic blood test/Hemoglobin A1c.

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 $500 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: https://uhealthplan.utah.edu/providers/policy-forms.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;
4. 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.

Medical Policy means the utilization review management guidelines both internal and external used to determine coverage of Services permitted under 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.”

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.

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.

Outpatient means treatment or services that are provided when the Covered Person is not confined as an inpatient patient in a Covered Facility. This includes outpatient treatment at a Covered Facility, observation admission to facilities 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 for individuals 18 years of age and younger as mandated by the federal Affordable Care Act.

Physician means a person who has completed allopathic or osteopathic medicine training and is licensed to practice medicine in the state where the service is provided.

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) internal medicine specialists such as cardiology, rheumatology, etc eligible for board certification by an accredited specialty board, and (8) 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.

Preventive Care is covered in accordance with the Patient Protection and Affordable Care Act (PPACA) and the recommendations by the United States Preventive Service Task Force with an A or B rating in the current recommendation, the Health Resources and Services Administration, or by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Covered services that do not meet the PPACA requirements will be covered the same as any other illness or injury

Primary Care Physician A physician, including an M.D. (Medical Doctor) or D.O (Doctor of Osteopathic Medicine), Certified Nurse Practitioner, clinical nurse specialist, or Physician Assistant, as allowed under State Law and the terms of the Plan, who provides, coordinates, or helps a Member access a range of health care services. For the purposes of this policy: 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) working independently or with a primary care practice; (d) Certified Nurse Midwife (CNM); and (e) Physician's Assistant (PA) working independently or in a primary care practice.

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.

Qualified Health Care Provider an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.

Services treatments, testing, procedures, supplies, devices, drugs, and accommodations or any other activities performed, and billable by a qualified health care provider.

Skilled Nursing Care means nursing services provided by, or under the supervision of, a registered nurse. Such care shall be for the purpose of providing intermediate or custodial care. These services require an order by a licensed qualified health care provider.

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, 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.
5. Has staffing and capabilities to perform skilled nursing services, including but not limited to IV infusion therapy, physical/occupational therapy, wound management, catheter care, and/or close monitoring of vital signs and medical equipment.

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 intended to provide necessary guidance and treatment in the management of addiction disorders. Residential Treatment or inpatient admissions require prior authorization for review of medical necessity.

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; or (i) endoscopy; tapping and other manual invasive and minimally invasive procedures when used in lieu of cutting for purposes of removal, destruction or repair of body tissue.

Telehealth means the use of a HIPAA compliant telecommunication video technologies such as your smart phone, tablet, or computer for online visit with an approved provider.

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.

Urgent Care medical care provided for illnesses or injuries which require prompt attention but are typically not of such seriousness to be life-threatening or require advanced technology available in emergency room or hospital setting.

Urgent Care Center A setting intended to handle non-life-threatening situations staffed with doctors advanced practice clinicians, and nurses who have access to x-rays and labs onsite. Most urgent care centers are open beyond usual clinical office hours and on weekends and holidays.

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 under the 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;
2. Adoption; or
3. 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 60 days of birth; and
3. The date of Placement for an adopted child, if Placement for adoption occurs 60 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 60 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 60-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 60 days 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 Disabled 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 801-213-4111 or 833-981-0214, 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 determined to be medically necessary per plan guidelines.

SECTION 9 – AUTISM BENEFIT

University of Utah Health Plans will cover the diagnosis and treatment of Autism Spectrum Disorder, in accordance with applicable state and federal law. Behavioral health treatment must be authorized after a diagnosis of Autism Spectrum Disorder. Treatment will be reviewed every six months.

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).

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.

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

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

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. Where the Plan covers a benefit not covered by the Plan, the benefit will be subject to this Plan's prior authorization policies. 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 12 months of the overpayment. 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 (CHIP) 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 do not agree with a claim denial, a benefit decision, or other action under the plan, you or your Representative (any person authorized by you in writing) may Appeal. There is a First- level Appeal and a 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.

First-level Appeals
The First-level appeal must be pursued within 180 days 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.

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.

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

Appeals can be initiated through:

- online at https://apps.uhealthplan.utah.edu/UHealthPlansForms/Appeals/Create
- a written request mailed to the Appeals Department at: University of Utah Health Plans, P.O. Box 45180, SLC, UT 84145
- a verbal request by calling Customer Service at (801) 213-4111 or (833) 981-0214

Expedited First-level Appeals
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. 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.

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 individuals 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 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 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, 4315 S. 2700 W., Suite 2300, Taylorsville, UT 84129.

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.

External Appeal - IRO decisions will be determined in the following time frame:

- 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

Expedited Voluntary Appeal - IRO
If you disagree with the decision made in the initial 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.

You are not required to exhaust other levels of appeal before this appeal is filed, if you file this level of appeal at the same time you file an Expedited Appeal. This level of appeal is available if the adverse decision:

- Involves a medical condition, which would seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function
- In the opinion of Your provider, would subject you to severe pain that cannot be adequately managed without the care of treatment that is the subject of the adverse benefit decision; or
- Concerns an admission, availability of care, continued stay or health care service for which You received emergency services, but have not been discharged from a facility.

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: 801-213-4111 or 833-981-0214 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.

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.

Administrative Evaluations
Evaluations undertaken to fulfill mandatory requirements for participation in work or recreational related activities such as scout physicals, executive physicals, sport participation physicals, court-ordered assessments, insurance physicals or similar evaluations are not covered.

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.

Sublingual Immunotherapy (SLIT) is not covered except for FDA approved therapies meeting coverage guidelines.

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 births in birthing centers.

Cardiac Rehabilitation

Phase 4 associated with cardiac rehabilitation.

Certain Illegal Activities

- Services for an illness, condition, accident or injury arising from You or Your Dependent who is 18 years or older directly related to the voluntary 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.

- Services for an illness, condition, accident, or injury arising from You or Your Dependent who is 18 years or older driving under the influence of alcohol, drugs, or both, or with specified unsafe blood alcohol concentration; or directly related to violating a law the prohibits operating a motor vehicle, in a state other than Utah, while exceeding the legal limit of concentration of alcohol, drugs, or a combination of both in the blood. Any violation shall be established in a criminal proceeding in which You or Your Dependent is found guilty, enters a no contest plea, or a plea in abeyance, or enters into a diversion agreement; or U of U Health Plans requests an independent review where the findings support a decision to deny coverage.

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 U of U Health Plans.

U of U Health Plans 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. Plan 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.

Complications of Noncovered Services
Treatment costs related to complications of services otherwise excluded from coverage or denied prior authorization and associated coverage are not covered for the first twelve months after the service was provided. Complications arising after 12 months will be considered for coverage if the original Service was/is not considered investigational by the plan.

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;
- 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 or as soon as reasonably possible 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 as outlined by the Women's Health and Cancer Rights Act

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 considered experimental, investigational, or unproven;
- services not medically necessary;
- complications from non-covered 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 or when done to correct functional valve collapse causing nasal obstruction;
- 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;
- 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, 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 to treat a covered medical/behavioral condition and performed at a participating hospital or by participating providers.

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; treatment for TMJ/TMD/Myofascial pain and disorders of manifestation not causing severe nutritional deficiencies at the time of the requested service.

Orthodontia and the replacement/repair of dental appliances are not covered, even after an incident.

Repairs for physical damage resulting from biting or chewing are not covered.

Dental Anesthesia including local, regional and general and/or intravenous sedation is not covered except in the following circumstance:

1. Administered by a participating provider, and
2. The individual receiving the anesthesia has one of the following conditions

    a. Is developmentally delayed to the point supporting documentation demonstrates the member is unable to cooperate with necessary services regardless of chronological age
    b. Regardless of age has a congenital cardiac or neurological condition with documentation provided demonstrating that dental anesthesia provided by anesthesiologist or nurse anesthetist is required to closely monitor the medical condition due to extensive nature of procedure(s) being performed
    c. Is under 5 years of age and has all the following:

        - The proposed dental work involves three or more teeth and
        - The diagnosis is nursing bottle-mouth syndrome or extreme enamel hypoplasia; and
        - The proposed procedures are restoration or extraction for rampant decay

Durable Medical Equipment (DME)
University of Utah Health Plans provides coverage for DME only in the following circumstances:

a. When used in conjunction with an otherwise covered condition and ALL the Following Conditions are met:
    i. It is only available by a Provider prescription;
    ii. Provides a therapeutic benefit to the member and is NOT primarily used for non - medical purposes;
    iii. Required for Activities of Daily Living;
    iv. Are Reusable and not disposable

v. Can stand repeated use for prolonged period
vi. Is usable only for member with specific health condition
vii. The equipment does not have significant non-medical uses (e.g., environmental control equipment, air conditioners, air filters, and humidifiers, whirlpool equipment, home exercise or SPA equipment)
viii. Not for duplication or replacement of lost, damaged, or stolen items; and
ix. Not attached to a home or vehicle.

b. Batteries only when used to power a wheelchair or other medical devices in which a specially configured proprietary battery is necessary to power the covered device, additionally batteries for insulin pumps and insulin infusion pump
c. Repair of DME is only covered if pre-approved and estimated costs are less than replacement costs
d. Excluded DME for which there is a lack of evidence of clinical benefit in the published peer reviewed of literature of benefit are not covered.
e. Training and testing in conjunction with DME and prosthetics
f. Equipment purchased from non-licensed DME vendor unless approved prior to purchase by the Plan
g. Specifically Excluded DME include but are not limited to the following:
    i. Transcutaneous electrical or neurostimulation
    ii. Incontinence supplies such as diaper, incontinence pads
    iii. Functional Neurostimulation
    iv. Home whirlpool or SPA equipment
    v. DME to allow participation in sporting activities
    vi. Continuous Passive Motion Devices
    vii. Custom Foot orthotics/inserts/heal pads except for specific custom shoes or inserts for diabetics which are prior authorized.

University of Utah Health Plans will not provide payment for rental costs exceeding the purchase price. For covered rental DME that is subsequently purchased, cumulative rental costs are deducted from the purchase price.

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 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.

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

Medical Prescription Drugs
For a list of medical drugs that require prior authorization or that are not covered, please refer to the Plan website at https://uhealthplan.utah.edu/providers/policy-forms.php. Claims for drugs anticipated to cost over $500 per dose may be subject to medical necessity review. The Plan has the discretion to require certain therapies be provided in the home versus in an infusion center in order to be eligible for coverage. In addition, the Plan will determine if a prescription drug is covered under medical or retail pharmacy.

Medication Samples, including any corresponding administration requirements such as intravenous infusion therapy and office visits for administration.

Medical Tourism

Traveling to another county to obtain medical care, also known as medical tourism, is not covered.

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

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

Noncovered Services performed at the time of a Covered Service are not covered.

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
The ACA requires dietary counseling for adults at higher risk of chronic conditions.".

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

Other Specific Services

- Mole mapping;
- Virtual colonoscopy as a screening for colon cancer;
- Basivertebral Nerve Ablation for Chronic Back Pain;
- Implantable Peripheral Nerve Stimulation for Treatment of Chronic Pain Conditions.

Over-the-Counter Contraceptives
Over-the-counter contraceptive supplies and oral contraceptive are not covered as a medical benefit. Refer to prescription drug benefit section.

Pain Management Therapies Prolotherapy, stem cell therapy, proliferation therapy or regenerative injection therapy for any indication beyond hematopoietic bone marrow transplant for established conditions.

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 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;
- molecular diagnostic testing in the course of evaluation for a genetic or congenital disease; and
- medical services for non-member surrogate mothers.

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 facility and costs for the use of the robot in a robotic surgery 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, or step or in-law relationship.

Services and Supplies Provided by a Halfway House
Services and supplies provided by a 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;
- 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 and medically reasonable to perform;
- autologous blood storage for future use;
- probability and predictive analysis and testing; and
- for 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 to 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 as required by PPACA and an annual 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.

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 and corneal crosslinking therapies for treatment of keratoconus.

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.

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 the number found on the back of your ID Card 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.

Definitions

The following definitions apply to this Covered Prescription Drug Benefits Section:

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. If a brand name drug has a generic equivalent, a band-generic charge will apply.

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

Generic Drug is a drug that has the same active ingredients compared to a brand name drug with regard to its dosage, strength, quality, performance, outcome, and intended use, but is manufactured by a generic drug manufacturer after the brand name drug patent has expired.

Prescription Drug means a drug or medicine which may only be obtained by a Prescription Order and is approved by the US Food and Drug Administration. These products typically bear the legend "Caution, Federal Law prohibits dispensing without a prescription".

Prescription Order means a written, electronic, or oral order for a medication or device Prescription Drug issued by a licensed prescriber within the scope of his or her practice to be administered to an individual.

Specialty Drugs are high risk, high-cost drugs that are used to treat complex conditions that may require special handling and administration. Specialty drugs generally 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 at the number found on the back of your ID Card for additional information.

Prescription Drug Coverage

Covered prescription drugs must be prescribed by a licensed provider and purchased at a network pharmacy, except in a medical emergency.

The Plan has the discretion to require certain therapies be provided in the home versus in an infusion center. In addition, The Plan will determine if a prescription drug is covered under medical or retail pharmacy.

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.

Your pharmacy benefit has four prescription drug tiers. These tiers determine your out of pocket responsibility and correspond to the copays and/or coinsurance shown on your OOC. In most cases, the prescription drugs on the lower tiers will cost less.

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

Please note that prescription drugs covered under the Preventive Drug List* have no cost to members. This is defined below under PRESCRIPTION DRUGS WITH ENHANCED BENEFITS.

Using your Prescription Drug Benefits

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 use your Health Plan Identification Card at a Participating Network Pharmacy, you will be required to pay the applicable Deductible, Copay, or Coinsurance amounts specified in the Summary of Benefits and Coverage (SBC) at the time of purchase;
- When you do not use your Health Plan Identification Card, you will be required to pay the entire cost of the prescription drug. You can submit a paper claim with University of Utah Health Plans Pharmacy Customer Service within 365 days of fill date for reimbursement of eligible expenses, not to exceed the amount the Plan would have paid a Participating Pharmacy if you had used your Health Plan Identification card. Any claims not submitted within 365 days of the fill date must be submitted as soon as reasonably possible, and may be denied if University of Utah Health Plans was prejudiced by your failure to submit your claim within 365 days of the fill date.
- If your premium payments are not current (delinquent), you will be required to pay the full price for your prescription. It is Your responsibility to contact the pharmacy after the premium payments are 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 order at an Out-of-Network Pharmacy You will be required to pay the entire cost of the prescription drug, unless it is related to a medical emergency. There is no reimbursement for prescription claims processed by an Out-of-Network Pharmacy.
- 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 ACA, preferred generic (Tier 1), and preferred brand/non-preferred generic drugs (Tier 2) at a Designated Mail Order or any University of Utah Health Pharmacy. Contact University of Utah Health Plans Pharmacy Customer Service at the number found on the back of your ID Card to see if your drug is eligible for the mail order or 90 day at Retail program.
- Prescriptions written by Out-of-Network Providers are not covered by the Plan.

Insulin Prescription Pricing Caps

For more information regarding insulin prescription pricing caps please refer to the formulary. The formulary can be found at:
https://cbg.adaptiverx.com/web/pdf?key=8F02B26A288102C27BAC82D14C006C6FC54D480F80409B68A42D5CD47F84F563

Prescription Drugs with Enhanced Benefits

***Preventive Drugs** (PREV)

Certain prescription drugs are considered preventive under the Affordable Care Act (ACA). ACA preventive drugs are covered at 100 percent by the Plan (no patient responsibility); although limits may apply. Drugs available under this benefit are listed as PREV on the Preferred Drug List.

Prescription Drug Limits & Requirements

Age
Some prescription drugs have a minimum or maximum age limit requirement under the Plan. Only members within those limits are able to fill those prescription drugs.

Brand-Generic Charge (Ancillary Charge)
A Brand-Generic Charge is applied to your cost if you receive a brand name prescription drug, regardless of reason or medical necessity, if your provider prescribes a brand name drug when a generic is available. A Brand-Generic Charge is the difference between the cost of the generic and the cost of the brand name prescription drug. This penalty is in addition to the regular cost-sharing outlined in your benefits summary. The Brand-Generic Charge does not apply towards Deductibles or Out-of-Pocket Maximum.

Prior Authorization (PA)
To ensure appropriate utilization, some generic and brand prescription drugs and all specialty drugs require Prior Authorization to be eligible for coverage under the prescription drug benefit. In addition, retail prescription drugs with anticipated costs over $1000 require prior authorization. The P&T Committee establishes the PA criteria. Your provider will be required to complete a PA form and provide clinical documentation to show why this prescription drug is needed for treatment of your disease state or medical condition. A letter of medical necessity is also recommended. Your provider should also include your diagnosis and previous therapies that have failed in the letter. If a PA is not received or if the prescription drug is filled prior to approval, the cost of the prescription drug. Prior Authorization is required for any quantities that exceed Plan limits.

Quantity Limit (QL)
Quantity Limit is a program that ensures members do not receive a prescription for a quantity that exceeds recommended Plan or safety limits. Limits are set because some prescription drugs have the potential to be abused, misused, shared, or have a manufacturer's limit on the recommended maximum dose. Quantity limits are based on FDA approved dosing, current medical practices, evidence-based clinical guidelines, and peer-reviewed medical literature related to a particular prescription drug. Prior Authorization is required for any quantities that exceed Plan limits.

Step Therapy (ST)
Step therapy is a program for prescription drugs that are taken on a regular basis to treat an ongoing medical condition. The program is developed around effectiveness, safety, and value. In ST, the covered prescription drugs are arranged in a series of "steps". The program typically starts with generic prescription drugs as the "first step". These generics are rigorously tested and approved by the FDA and allow you to have safe, effective treatment with prescription drug that is more affordable. More expensive brand-name prescription drugs are usually considered in the "second step". Step Therapy is developed under the guidance and direction of the P&T Committee. They review the most current research on thousands of drugs tested and approved by the FDA for safety and efficacy. The first time you submit a prescription that is not for a first-step drug, your pharmacist will receive a message to tell you that the Plan requires ST. This means if you don't want to pay full price for your prescription drug, your doctor needs to write a new prescription for a "first-step" drug. With ST, if you've already tried and failed the "first-step" drug, can't take the "first-step" drug (because of an allergy, etc.), and/or your provider can show medical necessity for the second step products, your

provider can submit a request for Prior Authorization review.

Financial Assistance Programs –RealRx CareLink Programs

RealRx is the Pharmacy Benefit Manager (PBM) acting on behalf of the Plan.

RealRx Care LinkAssist
Coverage for certain specialty medications is applicable if our **CareLink Assist** fails to provide a solution. Assistance solutions comes from a variety of sources, including manufacturer assistance program, copay cards, grants, and mail order pharmacies. If your plan is not a Qualified High Deductible Health Plan (QHDHP) it may cover the cost of these options so your out of pocket cost will not exceed the cost under the pharmacy benefit. The Plan may allow for a 60-day grace period for urgent medications to allow time to complete the advocacy process. As part of the CareLink Assist program, the Plan maximizes specialty copay assistance. For a list of medications included in the CareLink Assist program please contact customer service.

RealRx CareLink International
The Plan offers an option to access certain medications at a discount through our **CareLink International** Global Sourcing program. If you quality for this program, you may be contacted by the Plan to determine if you would like to access the benefit and to help coordinate this for you. Pharmacies in this special international network are located only in 1st Tier countries such as Canada, New Zealand, Australia, Great Britain, France and Germany.

RealRx CareLink Coupon Plus
Certain medications are identified by the Plan as eligible for a program called **CareLink Coupon Plus.** Targeted specialty and chronic condition medications eligible for this program are subject to participant copay or coinsurance. All targeted medications have pharmaceutical manufacturer sponsored copay card programs available. The CareLink Coupon Plus program offers support to assist members in enrolling in manufacturer copay card programs to help offset the member coinsurance responsibility partially or, in some instances, entirely.

Additional Policies and Processes

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 the plan. In this situation, there is no pharmacy benefit available under this plan.

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.

Mail Order
Mail order is when a 100 day supply of a generic or brand name prescription drug (Tier 0, 1, 2, and 3) is mailed directly through a designated Mail Order Pharmacy. Not all prescription drugs are available through Mail Order. Contact Pharmacy Customer Service at the number listed on the back of your ID card for more information or to get started on the Mail Order program.

Mandatory Generic
The plan mandates generic prescription drugs wherever available. If a brand-name prescription drug is requested when a generic is available, the generic will be available without Prior Authorization. If

brand is still desired, PA will be required, even if not indicated on the PDL below. If brand is approved through the PA process, the Brand-Generic penalty will still be applied (see Brand-Generic Change under the Prescription Drug Limits & Requirements section above).

Non-Formulary (not covered) or Exception Requests for Prescription Drugs
For prescription drugs that are not covered by the Plan (non-formulary), you or your provider may submit a formulary exception request. Your provider will be required to provide clinical documentation to show why this requested prescription drug is needed/required for treatment of your disease state or medical condition and to provide evidence that you cannot use a formulary alternative. A letter of medical necessity is also recommended. Your provider should also include in his/her letter your diagnosis and previous therapies that have been tried and failed. If an exception request approval is not received or the prescription drug is filled prior to approval, the cost of the prescription drug will be full member responsibility. Contact Pharmacy Customer Service at the number listed on the back of your ID card for more information.

Off-Label Use of Prescription Drugs
The FDA requires that prescription drugs used in the U.S. be safe and effective. The label information of a prescription drug outlines use for "approved" doses and specific conditions or disease states. The use of a prescription drug for a disease state or condition not listed on the label, or in a dose or therapy not listed on the label, is considered to be a "non-approved" or "off-label" use of the prescription drug. Off-label use of a prescription drug is not covered unless it meets the Plan's off-label use policy. A Prior Authorization is required when a prescription drug is used outside of its FDA indication, dosage, or treatment. Coverage will be reviewed under the off-label use policy and subject to the same conditions and limitations as any other prescription drug. Therapies deemed investigational or experimental or that do not meet the off-label criteria are not a covered benefit.

Specialty Pharmacy
The Plan requires that all prescription drugs noted, as Specialty must be filled through the Plan's designated Specialty Pharmacies. These drugs are usually listed on Tier 4, but certain generics of brand name specialty products may be placed in a lower tier but still be considered specialty. In cases where prescription drugs are available only through a limited distribution channel from the manufacturer, these prescription drugs will be directed by the Plan to another designated specialty pharmacy**.**

Therapeutic Interchange (TI)
Therapeutic Interchange is the practice of replacing, with your physician's approval, a prescription drug originally prescribed with a chemically different but therapeutically equivalent prescription drug. Prescription drugs used in therapeutic interchange programs are expected to produce similar levels of effectiveness and results. Therapeutic interchange programs are based on scientific evidence. These programs are developed under the guidance of the P&T Committee. The program is designed to work along with other tools that medical professionals use to promote safe and effective drug therapy. If therapeutic interchange is required on a prescription drug, your pharmacist will receive a message to request a therapeutic interchange from your provider. If you or your provider feel the interchange is not right for you and you do not want to pay full price for your prescription, your provider can submit a request for Prior Authorization review.

Third-Party Payments
Except for specific circumstances outlined below, we will not accept payment or the offer of payment by third-party service providers may to 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.

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. This drug list is subject to change as new drugs becoming available and others are removed from the market. For a complete list of covered and non-covered medications and plan limitations, refer to The Plan's website at uhealthplan.edu/individual/pharmacy.php to access the retail drug formulary.

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

- Anabolic Steroids
- Biological Sera, Blood, or Blood Plasma
- Compounded Products; Compounded products are limited and may not be covered without prior authorization if a commercial product is available or if exceeds the cost limit.
- 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.
- Experimental Trial medications
- Food Supplements, Special Formulas, and Special Diets
- Homeopathic Medications
- Infertility Medications to treat or enhance fertility
- Investigational, Experimental, Clinical Trial, or Unproven Drugs: Drugs labelled "Caution – limited by federal law to investigational use", or experimental drugs, even though a charge is made to the individual.
- Medications for Cosmetic purposes (for example, but not limited to, cosmetic hair growth and removal Products).
- Medications or immunizations administered for the purpose of prevention of disease when traveling to other countries.
- Medication Taken or Administered While in a provider office or facility: 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. Provider-administered medications are generally covered under the medical benefit, although exceptions may apply for a particular drug or on a case by case basis.
- Medications that are therapeutically the same as an over-the-counter medication
- Medications that are covered under a per diem or daily rate 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 vitiligo
- Medications to treat sexual dysfunction or impotence
- Medication samples, including any corresponding administration requirements such as intravenous infusion therapy and office visits for administration.
- Medications used to treat weight loss.

- Medications whose primary purpose is to correct vision.
- No Charge Medications received under worker's compensation laws, federal, state, or local programs.
- Non-Formulary Medications.
- Off-label use of Medication; except as outlined in the Plan Off-label Use Policy.
- Other Party Liability, Prescription Drugs which an eligible person is entitled to receive without charge under any workers compensation laws, or any other municipal, state, or federal program.
- 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 in excess of a 100-day supply or the Plan day or 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
- Synagis or other passive immunotherapies for the treatment of RSV outside of the state reported RSV reason
- 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 as required under PPACA. Please note vitamins may be limited to coverage by age and specific dosing requirements.

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Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of- pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of- network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out- of-network provider or facility, the most they can bill you is your plan's in-network cost- sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia,

pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in- network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may file a complaint with the federal government by visiting https://www.cms.gov/nosurprises or call 1-800-985-3059.

Visit*: www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.