Individual Exclusive Provider Organization (EPO) Plans Exchange Benefit Plan Medical Policy

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University of Utah Health Plans

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University of Utah Health Insurance Plans, Inc. is domiciled in the state of Utah.

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SECTION 1 – INTRODUCTION AND OVERVIEW

1.1. 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 **Section 12- Definitions** or where they are first used.

1.2. Policy

This Policy describes benefits effective January 1, 2025, 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 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.

1.3. 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 at the time of renewal.

1.4. 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).

1.5. Using Your Policy

University of Utah Health Plans 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 questions about benefits or procedures, please contact University of Utah Health Plans Customer Service Department or visit our website at www.uhealthplan.utah.edu.

1.6. Your Health Information

We will protect your health information. We will only use or share with others as needed for your care and treatment. We will also use and share it to help us process your claims and manage your Policy. When you accept coverage under this Policy, you agree to let your providers share your information with us. We will need information about your physical and mental condition and care. You can get a free copy of our *Notice of Privacy Practices* by visiting our website at https://uhealthplan.utah.edu or by calling the number on your ID card.

1.7. Your Application

By applying for coverage under this Policy, or accepting its benefits, you (or the person acting for you) represent that all information in your application and statements given as part of your application for this Policy are true, correct and complete, to the best of you knowledge and belief; and you agree to all terms, conditions and provisions of this Policy.

It is your responsibility to make sure the application that you submitted is accurate and complete. It is important that you notify us or, if you applied through the federal Exchange (the Exchange), the Exchange immediately of any mistakes that you find in your application.

If we learn that you defrauded us or you intentionally misrepresented material facts when you gave information and answers in the application, or in the application process, we may decide to cancel the Policy.

1.8. Guidance and Service Along the Way

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

By applying for coverage under this Policy, or accepting its benefits, you (or the person acting for you) represent that all you information in your application and statements given as part of your application for this Policy are true, correct, and complete, to the best of your knowledge and belief; and you agree to all terms, conditions, and provisions of the Policy.

SECTION 2 – USING YOUR PROVIDER NETWORK

2.1. You Select Your Provider

University of Utah Health Plans allows you to select your own providers within our network of contracted providers. You are not required to have a referral to see any provider, including a specialist. Our network of doctors, hospitals, and other health care providers is there to give you the care you need. You can find network providers and see important information about them most easily on our online provider directory. You can access the online provider directory at uhealthplan.utah.edu.

2.2. Exclusive Providers

This Policy is an Exclusive Provider Organization (EPO) which means this Policy does not provide benefits for any services you receive from an Out-of-Network Provider except:

- Emergency Services;
- Services for Stabilization and initial treatment of an Emergency Medical Condition;

- Certain Services received from an Out-of-Network Provider at an In-Network Facility; or
- Lack of availability of In-Network services in one 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 within Network Providers/Facilities.
    - Medically Necessary Services are not available with an In-Network Provider in a timely fashion to meet the member's needs.

NOTE: Refer to the "Notice: Your Rights and Protections Against Surprise Medical Bills" for more information regarding reimbursement and balance billing applicable to Out-of-Network Providers. See Section 14.2.

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. In-Network Providers include Physicians, Hospitals, and Other Health Care Facilities. Check the Provider directory at www.uhealthplan.utah.edu

2.3. Selection of a Primary Care Physician

You are not required to select a Primary Care Physician (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 **Section 12 - 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 after office hours care (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
- **Claims Processing.** The Plan will process your claims and notify you of the benefit determination within 30 days of receipt of the claim.

2.4. Access to Rural Healthcare Providers

You may be entitled to coverage for healthcare services from non-contracted providers if you live or reside within 30 paved road miles of an independent hospital, federally qualified health center, or a credentialed staff member at an independent hospital, federally qualified health center, or at his/her local practice location. If you have questions concerning your rights to see one of these providers, you may contact University of Utah Health Plans at 801-213-4111 or 833-981-0214. For a list, please visit our website at https://uhealthplan.utah.edu/notices. The non-contracting Independent Hospital or Federally Qualified Health Center may not balance bill you for services covered under this Rural Health Care Providers provision. 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 University of Utah Health Plans. Submitted claims must meet University of Utah Health Plans claims editing requirements (including National Correct Coding Initiative guidelines/edits adopted by (University of Utah Health Plans) in order to be processed for payment.

2.5. Continuity of Care

You may qualify to receive 90 days of continued coverage (or 90 days from the date you are no longer a continuing care patient, whichever is earlier) at the In-Network benefit level, if your Provider was a contracted In-Network Provider, but is no longer contracted (this provision does not apply if the contract with the Provider was terminated due to failure to meet quality standards or for fraud).
To qualify for continued coverage, you must be:

- Undergoing a course of treatment for a certain or serious and complex condition from the Provider;
- Undergoing a course of institutional or inpatient care from the Provider;
- Scheduled to undergo non-elective surgery from the Provider, (including receipt of postoperative care from such Provider with respect to such surgery);
- Pregnant and undergoing a course of treatment for pregnancy from the Provider; or
- Determined to be terminally ill and receiving treatment for such Illness from the Provider.

We will notify you of your right to receive continued care from the Provider or you may contact us with a need for continued care. Coverage under this Continuity of Care provision will be subject to the benefits of this Policy and provided on the same terms and conditions as any other In-Network Provider. Your Provider must accept the Allowed Amount and cannot bill you for any amount beyond any Deductible, Copayment and/or Coinsurance. Contact Customer Service for further information and guidance.

2.6. Services Received Outside the United States

Any Services, except Emergencies, provided outside the United States are not covered. This Policy providers benefits for Covered Expenses for services received from Providers outside the United States for Medical Emergencies and other urgent situations where treatment could not have been reasonably delayed until the Member was able to return to the United States.

University of Utah Health Plans does not accept assignment from Providers outside the United States. You and your Family Members can file a claim with University of Utah Health Plans for services from a Provider outside the United States but any payment will be sent to the Member. The Member is responsible for

paying the Provider. Benefits are subject to all terms, conditions, limitations, penalties, and exclusions of this Policy and will not be more than would be paid if the service or supply had been received in the United States.

2.7. Services Received Outside Service Area

Any Services outside the Service Area, except emergencies are not covered. (Out-of-Network).

2.8. Residential Treatment Centers (RTC)

Residential Treatment Centers (RTC) must meet Accreditation requirements as outlined in the University of Utah Health Plans Credentialing Policies.

SECTION 3 – WHEN COVERAGE TAKES EFFECT AND TERMINATES

This section describes the situations when coverage begins and ends for you and your Enrolled Dependents.

In general, an applicant may apply for a change in coverage in a Policy during an Annual Open Enrollment Period or as a result of a Special Enrollment Period. Special enrollment rights include but may not be limited to birth, adoption, marriage, divorce, legal separation, loss of minimum essential coverage, loss of coverage due to moving outside the Service Area, and any other event set out by applicable law. If coverage is allowed as a result of a special enrollment right, application must be made for coverage within sixty (60) das from the date of the special enrollment event. Coverage is contingent upon timely application and payment of the appropriate Premium as established by the Exchange and us.

3.1. Eligibility For Coverage

3.1.1. Policyholder

This Policy is issued to you on your application for this insurance and payment of the initial Premium. Your insurance coverage under this Policy is effective on the Policy Effective Date.

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

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

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

3.1.2. Eligible Dependents

Dependents who are eligible for coverage under this Policy are:

1. Your spouse or Domestic Partner; and
2. Your, or your spouse or Domestic Partner's Dependent Children, which include:
    a. Your natural children;

b. Your adopted children;
c. Your step-children provided you are married to the parent of the child;
d. A child for whom you are the legal guardian substantiated by a court order; and
e. A child who is the subject of an administrative court order and for whom you must provide coverage based on such administrative court order.

3.2. Continued Coverage for Disabled Children

A Covered Dependent Child, whose coverage under this Policy would otherwise be terminated solely due to the attainment of age 26 (the limiting age), will continue to be a Covered Dependent Child while such Covered Dependent Child is and continues to be both:

1. Incapable of self-support due to medically continuing intellectual or physical impairment; and
2. Chiefly dependent upon you for support and maintenance.

Proof of the intellectual disability or disability, and dependency must be furnished to us by you within thirty-one (31) days of the Covered Dependent Child's attainment of the limiting age and subsequently as may be required by us. However, we may not require proof more frequently than annually after the two-year period immediately following the Covered Dependent Child's attainment of the limiting age.

3.3. 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;
5. Does not reside within our service area.

If the Dependent Child does not reside with the parent, the Dependent Child's coverage is subject to the **Section 2.7 "Services Received Outside the Service Area**."

3.4. When Coverage Becomes Effective for Your Dependents

You must enroll your Dependents for coverage under this Policy. Eligible Dependents who are listed on your application for this Policy, and approved by us, will be insured under this Policy on the Policy Effective Date. Eligible Dependents who are acquired after the Policy Effective Date may be insured under this Policy as provided under the Newly Eligible Dependents provision.

3.5. Newly Eligible Dependents

If you acquire a newly Eligible Dependent after the Policy Effective Date, you may enroll the new Dependent under this Policy by providing us with the following:

1. Written notification of the newly Eligible Dependent; and

2. Payment of any additional Premium required for the newly Eligible Dependent's coverage under this Policy.

Applications for enrollment of a newly Eligible Dependent must be made within 60 days of the Dependent's attaining eligibility.

3.5.1. Adding a Dependent Child Due to Marriage/Domestic Partnership

If you have a new Dependent due to marriage or the establishment of a Domestic Partnership, the effective date of coverage for the Eligible Dependent 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.

3.5.2. Adding a Dependent Child due to Birth or Placement for Adoption

You must notify us when you acquire a newly 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 newly 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 within 60 days in order for coverage to be continued under this Policy.

We must receive notification and payment of any required Premium for the newly 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 the 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.

3.6. 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 **Section 3.3 "Coverage for Dependent Child Due to Court or Administrative Order"** for additional coverage details.

3.7. Effective Date of Coverage

You the Policyholder, 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 in the application in which you filed.

Eligible Dependents are covered under this Policy as follows:

I. On the date your coverage is effective if they are included in your application for this Policy;
II. 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 or administrative order.

SECTION 4 – TERMINATION OF INSURANCE

4.1. 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 ensure your Covered Dependents provided the required premiums continue to be paid;
2. Of your death;
3. This Policy terminates for any other reason.

4.2. Termination By Us

This Policy will terminate at 11:59 p.m. local time at your place of residence or the earliest of:

1. The end of the period for which no Premium is paid, subject to the Grace Period; refer to **Section 5 "Premiums."**
2. The Premium due date following the date we receive your written request to terminate this Policy;
3. The date of your death.

4.3. Nonrenewal or Discontinuance of This Policy by Us

This Policy will be renewed or continued at your option. However, we may cancel, non-renew or discontinue this Policy only if:

1. You fail to pay Premiums in accordance with the terms of this Policy or if we do not receive timely Premium payments;
2. You have: (a) performed an act or practice that constitutes fraud; or (b) made an intentional misrepresentation of a material fact under the terms of this Policy;

3. We cease to offer coverage in the individual market in accordance with applicable Utah State law;
4. You no longer live, reside, or work in:
   a. The Service Area.

But only if the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

We will not discontinue offering a particular type of individual health insurance coverage we offer in the individual market unless we discontinue such coverage in accordance with applicable state law and unless:

1. We give notice to each covered individual provided coverage of this Policy type in the individual market of the discontinuation at least ninety (90) days prior to the date of the discontinuation of the coverage, subject to the Health Insurance Marketplace guidelines;
2. We offer to each individual in the individual market provided coverage of this Policy type the option to purchase any other individual health coverage currently being offered by us to individuals in the individual market; and
3. In exercising the option to discontinue coverage of this Policy type and in offering the option of coverage under subparagraph II above, we act uniformly, without regard to:
   a. Any health status-related factor of individuals who may become eligible for coverage.

We will not discontinue offering all health insurance coverage in the individual market unless in accordance with applicable state law and unless:

1. We provide notice of discontinuation to each covered individual at least 180 days prior to the date of the discontinuation of coverage;
2. We provide notice to the Commissioner of Insurance at least 30 working days prior to our notification to covered individuals;
3. All health insurance issued or delivered for issuance in Utah in the individual market is discontinued; and
4. Coverage under the health insurance coverage in the individual market is not renewed. If we discontinue offering all health insurance coverage in the individual market as stated in the above paragraph, we will not provide for the issuance of any health insurance coverage in the individual market during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not renewed.

4.4. Termination Of Covered Dependents

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, except where expressly stated otherwise. 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. Coverage will terminate at the end of the Calendar Year when 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.

4.5. Dependents in the Military are Not 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.

4.6. Other Causes of Termination

If you or your Dependents engages in an act or practice that constitutes fraud in connection with coverage or makes an intentional misrepresentation of material fact in connection with coverage, coverage under this Policy will terminate for that Insured.

4.7. Fraud of Misrepresentation During Enrollment

If we find that you or your Dependents 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 effective provided we give you 30 days prior notice. Any Premiums paid for coverage for in ineligible person will be refunded minus any claims paid for that person. We are entitled to receive the claim amounts that exceed the amount of Premium paid.

4.8. 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 5 – Premiums

This Policy requires you to make Premium payments. We will not pay benefits under this Policy for Covered Services obtained after coverage ends if Premium payments are not made by the end of the Grace Period. Any benefit payment denial is subject to our appeals procedures. See **Section 10 – Appeals Process** of this Policy. The first Premium payment is due on or before your coverage start date. We may choose not to accept Premium that is paid for you by someone else unless we are required to by applicable law.

5.1. Payment of Premiums

All Premium, any changes, 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.

5.2. Late Payment Notice

University of Utah Health Plans will send written notification to the Policyholder’s address of record if fully payment of the Premium is not received on or behalf of the Due Date. This notification will inform the Policyholder of the amount owed, include a statement that University of Utah Health Plans will terminate the Policy for nonpayment if the full amount owed is not received prior to the expiration of the Grace Period

as described in the Late Payment Notice, and provide the exact time when the membership of the Policyholder and any enrolled Dependents will end if payment is not received timely.

5.3. 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 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 medical claims for services received during the Grace Period. You will be responsible for the full cost of retail medications until your Premium is paid through the current month. You will need to contact your pharmacy to have any pharmacy claims reprocessed once you have paid your Premiums. 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 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 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 any pharmacy claims reprocessed 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 11:59 p.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.

5.4. Premium Rate Changes

Subject to rate requirements applicable in the state of Utah, where this Policy is issues, 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.

5.5. Premium Refunds

In the event the Policy is cancelled 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.

5.6. Reinstatement

If any renewal Premium is not paid within the time granted to you for payment, a subsequent acceptance of Premium by University of Utah Health Plans or by any agent duly authorized to accept the Premium, without also requiring an application and issues a conditional receipt for the Premium tendered, the Policy shall be reinstated upon approval of this application from University of Utah Health Plans or, lacking this approval, upon the 45th day following the date of the conditional receipt, unless University of Utah Health

Plans has previously notified you in writing of our disapproval of the application. The reinstated Policy shall cover only lass resulting from such accidental injury as may be sustained after the date of reinstatement after the date of reinstatement and loss due to such sickness as may begin more than 10 adays after that date. In all other respects you and University of Utah 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 sixty (60) days prior to the date of reinstatement.

5.7. Third Party Payment of Premiums

Except are required by law, we will not accept payments of Premium or other Cost-Sharing obligations on behalf of a Member from a Hospital, Hospital system, health-affiliated aid program, health care Provider, or other individual or entity that has received or may receive a financial benefit related to the Member's choice of health care.
We will accept payment of Premiums and Cost-Sharing from:

1. A Ryan White HIV/AIDS Program
2. An Indian tribe or tribal organization
3. Local, state, or federal government programs, including grantees directed by a government program to make payments on its behalf
4. A private not-for-profit organization when all of the following criteria are met:
    a. The assistance is provided on the basis of the Member's financial need
    b. The assistance is provided regardless of your health status
    c. The institution/organization is not a healthcare provider
    d. 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.

We do not county any financially interested third party cost-sharing payments toward deductibles or Out of Pocket Maximums. If we discover financially interested third-party payments of this type after the fact and these payments have already been counted toward the Deductible or Out of Pocket Maximum, we will exclude the financially interested third-party from the accumulation toward the Deductible or Out of Pocket Maximum.

SECTION 6 – COVERED BENEFITS

This section explains your benefits for Covered Benefits. All benefits are listed alphabetically. Services not listed below in this section may be covered. Please call customer service to verify.

Before this Policy pays for any benefits, you and your Covered Dependents must satisfy any Deductibles that may apply. After you satisfy the appropriate Deductibles, we will begin paying for Covered Services as described in this section. Members should read this Policy completely and carefully in order to understand their coverage.

If you are inpatient in a Hospital or Other Health Care Facility on the day your coverage begins, we will pay benefits for Covered Benefits that you receive on or after your first day of coverage related to that inpatient

stay as long as you receive Covered Services in accordance with the terms of the Policy. These benefits are subject to any prior carrier's obligations under state or federal law or contract.

Payment to Providers is based on the Allowable Fee. In-Network Providers agree to accept payment of the Allowable Fee for Covered Medical Expenses as full payment. Out-of-Network can bill you for the difference between the amount that we pay, if any, and the amount of their billed charge (the balance billed amount). Member will be responsible for the balance billed amount. We may pay you directly for services provided by an Out of Network Provider. When you receive Emergency Care or receive certain services by an Out of Network Provider at an In-Network Hospital or Ambulatory Surgical Center, you are protected from surprise/balance billing. See **Section 14.2 "Surprise Billing"** in this Policy for additional information.

Payment of Covered Medical Expenses will be:

1. Based on the Allowable Fee; and
2. Subject to the Deductible, Coinsurance, Copayments, and Annual Out of Pocket Maximum.

6.1. 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 within 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. If you and/or your spouse are covered by multiple pans, University of Utah Health Plans will cover a prorated share of the adoption indemnity Benefit. The adoption Benefit is subject to Coinsurance, Copays, and Deductible applicable to the maternity Benefits as indicated in your Outline of Coverage.

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

University of Utah Health Plans may seek reimbursement if the postplacement evaluation disapproves the adoption placement; and a court rules the adoption may not be finalized because of an act or omission of an adoptive parent or parents that affects the child's health or safety.

6.2. Allergy Testing

Coverage will be provided for Covered allergy testing ordered by a physician or other qualified provider who is treating the Member.

6.3. Ambulance Services

Ambulance services to the nearest Hospital equipped to provide treatment are covered when any other form of transportation would endanger your health and the transportation is not for personal or convenience purposes. Covered Benefits include licensed ground and air ambulance Providers.

Covered Air Ambulance Emergency services, whether from Participating Provider or Non-Participating Providers, are subject to the Cost Sharing identified in the Outline of Coverage. Non-Participating Providers of Emergency Air Ambulance services may not Balance Bill Member for non-covered charges.

6.4. Anesthesia Services

Anesthesia services provided by a Physician (other than the attending Physician), certified anesthesia assistant or nurse anesthetist. Services include: (1) the administration of spinal anesthesia; and (2) the injection or inhalation of a drug or other anesthetic agent. When you receive care by an Out of Network Anesthesiologist at an In-Network Hospital facility, you are protected from surprise/balance billing. **See Section 14.2 "Surprise Billing"** in this Policy for additional information.

6.5. Approved Clinical Trial

Benefits are payable for all routine patient care costs provided during an approved clinical trial by a Participating Provider, including Phases I through IV, for an Insured Person who meets the following requirements:

(1) Is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the prevention, detection, and treatment of a disease or condition subject to the clinical trial and

(2) Either –

  (A) The referring health care professional is a participating health care Provider and has concluded that the Insured Person's participation in such trial would be appropriate based upon the Insured Person meeting the conditions described in paragraph (1); or

  (B) The Insured Person provided medical and scientific information establishing that the Insured Person's participation in such trial would be appropriate based upon the Insured Person meeting the conditions described in paragraph (1).

6.6. Autism Spectrum Disorder

Services for Autism Spectrum Disorder are covered. Covered Services include diagnosis (including non-investigational assessments, evaluations or tests) and proven treatments (including Applied Behavioral Analysis, Behavioral Health, Pharmacy Care, psychiatric care, psychological care, or Therapeutic Care, and related equipment) when found to be medically necessary.

6.7. Cardiac/Pulmonary Rehabilitation

Phase 1 (Inpatient) and Phase 2 (Outpatient) cardiac and pulmonary rehabilitation are covered.

Outpatient cardiac rehabilitation is considered reasonable and necessary only for patients with a clear medical need, who are referred by their attending physicians and (1) have a documented diagnosis of acute myocardial infraction within the preceding 12 months; or (2) have had coronary bypass surgery; and/or (3) have stable angina pectoris. A maximum of 36 sessions, 3 times a week for 12 weeks are covered.

Outpatient pulmonary rehabilitation is covered for individuals with moderate to very severe COPD (defined as GOLD classification II, III, and IV), when referred by the physician treating the chronic respiratory disease. It is limited to 2 one-hour sessions per day, for up to 36 sessions for up to 36 weeks for Pulmonary Rehabilitation Program services when documentation supports that all program requirements are met.

6.8. Cochlear Implants

Cochlear implants are covered if determined to be Medically Necessary per plan guidelines. Services associated with approved cochlear implants are also covered including programming, aural rehabilitation and batteries.

Bone anchored hearing aides (BAHA) devises are not covered as they are considered hearing aids which are excluded from coverage.

6.9. Diabetes

University of Utah Health Plans covers 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.

6.10. Dialysis

Services and supplies for inpatient and outpatient dialysis are covered (including outpatient hemodialysis, peritoneal dialysis, and hemofiltration) when provided by an in-network provider.

6.11. Durable Medical Equipment

Coverage will be provided for the purchase or rental of Durable Medical Equipment (DME) when certain criteria are met. Criteria for DME coverage (All must be met):

1. Require Provider prescription;
2. Provides a therapeutic benefit to the Member and is not primarily used for non-medical purposes;
3. Must be prescribed by a Qualified Healthcare Provider;
4. Required to complete Activities of Daily Living;
5. Can withstand repeated use over an extended period and is not disposable;
6. Is usable only for the Member with specific health conditions;
7. The equipment does not have significant non-medical uses;
8. Not used for duplication or replacement of lost, damaged, or stolen items; and
9. Is not attached to a home or vehicle.
10. Is not specifically excluded in **Section 9 - Limitations and Exclusions.**

Batteries are only covered in the following circumstances:

1. To power a wheelchair or other medical devices in which a specifically configured proprietary battery is necessary to power the covered device; or
2. For insulin pumps and insulin infusion pumps.

Repair of DME is covered only if Prior Authorization is obtained and estimated costs are less than replacement costs.

Replacement of DME items is only allowed every 5 years except for certain circumstances defined by the Plan.

Coverage will be provided for a supportive device for the body or a part of the body, head, neck, or extremities, including but not limited to, leg, back, arm, and neck braces. In addition, when Medically Necessary, Benefits will be provided for adjustments, repairs, or replacement of the device because of a change in the Member's physical condition.

The Plan will not pay for foot orthotics, inserts, or heal pads except for specific custom shoes or inserts for diabetics which require preauthorization.

Prior Authorization may be required for DME.

6.12. Emergency Services (Including Professional Charges)

Treatment received in a Hospital's emergency room or freestanding emergency facility for an Emergency Medical Condition are covered. This includes evaluation of, and treatment to stabilize, an Emergency Medical Condition.

Emergency Services, whether from Participating or Non-Participating Providers, are subject to the Cost Sharing for Emergency Services in the Outline of Coverage at the in-network level. Members are not subject to Balance Billing for Emergency Services. **See Section 14.2 - "Surprise Billing" for more information.**

Emergency room services do not need to be pre-authorized.

6.12.1. Post-Stabilization services

Except as set forth below when transfer to a Participating Hospital is appropriate or when any other benefit exclusions apply, University of Utah Health Plans covers Post-Stabilization Services obtained from Non-Participating Providers in accordance with State and Federal law. Covered Providers are subject to Cost Sharing for Emergency Services in the Outline of Coverage at the in-network level. Members are not subject to Balance Billing for Post-Stabilization Services unless they consent to waive Balance Billing protections according to the required process under federal law. For more information **See Section 14.2 – "Surprise Billing" for more information**.

"Stabilization" means to provide Medically Necessary treatment:

- To assure, within a reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during or to result from, the transfer of the Member from a facility; and
- In the case of a covered Member, who is pregnant, to perform the delivery (including the placenta).

If admitted to an Out-of-Network Hospital directly from the emergency room, services will be covered.

6.12.2. Transfer to a Participating Hospital

Prior Authorization is required to obtain elective Hospital services, except in the case of Emergency Services, Post-Stabilization Services, and other exceptions identified in this Policy. For Members admitted to a Non-Participating Facility for Emergency Services, University of Utah Health Plans will work with the Member and their Provider to provide transportation to a Participating Facility.

If the Member waives Federal Balance Billing protections and refuses the transfer, additional services provided in the Non-Participating Facility, including Post-Stabilization Services, are not Covered Services. Non-Covered Services may not be entitled to Balance Billing protections and the provider may balance bill Members for these services. The Member will be 100% responsible for payments, and the payments will not apply to the Annual Maximum Out-of-Pocket. For more information on "Surprise Billing, **See Section 14.2 – "Surprise Billing" for more information.**

6.13. Habilitative Care and Rehabilitative Care

Coverage will be provided for habilitative care services when the Member requires help to keep, learn, or improve skills and functioning for daily living. These services include, but are not limited to:

1. Physical and occupational therapy;
2. Speech-language pathology; and

3. Other services for people with disabilities.

These services may be provided in various Inpatient and/or Outpatient settings as prescribed by a Physician.

Coverage will be provided for rehabilitative care services when the Member needs help to keep, get back or improve skills and functioning for daily living that have been lost or impaired because the Member was sick, hurt, or disabled. These services will include but are not limited to:

1. Physical and occupational therapy;
2. Speech-language pathology; and
3. Psychiatric rehabilitation.

These services may be provided in various Inpatient and/or Outpatient settings as prescribed by a Physician.

Coverage for habilitative care and rehabilitative care are subject to the Limitation found in the SBC (Summary of Benefits and Coverage) under habilitative and rehabilitative services.

6.14. Home Health Care Services

Home health care is covered when provided by a licensed agency or facility for home health care when determined to be medically necessary based on evidence-based established guidelines by the Plan Home health care includes all services for patients that would be covered if the patient were in a Hospital or Skilled Nursing Facility.

Home health care services are covered only if authorization is obtained prior to the services being provided. These services additionally require periodic re-determination of medical necessity as defined by the Plan.

DME associated with home health care services is covered in the DME benefit.

6.15. Hospice Care Services

Coverage will be provided for Hospice Care Services. Hospice Care Services is a coordinated program of home care and inpatient care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill Member and the Member’s Immediate Family. Benefits include:

1. Inpatient and Outpatient care;
2. Home care;
3. Skilled and non-skilled nursing care;
4. Counseling and other support services provided to meet the physical, psychological, spiritual and social needs of the terminally ill Member; and
5. Instructions for care of the Member, counseling, and other support services for the Member’s Immediate Family.

To be eligible for benefits for Hospice Care Services, the Member must be suffering from a Terminal Illness, as certified by his or her Physician, notice of which is submitted to us in writing.

Hospice Services that are applied toward any Deductible will be applied against the Maximum Benefit limit on these services Durable Medical Equipment associated with hospice care is covered in the DME benefit. Prior Authorization is required for Hospice Services.

6.16. Hospital Care – Inpatient, Outpatient, And Ambulatory Surgical Center

Services and supplies of a Hospital or an Ambulatory Surgical Center (including services of staff Providers) are covered for treatment of Illness or Injury.

Emergency hospitalization to an Out-of-Network Hospital directly, services will be covered at the in-network rate. Contact Customer Service for further information and guidance. Emergency Services received at an Out-of- Hospital facility, you are protected from surprise/balance billing. Certain services provided by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center are protected from Surprise/balance billing. See "Surprise Billing" in this Policy for additional information

6.17. Infusion Therapy Services

Inpatient, outpatient, and home therapy services, supplies (including infusion pumps) and medications for infusion therapy are covered when medical necessity is established.

Services provided include, but are not limited to:

1. Therapy and drug administration education for the Member, the Member's caregiver, or a family Member.
2. Drugs and other diluents necessary for injection or infusion.
3. Supplies
4. Equipment.
5. Parenteral and enteral therapy.
6. Skilled Nursing services when billed by a Home Infusion Agency or Outpatient Infusion Pharmacy. (Please note: Skilled Nursing Services billed by a Home Health Agency will be covered under the Home Health Care Benefit.)

Preauthorization is required for most infusion therapy benefits and related services. Please refer to the section on Preauthorization.

6.18. Mastectomy / Reconstructive Services

In accordance with the Women's Health and Cancer Rights Act (WHCRA), mastectomies and reconstructive surgery after a mastectomy are covered. If you are receiving Benefits in connection with a mastectomy, coverage for reconstructive surgery, including modifications or revisions, will be provided according to University of Utah Health Plans Utilization Management criteria and in a manner determined in consultation with you and the attending Physician, for:

1. All stages of reconstruction on the breast on which the mastectomy was performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and treatment of physical complications of the mastectomy; including lymphedema.

Prophylactic mastectomies are covered in limited circumstances in accordance with University of Utah Health Plans medical policy.

These benefits will be provided subject to the same Deductibles, Copays, and Coinsurance amounts applicable to other medical and surgical procedures covered by the Plan.

6.19. Maternity Care

Your Policy provides pregnancy and post-delivery case benefits for you and your Family Members. Coverage for maternity and newborn care services will be treated as any other Illness. The mother and her Newborn are entitled to Inpatient Hospital coverage for a period of 48 hours following a vaginal delivery; and 96 hours following a delivery by cesarean section.

Any decision to shorten the period of inpatient care for the mother or the Newborn must be made by the attending Provider in consultation with the mother.

6.19.1. Newborn Care

Services and supplies in connection with nursery care for the natural newborn or newly adoptive child are covered by the newborn's own coverage. The newborn child must be eligible and enrolled as explained in **Section 3.** "Newborn care" means the medical services provided to a newborn child following birth including Hospital nursery charges, the initial physical examination and an appropriate lab testing.

6.20. 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. Claims for drugs anticipated to cost over $500 per dose may be subject to medical necessity review. The Plan has discretion to require certain therapies be provided in the home versus 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.

6.21. Mental Health And Substance Use Disorder Services

Mental Health and Substance Use Disorder Services are covered for treatment of Mental Health Conditions or Substance Use Disorders.

Coverage for the diagnosis and treatment of Mental Health and Substance Use Disorders will be provided on the same basis as any other Illness. Outpatient non-investigational behavioral health is covered if provided by a participating provider.

Services eligible for coverage for Mental Health and Substance Use Disorders include the following:

1. Inpatient Care
2. Intensive Outpatient Care
3. Partial Hospitalization
4. Residential Treatment
5. Applied Behavioral Analysis in the Treatment of Autism Spectrum Disorder
6. Medication Assisted Therapy in the Management of Substance Use Disorder

Preauthorization is required for the above services; refer to **Section 7 "Utilization Review Management Program".**

Mental Health and Substance Use Disorder services that are not covered by this Policy are listed in **Section 9 – Limitations and Exclusions.**

6.22. Pediatric Vision Care

Coverage will be provided for vision care services for Covered Dependent Children up to age eighteen (18). Benefits will be provided for the covered services shown in the SBC for the stated frequency of services The frequency of service for each covered service is once per year, unless otherwise stated in the SBC.

Coverage will be provided for one pair of lenses per Calendar Year. Benefits payable under this Pediatric Vision Care Program benefit are subject to the terms, conditions, exclusions, limitations outlined in this Covered Benefit and this Policy.

6.23. Phenylketonuria (PKU) and other Inborn Errors of Metabolism

University of Utah Health Plans covers testing and treatment of phenylketonuria (PKU). We also cover inborn errors of metabolism that involve amino acids. This includes formulas and special food products that are part of a diet prescribed by a Participating Provider and managed by a licensed healthcare professional. The healthcare professional will consult a physician who specializes in the treatment of metabolic disease. The diet must be deemed Medically Necessary to prevent the development of serious physical or mental disabilities or to promote normal development or function.

6.24. Preventive Care Services

The Policy provides benefits for routine preventive care services. Payment will be provided for Covered Expenses for Preventive Care services including the following:

- Two Smoking Cessation Attempts; Prescription Drugs for smoking cessation treatment are covered under the Prescription Drug benefit;
- Items or services that have an A or B rating in current recommendations on the U.S. Preventive Services Task Force (USPSTF);
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines by the Health Resources and Services Administration; and
- For women, such additional preventive care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

All Preventive Services must be furnished by a Participating Provider to be covered under this Policy. As new recommendations and guidelines for preventive services are published and recommended by the government agencies identified above, they will become effective under this Policy. Coverage will start for product years the begin one year after the date the recommendation or guideline is issued or on such other date as required by the ACA and its implementing regulations.

If an existing or new government recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a preventive service, then we may impose reasonable coverage limits on such preventive care. Coverage will be consistent with the ACA, its corresponding federal regulations and applicable State law.

6.25. Telehealth

Coverage will be provided for the use of interactive audio, video, or other telecommunications technology that is used by a Provider or Facility to deliver health care services at a site other than where the patient is located and delivered over a secure HIPAA compliant connection. Health Care Services administered via telehealth must be deemed Medically Necessary and administered by a licensed Health Care Provider.

6.26. Transplants

Coverage for transplants are covered:

1. Only if provided by In-Network Providers in an In-Network Facility unless otherwise preapproved in advance by University of Utah Health Plans; and
2. Only eligible transplants, including the following
    a. Bone marrow as outlined in University of Utah Health Plans criteria;
    b. Combined heart/lung;
    c. Combined pancreas/kidney;
    d. Cornea;
    e. Heart;
    f. Kidney;
    g. Liver;
    h. Pancreas after kidney;
    i. Single or double lung;
    j. Small bowel.

For covered transplants, organ harvesting from donors is covered. Services for both the donor and the recipient are only covered under the recipient's coverage. University of Utah Health guidelines for donor services are available by calling Customer Service.

Prior authorization is required for all Transplant services.

6.27. Urgent Care

Care for an Illness or Injury, or condition serious enough that a prudent layperson would seek care right away, but not so severe to required Emergency Room Care.

If a condition requiring Urgent Care develops, we recommend that you go to the nearest In-Network Urgent Care Center of Physician's office. This treatment may be subject to a Copayment and/or Coinsurance.

SECTION 7 – UTILIZATION REVIEW MANAGEMENT

University of Utah Health Plans works to optimize the cost of health care while protecting the quality of care. The Utilization Review Management Program reviews three aspects of medical care: appropriateness of the care setting, Medical Necessity, initial elective inpatient hospitalizations and appropriateness of Hospital lengths of stay. The Utilization Management process takes several forms.

7.1. Medical Necessity

Your Policy will pay for its share of expenses for Covered Services only if the general requirements are met. They are:

- The service is Medically Necessary.

- It is not considered investigational/experimental/unproven
- You get the service from a Participating Provider
- You or your Provider obtains Prior Authorization before receiving the Service when prior authorization is required.

The Medical Necessity requirements is in the Definitions section, where we define “Medical Necessity.”

7.2. Preauthorization

University of Utah Health Plans must approve your use of some medical services and drugs before they will be covered. This approval is called Prior Authorization also referred to as preauthorization. Members may receive many Covered Services without Prior Authorization.

Obtaining Prior Authorization does not guarantee payment of benefits. Payment may be contingent to other requirements. Your Benefits for the Preauthorized Services are subject to the Eligibility requirements, Limitations, Exclusions, and all other provisions of the Plan. Prior Authorization for Prescription Drugs are also found in the **Section 8 - Prescription Drug Benefits**.

University of Utah Health Plans will review a request for Prior Authorization after receiving all needed information. Member’s Provider may ask the University of Utah Health Plans to speed up the Prior Authorization process if the request is Urgent. University of Utah Health Plans will tell the Member and the Member’s Provider about the decision within the timeframe allowed by State and Federal Law.

Members will be told if the request for Prior Authorization is denied. If the Prior Authorization is denied, the Member will get information about how to appeal the denial.

Services requiring Prior Authorization can be found here and by selecting individual:

https://apps.uhealthplan.utah.edu/UHealthPlansForms/PACodeSeach/CodeRecords

7.2.1. Who Is Responsible For Obtaining Prior Authorization?

In-Network Providers and Facilities are responsible for obtaining Prior Authorization on your behalf; however, you should verify that they have obtained Prior Authorization prior to receiving Services. You are responsible for obtaining Prior Authorization when using an Out-of-Network Provider or Facility. Network Providers must obtain Prior Authorization as specified in University of Utah Health Plans Medical Policy.

Participating Providers cannot bill you if they fail to ask us for Prior Authorization. But if your Physician or PCP requests Prior Authorization and we deny it, and you still choose to get the care, you will have to pay for it yourself.

To verify Prior Authorization requirements, you can call the number on the back of your ID card.

7.2.2. Preauthorization for inpatient Services

Prior Authorization is required to for all non-emergency inpatient admissions, and certain other admissions, in order to be eligible for benefits.

Prior Authorization can be obtained by you, your Family Member(s) or the Provider by calling the number on the back of your ID card.

Please note that emergency admissions will be reviewed post admission.

Inpatient Prior Authorization reviews both the necessity for admission and the need for the continued stay in the Hospital.

Plan Notification is recommended for any Inpatient admission, including admissions to a Hospital, Chemical Dependency Treatment Center, Mental Illness Treatment Center, Chemical Dependency or psychiatric residential treatment facility, intensive Outpatient programs, or other medical procedures or services, as soon as the Participating Provider recommend or schedules to allow the Utilization Review Management Program to begin working with the Member on the benefit management for the Service.

7.3. Prior Authorization For Outpatient Services

Prior Authorization is also required for certain outpatient procedures and services in order to be eligible for benefits.

7.4. Prior Authorization For Emergency Medical Conditions

You do not need Prior Authorization for Emergency Medication Conditions and Post-Stabilization Services. However, Post-Stabilization Services received in the inpatient department of a hospital are subject to the inpatient Concurrent Review process described below.

7.5. Post-Service Medical Necessity Reviews

When a Member or their representative requests a Medical Necessity determination after services have been rendered, we will notify them of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond our control, we will notify the Member or their representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after their receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the Member or their representative must provide the specified information to us within 45 days after receiving the notice. The determination period will be suspended on the date we send such a notice of missing information, and the determination period will resume on the date the Member or their representative responds to the notice.

For an Emergency admission, a Member, their Provider, or the admitting Facility should notify us within twenty-four (24) hours after the Member has been admitted.

7.6. Inpatient Concurrent Review

When an ongoing course of treatment has been approved for a Member and they wish to extend the approval, the Member or their representative must request a required concurrent medical necessity determination.

If a continue stay is deemed not Medically Necessary and our Medical Director has determined to terminate, suspend, or change the original authorized stay, there must be a 10-day advance notice to the Member to file an appeal prior to the termination of the authorized services if the Member wishes to continue the services.

7.7. Prescription Drugs and Medication

Claims for medical drugs anticipated to cost over $500 per dose may be subject to medical necessity review. As outline in the Prescription Drugs section of this Policy, some retail prescription drugs also

require Prior Authorization. Please refer to the Prescription Drug (Rx) Information on our website at uhealthplan.utah.edu/individual/pharmacy.php.

7.8. Utilization Review

Licensed staff processes Prior Authorization requests and conducts concurrent review. Upon request Providers and Members requesting authorization for Covered Services will be provided with the criteria used for making coverage determinations. We provide assistance and inform Members of alternatives for care when a Member is not authorized for a service. Please contact Customer Service for utilization review questions.

7.9. Care Management

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.

7.10 American Health's Discretionary Utilization Review Services

For claims outside of Utah processed through our National Network; American Health has discretionary authority to perform its Discretionary Utilization Review duties hereunder, including the right to make final and binding decisions for the services they provide.

SECTION 8 – PRESECRITPION DRUG BENEFITS

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 more 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.

8.1. Definitions

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

8.1.1. Brand Name Drug

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 brand-generic charge will apply.

8.1.2. Designated Pharmacy

You must use the pharmacy designated by the Health Plan for that particular pharmacy benefit to apply.

8.1.3. Generic Drug

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.

8.1.4. Prescription Drug

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".

8.1.5. Prescription Order

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

8.1.6. Specialty Drugs

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 filed through a specialty pharmacy that is designated by the Plan. Please call University of Utah Health Plans Pharmacy Customer Service at the number found on the back of your ID Card for additional information.

8.2. 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 to 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 showing in your Outline of Coverage. Your responsibility will be based on the type of drug (generic, brand, or specialty) and what the tier the drug is in.

Your pharmacy benefit has five prescription drug tiers. These tiers determine your out-of-pocket responsibility and correspond to the copays and/or coinsurance shown on your Outline of Coverage. 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
Tier 5 – Non-Preferred Specialty Drugs

8.3. 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 ID 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 request for Direct Member reimbursement (DMR) through 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 during your Grace Period. Once your Premiums are paid current, it is your responsibility to contact the pharmacy to have the pharmacy reverse and reprocess the claim through the plan. If the pharmacy is unable to reprocess your retail pharmacy claims through the Plan, you can contact Pharmacy Customer Service for help in submitting a Direct Member Reimbursement (DMR).
- If you fill a prescription order from an Out-of-Network Pharmacy you will be required to pay the entire cost of the prescription drug. There is no reimbursement for prescription claims processed by an Out-of-Network Pharmacy unless it is related to a medical emergency.
- You are able to fill a 30-day supply at any In-Network Pharmacy. The Plan uses a Nationwide Network of Pharmacies. You can locate a network pharmacy at http://uhealthplan.utah.edu/individual/pharmacy.php. You are also able to fill a 90-day supply on 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 program or 90 days at an In-Network Pharmacy.
- Prescriptions written by Out-of-Network Providers are not covered by the Plan.

8.4. Insulin Pricing Caps

For more information regarding insulin prescription pricing caps please refer to the formulary. The formulary can be found at 2025 Individual & Family Plans Preferred Drug List.

8.5. Prescription Drugs with Enhanced Benefits

8.5.1. 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.

8.6. Prescription Drug Limits & Requirements

8.6.1. 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.

8.6.2. **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 charge 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.

8.6.3. **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 and approved or if the prescription drug is filled prior to approval, you will be required to pay the entire cost of the prescription drug. No reimbursement is available on prescription drugs filled prior to approval.

8.6.4. **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.

8.6.5. **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.

8.7. Financial Assistance Programs – RealRx CareLink Programs

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

8.7.1. RealRx Care Link Assist

The Plan offers an option to access certain medications through our CareLink Assist Program. 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. Coverage for certain specialty medications is applicable if our CareLink Assist fails to provide a solution.

8.7.2. RealRx Care Link International

The Plan offers an option to access certain medications at a discount through our CareLink International Global Sourcing program. If you qualify 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.

8.7.3. 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.

8.8. Additional Policies and Processes

8.8.1. Coordination of Benefits

The Plan does not coordinate retail 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 the situation where this Plan is secondary, there is no retail pharmacy benefit available under this plan.

8.8.2. 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. If the stolen replacement prescription is approved, it will be limited to one incident.

8.8.3. Mail Order

Mail order is when a 90-day supply of a generic or brand name prescription drug (Tier 0, 1 and 2) 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.

8.8.4. 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 may 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 Charge will be applied (see Brand-Generic Change under the Prescription Drug Limits & Requirements section above).

8.8.5. 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 the 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 and no Direct Member Reimbursement will be available. Contact Pharmacy Customer Service at the number listed on the back of your ID card for more information.

8.8.6. 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 uses 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.

8.8.7. 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.

8.8.8. Therapeutic Interchange (TI)

Therapeutic Interchange is the practice of replacing, by regulation or 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

8.8.9. Third-Party Payments

Except for specific circumstances outlined below, we will not accept payment or the offer of payment by third-party service providers 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:

- Assistance is provided based on 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.

8.9. 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, except where only provided through retail 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 to prevent 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 (Respiratory Syncytial Virus) 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.

SECTION 9 – LIMTATIONS AND EXCLUSIONS

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

9.1. Waiting Period for Preexisting Conditions

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

9.2 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.

9.3 Abortions/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

9.4 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.

9.5 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.

9.6 Administrative Services

Services obtained 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.

9.7 Adoption

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 are not Covered Services.

9.8 Allergy Services

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

9.9 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.

9.10 Anesthesia Services

No benefits will be paid for:

1. Local anesthesia or intravenous (IV) sedation that is considered to be an inclusive service or procedure;
2. Hypnosis;
3. Anesthesia consultations before surgery that are considered to be inclusive services and procedures because the Allowable Fee for the anesthesia performed during the surgery includes the anesthesia consultation; or
4. Anesthesia for dental services.

9.11 Billing of Services

The following are improper billing practices:

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

9.12 Birthing Centers

Services and supplies related to birth in birthing centers.

9.13 Cardiac Rehabilitation

Phase 4 associated with cardiac rehabilitation.

9.14 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 University of Utah Health Plans requests an independent review where the findings support a decision to deny coverage.

9.15 Chiropractic Treatment

Any Services associated with chiropractic treatment.

9.16 Claims After One Year

Claims are denied if submitted more than one year after the Services were provided unless notice was given, or proof of loss was filed as soon as reasonably possible. Adjustments or corrections to claims can be made only if the supporting information is submitted within one year after the claim was first processed by University of Utah Health Plans unless the additional information relating to the claims was filed as soon as reasonably possible.

When University of Utah Health Plans is the secondary payer, Coordination of Benefits will be performed only if the supporting information is submitted to University of Utah Health Plans within one years after the claim was processed by the primary plan unless the information was provided as soon as reasonably possible.

9.17 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 are typically covered for a qualified individual who is not enrolled in a approved 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.

9.18 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.

9.19 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 as a result of Injury or Illness;
- Required as a result of an Accidental Injury, Illness, or therapeutic intervention and Services are rendered or planed (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

9.20 Counseling

Charges for counseling a Member, 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 schoolteacher

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

9.23 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.

9.24 Custodial Care

Custodial Care is not covered.

9.25 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.

9.26 Dental Anesthesia

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.

9.27 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. Batters 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.

9.28 Expenses Before Coverage Begins or After Coverage Ends

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.

9.29 Experimental or Investigational

Experimental or Investigational 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 are also excluded.

9.30 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.

9.31 Food Supplements

Except for Dietary Products, as described in **Section 6 – "Covered Services"**, food supplements and substitutes are not covered.

9.32 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.

9.33 Gene Therapy

Gene Therapy including, but not limited to, the cost of the Gene Therapy product, and any medical, surgical, professional and facility services directly related to the administration of the Gene Therapy product.

9.34 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.

9.35 Growth Hormone Therapy

Growth hormone therapy, once bone growth is complete.

9.36 Hearing Care

Hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them. This includes Bone Anchored Hearing Aids (BAHAs) as well as auditory brain stimulation. This exclusion does not apply to cochlear implants.

9.37 Home Birth

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

9.38 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.

9.39 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.

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

9.41 Medical Tourism

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

9.42 Mental Health and Substance Use Disorders

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 boarding schools and academies and services that are educational;
- 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
- Substance Use Disorder services rendered via (a) marriage counseling, (b) hypnotherapy, or (c) services given by a staff member of a school or halfway house will not be covered.

Refer to **Section 12 - Definitions** for additional information regarding Behavioral Health and Substance Abuse.

9.43 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.

9.44 Non-Covered services in Conjunction with a Covered Service

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

9.45 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.

9.46 Nutritional Counseling for Non-nutritional Related Disorders

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

9.47 Organ and Tissue Donation

Organ and tissue donor charges, when a University of Utah Health Plans member is not the organ recipient.

9.48 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.

9.49 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.

9.50 Pain Management Therapies

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

9.51 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.

9.52 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.

9.53 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
- Services for or related to surrogate pregnancy for both the Member and non-member surrogate including diagnostic screening, physician services, reproduction treatments, and pre-natal/delivery/post-natal service.

9.54 Prescription Drugs Covered Under a Per Diem for a Skilled Nursing, Long-Term Care, or Acute Rehab Facility Contract

9.55 Psychoanalysis/Psychotherapy

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

9.56 Pulmonary Rehabilitation

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

9.57 Repatriation

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

9.58 Reversals of Sterilizations

Services and supplies related to reversals of sterilization.

9.59 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.

9.60 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.

9.61 Services and Supplies for which 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 Member cannot be held liable because of an agreement between the Provider rendering the service and other third-party payor which has already paid for such service or supply;
- Services for which the Member incurs no charge or has no legal obligation to pay.

9.62 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.

9.63 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.

9.64 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.

9.65 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.

9.66 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**.**

9.67 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.”

9.68 Terrorism or Nuclear Release

Services for an illness, injury, or connected disability are not covered when caused by or arising out of an act of international or domestic terrorism, as defined by United States Code, Title 18, Section 2331, or from an accidental, negligent, or intentional release of nuclear material or nuclear byproduct material as defined by United States Code, Title 18, Section 831.

9.69 Therapeutic Boarding Schools

9.70 Third-Party Liability

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

9.71 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.

9.72 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.

9.73 Varicose Veins

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

9.74 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.

9.75 War or Insurrection

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

9.76 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
- Complication 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.

9.77 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 10 – 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.

10.1. 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 acknowledgment 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 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.

10.2. 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.

10.3. 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 receipt of the request.

10.4. 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.

10.5. 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.

10.6. Definitions Specific to the Appeals Process

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

- Access to health care benefits, including an adverse benefit determination made pursuant to utilization management;
- Claims payment, handing, 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.

10.6.2. Independent Review Organization (IRO) is an independent Physician Review Organization which acts as the decision-maker for voluntary expedited Appeals and voluntary external Appeals, through an independent contractor relationship with the 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.

10.6.3. Medical Director means for the 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.

10.6.4. 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 a 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 11 – 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.

The Coordination of Benefits provision applies when a Subscriber or the Subscriber's covered Eligible Dependents have health care Coverage under more than one health benefit plan.

11.1. Benefits Subject to this Provisions

All medical benefits provider under this Plan are subject to this Coordination of Benefits section.

11.2. Definitions

11.2.1. Allowable Expense

In relation to services covered either fully or partially by this Plan or any Other Plan(s) covering you, the amount on which that would base its benefit payment for a service, including Coinsurance or Copayments and without reduction for any appliable 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 the 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 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 contract with the Secondary Plan to provide the benefit 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 an Allowable Expense and a benefit paid.

11.2.2. Birthday Rule

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

11.2.3. Custodial Parent

The parent awarded custody of a child by a court or; or in the absence of a court order, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

11.2.4. Other Plan

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.

11.2.5. Primary Plan

The plan 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 benefit first.

11.2.6. Secondary Plan

A plan that is not a Primary Plan. The plan that pays after the Primary Plan as determined by the Coordination of Benefits section.

11.2.7. Year

11.2.8. Order of Benefit Determination Rules

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

11.2.9. 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.

11.2.10.Child covered under more than one plan

Plans that cover you as a child shall determine the order of benefits as follows:

- If you are a Dependent child whose parents are married or living together (whether or not they have ever been married), the plan of the patent 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.
- If you are a Dependent child whose 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 the parents have joint custody of you, without specifying that one of the parents is responsible for your health care expense care coverage, the provisions of the first bullet above (based on parental Birthdays) shall determine the order benefits.
- If there is no court decree allocating responsibility for your health care expense of 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 spouse.

If you are covered under more than one plan and one or more of the plans provides your coverage through individuals are not your parent (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.

11.2.11.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.

11.2.12.COBRA or state continuation of 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.

11.2.13. 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, providers 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 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 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 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.

11.3. 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.

11.4. Secondary Health Plans 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 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 Administrators 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 section 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 section operate to increase this Plan's payment over what would have been paid in the absence of this Coordination of Benefit section.

11.5. 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.

11.6. 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 12 – DEFINITIONS

The following definitions contain the meanings of key terms used in this Policy. Throughout this Policy, the terms defined appear with the first letter of each word in capital letters.

12.1. Acceptable Third-Party Payor

1. The Ryan White HIV/AIDS Program established under Title XXVI of the Public Health Service Act;
2. An Indian tribe, tribal organization, or urban Indian organization;
3. A local, state, or federal government program, including a grantee directed by a government program to make payments on its behalf; or
4. An independent private entity that (i) is organized as a not-for-profit organization under state law, (ii) has received a determination from the Internal Revenue Service that the entity qualifies for an exemption from federal income tax under 26 U.S.C. § 501(c)(3), and (iii) makes payments on y our behalf solely on the basis of publicly available criteria and does not in any consider the health status of any Insured Person in determining whether to make such payments on your behalf.

12.2. Accident

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 that occurs while the insurance is in force.

12.3. Advanced Premium Tax Credit

Tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan through a Marketplace in accordance with the Affordable Care Act.

12.4. Affordable Care Act

The Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 and associated regulations.

12.5. Allowed Amount

The maximum amount on which payment is based for Covered Services for both In-Network and Out-of-Network Providers.

12.6. Annual Out-of-Pocket Maximum

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 (SBC). Unless otherwise specified, it applies to all Covered Benefits except the Preventive Health Care Services Benefit.
The Annual Out-of-Pocket Maximum includes the following:

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

When the Annual Out-of-Pocket Maximum is satisfied in the Calendar Year, we will 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.

12.7. Ambulatory Surgical Facility

A Facility licensed by the state where Services are provided to render surgical treatment and recover on an outpatient basis to sick or injured persons under the direction of a Physician. Such a Facility does not provide inpatient Services.

12.8. Annual, Calendar Year, Year

A 12-month period beginning each January 1 at 12:01 a.m. Mountain Standard Time and ends on December 31, at 11:59 p.m. Mountain Standard Time.

12.9. Applicable Law

All federal, state, and local laws, as passed or issued, apply to topics covered by this Policy. These may change over time.

12.10. Approved Clinical Trials

A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease (any disease or condition form which the likelihood of death is probable unless the course of the disease or condition is interrupted) and is described in any of the following:

1. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following
    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.

d. The Centers for Medicare & Medicaid Services.
e. Cooperative group or center of any of the entities described in (a) through (d), the Department of Defense or the Department of Veterans Affairs.
f. Any of the following if the appropriate review and approval through a system of peer review has been attained:
    i. The Department of Veterans Affairs.
    ii. The Department of Defense.
    iii. The Department of Energy.

2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

12.11. Autism Spectrum Disorder

Autism Spectrum Disorder means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorders not otherwise specified.

12.12. Authorized Representative

A person to whom a Covered Person has (a) given express written consent for representation in an external review; (b) a person authorized by law to provide substituted consent for a Covered Person; or (c) when the Covered Person is unable to provide consent: (i) a family member of the Covered Person; or (ii) the Covered Person's treating health care provider.

12.13. Balance Billing/Surprise Billing

When a Provider bills a Member for the difference between the Provider's charged amount and the Allowed Amount. A University of Utah Health Plans Participating Provider may not Balance Bill a Member for a Covered Service.

12.14. Behavioral Health

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

12.15. Charges

The actual billed charges, except when the Provider has contracted with University of Utah Health Plans for a different amount, including where University of Utah Health Plans has contracted with an entity to arrange for the provision of Covered Services through contracts with Providers of such services and/or supplies.

12.16. Coinsurance

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.

12.17. Complications of Pregnancy

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.

12.18. Concurrent Care or Ongoing Care

When we approve an ongoing course of treatment over a specified period or number of treatments.

12.19. Concurrent Care Decisions

Decisions by University of Utah Health Plans regarding coverage of an ongoing course of treatment that has been approved in advance.

12.20. Copay or Copayment

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 the time of Service.

12.21. Cosmetic Surgery

Any surgical procedure performed primarily to improve physical appearance.

12.22. Cost Sharing

The Deductible, Copayment, and Coinsurance amounts you are responsible to pay under the Policy. Where required for Covered Services captured under the federal No Surprises Act, this amount will be calculated based on the Recognized Amount.

12.23. Covered Benefits / Covered Services

The Services listed as covered in **Section 6 - Covered Services**, **Section 8 - Prescription Drug Benefits**, **Section 8 - Limitations and Exclusions**, and not excluded in this Policy. Covered Services are payable as shown in the SBC. Services must be Medically Necessary.

12.24. Covered Dependent

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.

12.25. Covered Medical Expense

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.

12.26. Covered Person

The Policyholder and/or the Policyholder’s Covered Dependents.

12.27. 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.

12.28. Deductible(s)

The fixed dollar amount of Covered Medical or Prescription Expenses that the Covered Person must incur for certain Covered Benefits before we being 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.

12.29. Dependent

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

12.30. Dependent Child or Dependent Children

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; (f) children of a Domestic Partner 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.

12.31. Disabled Child

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.

12.32. Domestic Partner

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

12.33. Domestic Partnership or Civil Union

A long-term committed relationship or 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.

12.34. Durable Medical Equipment (DME)

Equipment that:

1. Can withstand repeated use;
2. is primarily and customarily used to serve a medical purpose;
3. generally, is not useful to a person in the absence of an illness or injury;
4. is suitable for use in a health care facility or in the home; and
5. may include devices and medical supplies.

12.35. Emergency Medical Condition

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.

This definition includes mental health conditions and substance use disorder.

12.36. Emergency Care Services

Health care items or services furnished or required to evaluate and treat an Emergency Medical Condition. Such emergency care services must be provided 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.

12.37. Essential Health Benefits or EHB

A standardized set of essential health benefits that are required to be offered by University of Utah 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.

12.38. Exclusions

Those services or supplies incurred by a Covered Person, which are not eligible under this Policy.

12.39. 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.

12.40. Family Coverage

Coverage for: (1) you; and (2) your spouse or Domestic Partner; and/or (3) one or more Dependent Children.

12.41. Family Member

Your spouse, children, or other persons enrolled for coverage under this Policy. Family Members who may be eligible for coverage under this Policy are described in this Policy.

12.42. Gene Therapy

Human gene therapy products include all products that mediate their effects by transcription or translation of transferred genetic material, or by specifically altering host (human) genetic sequences.

12.43. Habilitative Care

Health care services that help a Covered Person keep, learn, or improve skills and functioning for daily living. Habilitative services may include:

(a) Physical therapy;
(b) Occupational therapy;
(c) Speech-language pathology; or
(d) Other services.

12.44. Health Insurance Marketplace (Exchange)

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.

12.45. Home Health Agency

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.

12.46. Home Infusion Therapy Agency

A licensed health care facility that provides home infusion therapy services.

12.47. Home Infusion Therapy Services

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.

12.48. Hospice

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.

12.49. Hospital

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 Licensed 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.

12.50. Hospital Stay

The time period, in days, in which the Covered Person resides in a hospital from the day of admission to the day or discharge.

12.51. Illness

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.

12.52. Indian

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

12.53. Indian Services

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.

12.54. Indian Tribe

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.

12.55. Injury

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

12.56. Inpatient or Inpatient Care

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.

12.57. Investigational/Experimental Service

Surgical procedures or medical procedures, supplies, devices, or drugs which at the time provided, or sought to be provided, are in our judgement not recognized as conforming to accepted medical practice or the procedure, drug, or device:

1. Has not received the final approval to market from appropriate government bodies; is one of 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.

12.58. Major/Minor Diagnostic Tests

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 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.

12.59. Major/Minor Surgery

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. Hear surgery including transcatheter valve replacements
5. Upper or Lower Endoscopic procedures
6. Cardiac catherization procedures such as stent placement or ablations for heart rhythm.

12.60. Marketplace

The Health Insurance Marketplace (formerly known as an Exchange) in Utah established under the Affordable Care Act that offers Qualified Health Plans to individuals and employers.

12.61. Maximum Allowable Fee

The maximum amount that a Participating Provider agrees contractually to accept as full payment for providing services for Covered Benefits under this Policy.

12.62. Medically Necessary or Medical Necessity

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.

12.63. Medical Policy

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 agencies;
2. Scientific studies showing conclusive evidence of improved net health outcome; and
3. In accordance with any established standards of good medical practice.

12.64. Medicare

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

12.65. Medical Supplies

Items for medical use that are:

(a) Suitable for use in a health care facility or in the home; and
(b) Disposable or semi-disposable and non-reusable.

12.66. Member

A Subscriber, Subscriber's spouse, Subscriber's Domestic Partner or a Subscriber's Dependents who are enrolled in the Plan.

12.67. Mental Health Services

Intensive Outpatient Program is a structured outpatient mental health or substance-related and addictive disorders treatment program. The program may be freestanding or Hospital-based.

Interventions-assessment, diagnosis, treatment, or counseling – offered in private, public, inpatient, or outpatient settings for the maintenance or enhancement of mental health or the treatment of mental or behavioral disorders in individual and group contexts.

Mental Health or Substance Use Disorder Services mean Medically Necessary outpatient services, Residential Care, Partial Hospitalization, or inpatient services provided by a licensed facility or individual with the exception of court ordered treatment (unless the treatment is Medically Necessary).

Mental Health Conditions mean mental disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association except as otherwise excluded. Mental disorders that accompany an excluded diagnosis are covered.

Residential Care means care in a facility that offers a defined course of therapeutic intervention and special programming in a controlled environment that also offers a degree of security, supervision, and structure, and is licensed by the appropriate state and local authority to provide such services. Residential Care does not include half-way house, supervised living, group homes, wilderness courses or camps, Outward Bound, outdoor youth programs, outdoor behavioral programs, boarding houses, or settings that primarily either focus on building self-esteem or leadership skills or provide a supportive environment to address long-term social needs. However, services by Physicians or Practitioners in such settings may be covered if they are billed independently and otherwise would be a Covered Services

Substance Use Disorders means substance-related disorders included in the most recent edition of the DSM. Substance Use Disorder does not include addiction to or dependency on tobacco, tobacco products, or foods.

12.68. Open Enrollment

Then Open Enrollment Period is the period of time, as designated by law, during which you and/or your Eligible Dependents may enroll.

12.69. Out-of-Network Provider

A Physician, Facility, or Other Provider that does not have an active contract to provide Services to Covered Persons under this Policy.

12.70. Outpatient

Treatment or services that are provided when the Covered Person is not confined as an inpatient 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 under this Policy.

12.71. Participating or In-Network Provider

A Physician, Facility, or Other Provider that has an active contract with the Network to provide services to Covered Persons under this Policy.

12.72. Pediatric Services

Coverage will be provided for Pediatric Services for individuals 18 years of age and younger as mandated by the Affordable Care Act.

12.73. Physician

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

12.74. Physician Specialist

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.

12.75. Plan

Health insurance coverage issued to an individual and Dependents, if applicable that provides benefits for Covered Services. Depending on the services, Member Cost Sharing may apply.

12.76. Policy

The set of benefits, conditions, exclusions, limitation, and Premiums described in this document, the completed and accepted application for coverage, and any amendments, or endorsements to this document.

12.77. Policy Effective Date

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

12.78. Policyholder

The person to whom this Policy is issued and is named as the Policy owner in the SBC. The policy owner is the owner of this Policy, which means the Policy owner may exercise the rights set forth in this Policy. On the Policy Effective Date, the Policyholder is as designated in the application for this Policy. The policyholder is also referred to as “you” or “your.”

12.79. Post-Service Appeal

An Appeal which has been submitted after medical services have been rendered.

12.80. Preauthorization or Prior Authorization

Prior authorization or preauthorization is prior approval from University of Utah Health Plans for certain Services. See **Section 7 – “Utilization Review Program.”**

12.81. Pre-Service Appeal

An appeal which has been submitted before medical services have been rendered.

12.82. Preventive Care

Services 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.

12.83. Primary Care Physician

A Physician, including a Medical Doctor (M.D.) or Doctor of Osteopathic Medicine (D.O.), 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.

12.84. Provider

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.

12.85. 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.

12.86. Recognized Amount

Where required by the federal No Surprises Act, means the amount on which Member Cost Sharing amounts are calculated for Covered Services that are captured under the federal No Surprises Act.

12.87. Rehabilitative

Treatment of disease, injury, developmental delay, or other cause, by physical agents and methods to assist in the rehabilitation of normal physical bodily function, that is goal-oriented and where the person has potential for functional improvement and ability to progress.

12.88. Rescission

A cancellation or discontinuance of coverage that has retroactive effective, except to the extent it is attributable to a failure to timely pay required Premiums or contributions towards the cost of coverage.

12.89. Reside/Resident

You are a resident or Utah if you are able to provide satisfactory proof of currently residing in Utah, including without a fixed address. We may request proof of residency. The following are a few of the items accepted as proof of residency:

a. State Tax Returns
b. Driver's License
c. Voter Registration
d. Voter Registration
e. Vehicle Registration
f. Utility Bill

An inpatient hospital or similar medical facility stay alone does not establish residency.

12.90. Services

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

12.91. Service Area

Any place that is within the counties, cities, and/or zip code areas in the state of Utah that has been designated by University of Utah Health Plans as the area where this Policy is available for enrollment.

12.92. Skilled Nursing Care

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.

12.93. Skilled Nursing Facility

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.

12.94. Special Enrollment Period (SEP)

A time outside the Open Enrollment Period when you can sign up for health insurance. You qualify for a Special Enrollment Period if you’ve had certain life events, including losing health coverage, moving, getting married, having a baby, or adopting a child, or if your household income is below a certain amount.

12.95. 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.

12.96. Surgery or Surgical Procedure

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.

12.97. Telehealth

The use of a HIPPA compliant telecommunication video technologies such as your smart phone, tablet, or computer for online visits with an approved provider.

12.98. Treatment

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, itself, mean that the Treatment will be determined to be Medically Necessary.

12.99. Urgent Care

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

12.100. 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 13 – GENERAL PROVISIONS AND LEGAL NOTICES

This section explains various general provisions and legal notices regarding your benefits under this Policy.

13.1. Entire Contract

This Policy, including the application, endorsements, and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless approved by an executive officer of University of Utah Health Plans and unless such approval be endorsed hereon or attached hereto. No insurance producer has authority to change this Policy or to waive any of its provisions.

13.2. 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.

13.3. Assignment

Member may not assign any rights they may have under this Policy. No person, other than a Member, is entitled to Covered Benefits under this Contract. This Contract is not assignable or transferrable to any other person.

13.4. Time Limit on Certain Defenses

After two years from the date coverage is effective under this Policy no misstatements, except fraudulent misstatements, made by the applicant in the application of such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two-year period.

13.5. Limitations on Liability

You have the right to choose a health care Provider. We are not responsible for the quality of health care you receive, since all those who provide are do so as independent contractors. Since we do not provide any health care services, we cannot be held liable for any claims or damages connected with Injuries you

suffer while receiving health services or supplies provided by professionals who are neither our employees nor our agents.

In addition, we will not be liable to any person or entity for the inability or failure to procedure or provide the benefits in this Policy by reason of epidemic, disaster, or other cause or condition beyond our control.

13.6. Notices

We will send notices required by this Policy using the United States mail, postage prepaid. Notices will be mailed to the address appearing on our records. Member must send notice to us at the address listed on our website www.uhealthplan.utah.edu. Any required time periods will be measured from the date the notice was mailed.

13.7. Validity of Contract

If any provision or any word, term, clause, or part of any provision of this Policy shall be invalid for any reason, the same shall be ineffective, but the remainder of this Policy and of the provision shall not be affected and shall remain in full force and effect.

13.8. 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 claim, unless it is contained in a signed application.

13.9. Rescission

This Policy is subject to rescission if a Member commits an act or omission that constitutes fraud or intentional misrepresentation of a material fact following a 30 day notification.

13.10. Time Limits on Legal Actions

13.10.1.Legal Actions

No action will be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss that 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 recover under the Policy if the insurer fails to show it was prejudiced by the failure.

13.10.2.Improper Payment

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.

13.11. Choice of Forum

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

SECTION 14 – REQUIRED NOTICES

14.1. Notice of Privacy Practices

We will protect your health information. We will only use or share it with others as needed for your care and treatment. We will also share it to help us process your claims and manager your Policy. You can get a free copy of our *Notice of Privacy Practices.* Just contact us. You can also find it on our on our website: Notice of Privacy Practices.

14.2. Your Rights and Protections Against Surprise Medical Bills

For more information on your rights and protections against surprise medical bills please visit our website. You can also find the notice on our website at https://doc.uhealthplan.utah.edu/notices/balance-billing.pdf

14.3 Health Insurance Portability & Accountability Act Non-discrimination

The Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals with respect to premiums, eligibility, or benefits based on an individual's health factors.

These health factors include: health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history genetic information, evidence of insurability and disability.

14.4 Notice of Newborns' and Mothers' Health Protection Act

In accordance with the Newborns' and Mothers' Health Protection Act of 1996, the Policy providers protections for mothers and their newborn children relating to the length of their hospital stays following the 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.

14.5 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 of 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 Outline of Coverage and Summary of Benefits and Coverage (SBC).

14.6 Non-Discrimination Notice

University of Utah Health Plans will not discrimination against any Member based on race, sex, religion, national origin, or any other basis forbidden by law. University of Utah Health Plans will not terminate any Member because of the health status or the healthcare needs of the Member or because he or she exercised any right under University of Utah Health Plans complaint resolution system. You can find the Non-Discrimination Notice on our website at https://doc.uhealthplan.utah.edu/nondiscrimination_notice_92020.pdf