HEALTH PLANS

UNIVERSITY OF UTAH

Large Group Plans

Summary Plan Description

University of Utah Health Plans

PO Box 45180 www.uhealthplan.utah.edu

Salt Lake City, UT 84145

Customer Service, Care Management, and Appeals: 801-213-4008 833-981-0213

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SECTION 1 – INTRODUCTION AND OVERVIEW

Introduction

As You read this Summary Plan Description (SPD), 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 “Group Administrator” means the employer group who enrolled You 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 Group to whom this Policy was issued. Other terms are defined in the Definitions Section at the back of this Policy or where they are first used.

Policy

This Policy describes benefits effective as of your effective date, for You and Your Enrolled Dependents. This Policy provides the evidence and a description of the terms and benefits of coverage.

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

Renewability of Policy

This Policy is renewable at the option of the Group Administrator upon payment of the monthly premium, except in cases of intentional misrepresentation of material fact or fraud in connection with the coverage, or Our decision to cease offering coverage in the large employer health benefit plan 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 Group Administrator (except for modification of premium, which shall not be effective until 45 days after written notice has been given to the Group Administrator), and modification must be uniform within the product line and at the time of renewal.

Open Enrollment Period

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

Using Your Policy

The University of Utah Health Plan offers the medical plan described in this Policy. It is important for You to understand how the Plan works before You need health care services. Please read this material carefully. If You have any questions about benefits or procedures, please contact University Health Plans Customer Service Department or visit Our website at www.uhealthplan.utah.edu.

You Select Your Provider

University of Utah Health Plans allows You to select your own providers.You are not required to have a referral to see any provider, including a specialist. If your plan includes Out-of-Network benefits you may see an Out-of-Network provider based on your benefits outlined in the Schedule of Benefits.

- **In-Network Provider.** When You choose to see an In-Network Provider, You will receive the highest level of benefits and will not be billed for balances on Covered Services beyond any Copayment, Deductible, and/or Coinsurance.

- **Out-of-Network Provider.** If your plan includes Out-of-Network benefits, and you choose to see an Out-of-Network Provider, Your out-of-pocket expenses will generally be higher than an In-Network Provider. Group Out-of-Network means You may be billed by the Out-of-Network Provider for balances beyond any Copayment, Deductible, and/or Coinsurance. This is sometimes referred to as balance billing.

If your plan does not include Out-of-Network benefits no claims from an Out-of-Network Provider will be covered by your plan and You are responsible to pay 100% of the charges, unless they are associated with a medical emergency. Medical emergencies will be paid at the In-Network rate.

Refer to your SBC or Schedule of Benefits to determine if your plan has Out-of-Network coverage.

- **Rural Health Care Providers.** You may be entitled to coverage for health care services from non-contracted providers if You live or reside within 30 paved road miles of an independent hospital, federally qualified health center, or a credentialed staff member at an independent hospital, federally qualified health center, or at his/her local practice location. If You have questions concerning your rights to see one of these providers, You may contact University of Utah Health Plans at 801-213-4008. If we do not resolve your problem, You may contact the Office of Consumer Health Assistance in the Insurance Department, toll free.

You can go to **www.uhealthplan.utah.edu**for additional Provider network information and to find In-Network Providers. All claims submitted by both In-Network and Out-of-Network Providers must be submitted in a format approved by UUHP. Submitted claims must meet UUHP's claims editing requirements (including meeting the AMA-CPT, National Correct Coding Initiative guidelines/edits, or other coding edits as adopted by UUHP) in order to be processed for payment.

Guidance and service along the way

This Policy was designed to provide information and answers quickly and easily.

- **Learn more and receive answers about Your coverage.** Call Customer Service at 801-213-4008 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 listed on your ID Card**.**

- **Primary Care Physician (PCP).** You are not required to select a PCP, but we highly recommend it. A PCP will work to treat your overall health and make sure you get the care you need. The following types of doctors may be selected as your PCP:

  - Family Practice (for all ages)
  - Internal Medicine (for adults)
  - Pediatrics (for children)
  - Obstetrics and Gynecology (OB/GYN – for women)

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

If you would like help finding a PCP in your area, call Access Assistance at 801-213-4008 or 833-981-0213, Option 2.

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.

Prior Authorization. This Plan requires prior authorization for inpatient services and select outpatient services excluding emergencies and maternity services. U of U Health Plans will notify you of the decision related to the prior authorization request within 14 days of receipt of request for care. If we are unable to make a decision within the applicable time frame we will notify you of any missing information and our time frame to make a decision will be extended an additional 14 days. In certain circumstances outlined in the Prescription Drug Benefits section of this policy some prescription drugs also require prior authorization. In case of urgent care, we will notify you no later than 72 hours. All services, not limited to only inpatient services, must meet standards of medical necessity, and we reserve the right to review any and all services to ensure these standards are met. Providers are encouraged to submit a pre-service review if they are unsure whether the service meets the standards of medical necessity.

Emergency Conditions. In-Network benefits apply to emergency room services regardless of whether they are received at an In-Network or Out-of-Network facility. If You or Your Dependent is hospitalized for an emergency:

- You or Your representative must contact Member Services within two working days, or as soon as reasonably possible; and
- If You or Your Dependent are in an Out-of-Network facility, once the emergency condition has been stabilized, You or Your Dependent may be asked to transfer to an In-Network facility in order to continue receiving benefits at the In-Network level.

SECTION 2 – NOTICES

UNIVERSITY OF UTAH HEALTH PLANS PRIVACY POLICY REGARDING PROTECTED HEALTH INFORMATION (PHI)

This notice describes how medical information about you may be used or disclosed and what your rights are in managing your health information.

Please review it carefully. We reserve the right to make changes to this notice at any time. Current notices will be available on our website at http://privacy.utah.edu/pdf/notice-of-privacy-practices-english.pdf.

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

You Have A Right To:

Get a copy of this privacy notice

Get a copy of health and claims records
You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee if detailed records are requested.

Ask us to correct health and claims records
You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
We may say “no” to your request, but we’ll tell you why, in writing, within 30 days.

Request confidential communications
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

Ask us to limit what we use or share
You can ask us not to use or share certain health information for treatment, payment, or our operations.

We are not required to agree to your request, and we may say “no” if it would affect your care.

Receive notification if there is a breach of your health information
We will notify you in writing about a breach and provide detailed information and instructions.

Get a list of those with whom we’ve shared information
You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures, except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free, but we will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
You can complain if you feel we have violated your rights by contacting us using the information listed below.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue SW, Washington, D.C. 20201,calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

We will not retaliate against you for filing a complaint.

Requests must be made in writing. Contact the Health Information Department at (801) 587-3887 or visit our web site at http://www.privacy.utah.edu to find the right form for your request.

If you have concerns or wish to file a complaint, contact:
University of Utah Health Plans
PO Box 45180
Salt Lake City, UT 84145
801-213-4008
E-mail: uuhp@hsc.utah.edu

We will investigate all complaints and will not retaliate against you for filing a complaint. You may also file a written complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services.

Our Organization:

This Notice describes the privacy practices of The University of Utah Health Plans.

University of Utah Health Plans is required by law to:

- Maintain the privacy and security of your health information;
- Notify you promptly if a breach occurs that may have compromised the privacy or security of your health information; and
- Follow the terms and provide you a copy of the Notice currently in effect.

Privacy Promise

Privacy and Customer Service are our greatest concerns. Claims are processed quickly and confidentially. We follow strict federal and state laws that require us to maintain the confidentiality of your health information.

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you. Examples may include: A health plan administrator communicates information about your diagnosis and treatment plan so a doctor can arrange additional services.

Help ensure patient satisfaction while controlling costs to you
We can use your health information to ensure that your primary care provider receives key information to help you make informed, cost-effective choices about all of your care.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage or the price of that coverage. Example: We use health information about enrolled members in the aggregate to develop better services for them.

Pay for your health services

We can use and disclose your health information as we pay for your health services. *Example: We share information about you with any other insurance plans you might have to coordinate payment for services you receive.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways. Non-identifying information can be used to contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situation such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Comply with the law

We will share information about you if state or federal laws require it.

Address other government requests

We can use or share health information about you:

- With health oversight agencies, like the FDA, for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

<u>Your Choices</u>

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
- Confidential communications with a mental health professional (psychotherapy notes) and substance abuse treatment records

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

All other uses and disclosures, not described in this notice, require your signed authorization. You may authorize us to use or share your health information, OR revoke your authorization at any time by completing the required form available through University of Utah Health Plans, or online at http://www.privacy.utah.edu, and submitting it to:

University of Utah Health Plans
PO Box 45180
Salt Lake City, UT 84145
801-213-4008 E-mail: uuhp@hsc.utah.edu

For more information about the practices and rights described in this notice:

- Visit our website at http://www.privacy.utah.edu; **OR**
- Contact the Information Privacy Office at:
  University of Utah Information Security and Privacy Office
  650 Komas Drive, Suite 102
  (801) 587-9241
  Fax: (801) 587-9443

Notice of Women's' Health Cancer Rights Act

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

1. All stages of reconstruction on the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications in all stages of mastectomy, including lymphedemas.

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

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

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

Notice of Newborns' and Mothers' Health Protection Act

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

SECTION 3 – DEFINITIONS

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

Accident means an accidental bodily injury sustained by the injured 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.

Allowed Amount is the maximum amount the Plan will pay for a covered health service. For Participating or In-Network Providers, the Allowed Amount is based on the contract the provider has with the Plan. If your Plan includes Out-of-Network benefits, for Out-of-Network Providers, the Allowed Amount is based on UCR (Usual, Reasonable and Customary) rates. Refer to your SBC or Schedule of Benefits to determine if your Plan has Out-of-Network coverage.

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

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

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

When the Annual Out-of-Pocket Maximum is satisfied in the Calendar Year, We will then pay 100% of Covered Medical Expenses incurred for Covered Benefits for the remainder of that Calendar Year. The Annual Out-of-Pocket Maximum must be satisfied each Calendar Year.

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. Prescritpion drug brand-generic charges do not apply to the Out-of-Pocket Maximum.

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

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

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

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

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

Such Convalescent Home services must be provided by or under the direction and supervision of a licensed registered nurse, on a 24-hour basis, for Ill or Injured persons during the convalescent state of their Illness or Injuries. A Convalescent Home is not, other than incidentally: (1) a rest home; (2) a home for custodial care; or (3) a home for the aged. It does not include an institution or any part of an institution otherwise meeting this definition, which is primarily engaged in the care and treatment of Mental Illness or Chemical Dependency.

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

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

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

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

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

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

Covered Person means You and/or Your Covered Dependents.

Custodial Care means providing a sheltered, family-type setting for an aged person or disabled adult so as to provide for the person's basic needs of food and shelter and to ensure that a specific person is available to meet those basic needs.

Deductible means the fixed dollar amount of Covered Medical Expenses that the Covered Person must incur for certain Covered Benefits before We begin paying benefits for them. The Deductible must be satisfied each Plan or Calendar Year by each Covered Person, except as provided under *"Family Deductible Limit"* provision. The Deductible is shown in the SBC and Schedule of Benefits. 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
The Family Deductible will be satisfied during the Plan or Calendar Year when the total expenses paid toward the Family Deductible by Your insured family members combined equals the Family Deductible amount.

Refer to Your Schedule of Benefit and SBC to determine if your accumulators are on a Plan or Calendar Year, or if there are any exceptions to an Individual Deductible being met within a Family Deductible.

Dependent means Your:

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

Dependent Child or Dependent Children means Your children who are:

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

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

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

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

Not all employers allow for domestic partner coverage. Please check with your employer to determine eligibility.

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

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

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

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

Handicapped Child means a child who is unable to engage in substantial gainful employment to the degree that the child can achieve economic independence due to a medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months and chiefly dependent upon You for support and maintenance since the child reached age 26.

Home Health Agency means a public agency or private organization or subdivision of the agency or organization that is engaged in providing home health services to individuals in the places where they live. Home health services must include the services of a licensed registered nurse and at least one other therapeutic service and may include additional support services.

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

Home Infusion Therapy Services means the preparation, administration, or furnishing of parenteral medications or parenteral or enteral nutritional services to an individual in that individual's residence. The services include an educational component for the patient, the patient's caregiver, or the patient's family member.

Hospice means a coordinated program of home and inpatient health care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill patient and the patient's family arising out of physical, psychological, spiritual, social, and economic stresses experienced during the final stages of illness and dying and that includes formal bereavement programs as an essential component. The term includes:

1. An Inpatient hospice facility, which is a facility managed directly by a Medicare-certified hospice that meets all Medicare certification regulations for freestanding inpatient hospice facilities; and
2. A residential hospice facility, which is a facility managed directly by a licensed hospice program that can house three or more hospice patients.

Hospital means an institution which:

1. Is operated for the care and treatment of sick or injured persons as in-patients; and
2. On its premises or in facilities available to the hospital on a pre-arranged basis, meets fully each of the following requirements:

a. It is operated in accordance with the laws pertaining to hospitals in the jurisdiction in which it is located;
b. It is under the supervision of a medical staff and has one or more Physicians available at all times; and
c. It provides 24 hours a day service by registered graduate nurses (RNs).

A Covered Person will not be considered hospital confined if he or she is in a special unit of a hospital used as a nursing, rest, or convalescent home. Hospital includes a licensed ambulatory surgical facility.

The term "Hospital" does not include the following even if such facilities are associated with a Hospital:

1. A nursing home;
2. A rest home;
3. A hospice facility;
4. A rehabilitation facility;
5. A skilled nursing facility;
6. A place for the mentally ill;
7. A Convalescent Home or nursing home;
8. A long-term, chronic care institution or facility providing the type of care listed above.

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

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

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

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

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

Such facilities must be licensed or certified by the state in which it operates.

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

1. Has not received the required final approval to market from appropriate government bodies; Is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes;

2. Is not demonstrated to be as beneficial as established alternatives;
3. Has not been demonstrated to improve the net health outcomes; or
4. Is one in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

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

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

Anything not defined as major is considered a minor diagnostic

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

1. Open or closed intra-Abdominal surgery such as removal of the gallbladder or appendix, hysterectomy, c-section delivery
2. Any intracranial procedure either open or closed
3. Joint replacement surgery or arthroscopic surgery
4. Heart surgery including transcatheter valve replacements
5. Upper or Lower Endoscopic procedures
6. Cardiac catheterization procedures such as stent placement or ablations for heart rhythm disturbances

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

Medical Prescription Drugs means prescription drugs that are covered under the medical benefit. Medical Prescription drugs with anticipated costs over $1,000 require prior authorization. For a list of medical drugs that require prior authorization or that are not covered, please refer to your Plan website.

Medically Necessary or **Medical Necessity** means health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:

1. In accordance with generally accepted standards of medical practice in the United States;
2. Clinically appropriate in terms of type, frequency, extent, site, and duration;
3. Not primarily for the convenience of the patient, physician, or other health care provider;
4. Covered under the contract;

5. Not more costly than an alternative drug, service(s), or supply that is at least as likely to produce equivalent therapeutic or diagnostic results to the diagnosis, injury, disease, or symptoms.

When a medical question-of-fact exists medical necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective. For interventions not yet in widespread use, the effectiveness shall be based on scientific evidence. For established interventions, the effectiveness shall be based on:

1. Scientific evidence;
2. Professional standards; and
3. Expert opinion.

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

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

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

Out-of-Pocket Maximum is the maximum you pay for your pharmacy and medical costs out-of-pocket. Once you have met your Out-of-Pocket Maximum your covered medical costs and prescriptions are covered at 100%. Brand penalty amounts do not count towards your out-of-pocket maximum. Third party assistance, copay cards, and coupons may be used to satisfy your out-of-pocket maximum. Refer to your Summary of Benefits and Coverage for more information.

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

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

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

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

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

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

Provider means a licensed practitioner of the healing arts acting within the scope of the Provider's practice, limited to the following Providers: (1) Medical Doctor (MD); (2) Chiropractor (DC); (3) Osteopath (DO); (4) Podiatrist (DPM); (5) Psychologist (PhD); (6) Licensed Clinical Social Worker (LCSW); (7) Psychiatric Nurse Specialist (RN, NS); (8) Doctor of Medical Dentistry (DMD); (9) Dentist (limited) (DDS); (10) Registered Nurse (RN); (11) Advanced Practical Registered Nurse (APRN); (12) Nurse Practitioner (NP); (13) Physician Assistant (PA); (14), Licensed Practical Nurse (LPN); (15) Certified Registered Nurse Anesthetist (CRNA); (16) Certified Nurse Midwife (CNM); (17) Registered Physical Therapist (RPT); (18) Occupational Therapist (OT); (19) Speech Therapist (ST); (20) Optometrist (limited OD); (20) Audiologist, Licensed Professional Counselor (LPC); and (21) Registered Dietician.

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

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

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

Any institution that is, other than incidentally, a rest home, a home for the aged, or a place for the treatment of mental disease, drug addiction, or alcoholism, is not considered a Skilled Nursing Facility.

Substance Use Treatment: Services provided by trained specialists in Addiction or Behavioral Health Services to provide necessary guidance and treatment. Residential Treatment or inpatient admissions require prior authorization for review of medical necessity.

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

Telehealth means the use of telecommunication technologies such as your smart phone, tablet, or computer for a doctor or therapist online visit. Online visits are available 24 hours a day.

Telehealth means the use of a HIPPA compliance telecommunication technology such as your smart phone, tablet, or computer for a doctor or therapist online visit. Online visits are available 24 hours a day on most plans. See you benefit summary to determine coverage.
Treatment means medical care, services or treatment or course of treatment which is ordered, prescribed and/or provided by a Physician to diagnose or treat an Injury or Illness, including:

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

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

Urgent Care handles non-life-threatening situations, and many are staffed with doctors and nurses who have access to x-rays and labs onsite. Most urgent care centers are open late and on weekends and holidays. Choosing an urgent care over the emergency room (ER)can save you time and money.

SECTION 4 - WHEN COVERAGE BEGINS AND ENDS

When Coverage Begins

What is the Effective Date of Coverage?

You are covered under this Policy upon Our receipt of Your application and remittance of the required premium payment from the Group Administrator. Your effective date is determined by your employer based on the companies applicable waiting periods.

Eligible Dependents are covered under this Policy as follows:

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

When may You Enroll for Coverage

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

Coverage for Dependent Child Due to Court or Administrative Order

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

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

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

How do You Enroll Dependents After the Policy Effective Date?

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

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

The Dependent may be enrolled for coverage within the time period indicated below in the *Adding a Dependent Due to Marriage/Domestic Partnership, Adding a Dependent Child,* and *Adding a Dependent Due to Court or Administrative Order* provisions or by Exchange Rules if this Policy is purchased on the Exchange.

Adding a Dependent Due to Marriage/Domestic Partnership:

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

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

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

1. Birth; or
2. Placement for adoption.

The effective date of coverage for the new Eligible Dependent will be:

1. The date of birth for a newborn natural child;
2. The date of birth for newborn adopted child if placement for adoption occurs within 60 days of birth; and
3. The date of Placement for an adopted child, if Placement for adoption occurs 60 days or more after the child's birth.

We must receive notification for the new Eligible Dependent Child within 60 days in order for coverage to be continued under this Policy.

With regard to an adopted child, coverage under this Policy will cease prior to end of the 60-day period if:

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

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

Adding a Dependent Child Due to Court or Administrative Order:

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

How Long Is Coverage Effective Under This Policy?

You may elect to continue this Policy or discontinue this Policy during an open enrollment period or due to a qualifying event.

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

1. Your termination with the Group;
2. Your death; or
3. Termination for any other reason.

When Your Covered Dependents are no longer eligible for coverage under this Policy: The coverage for Your Covered Dependent will continue in force through the last day of the month in which he or she

ceases to be a Covered Dependent. A Covered Dependent will cease to be a Covered Dependent upon the occurrence of any of the following events:

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

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

When May We Rescind this Policy?

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

When Can We Terminate this Policy?

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

1. During any open enrollment period that the policy is not renewed;
2. If You are no longer employed by the Group Administrator;
3. If there is no longer any enrollee under the group health plan who lives, resides, or works in the service area of UUHP or the area for which UUHP is authorized to do business;
4. If Your Group Administrator fails to pay the required premium payment when due, subject to the Grace Period;
5. If Your Group fails to meet the minimum participation or employer contribution requirements;
6. If you obtained this Policy through fraudulent means;
7. If We elect to discontinue all of our health benefit plans in the large employer market, provided We give You at least one-hundred eighty (180) days prior written notice; or
8. For any other reason for termination of this Policy as specified in this Policy, provided We give You at least ninety (90) days prior written notice.

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

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

Qualification for a Subsidy Through Utah's Premium Partnership

You and Your Eligible Dependents who qualify for a subsidy through the state Medicaid program to purchase health insurance may enroll in the Plan if application is made within 60 days of receiving written notification of eligibility for the subsidy. If you enroll within this time period, the Effective Date of coverage is the first of the month following date of enrollment.

SECTION 5 – CARE MANAGEMENT PROGRAM

You have access to care management programs through the University of Utah Health Plans. 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 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.

SECTION 6 – DIABETES COVERAGE

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

SECTION 7 – AUTISM BENEFIT

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

SECTION 8 – ADOPTION BENEFIT

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

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

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

SECTION 9 – SMOKING CESSATION

University of Utah Health Plans has a comprehensive program in place to help you quit smoking. There is no prior authorization required to participate in this program, and the services are provided at no cost to you. Included in the program are individual, group and telephone cessation counseling, and all FDA-approved tobacco cessation medications (nicotine patch, lozenge, nasal spray and inhaler; approved oral medications).

SECTION 10 – 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.

Benefits Subject to this Provision

All of the benefits provided under this Plan are subject to this Coordination of Benefits provision.

Definitions

The following are definitions that apply to this Coordination of Benefits:

Allowable Expense means, with regard to services that are covered in full or part by this Plan or any Other Plan(s) covering You, the amount on which that plan would base its benefit payment for a service, including Coinsurance or Copayments and without reduction for any applicable Deductible, except that the following are examples of expenses that are not an Allowable Expense:

- An expense or portion of an expense not covered by any of Your involved plans.
- Any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You.
- The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room, unless one of Your involved plans provides coverage for private Hospital rooms.
- Any amount by which a Primary Plan’s benefits were reduced because You did not comply with that plan’s provisions regarding second surgical opinion or preauthorization.
- If You are covered by two or more plans that: 1) compute benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the Provider in excess of the highest reimbursement amount for a specified benefit; or 2) that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.
- If You are covered by a plan that calculates its benefits or services on the basis of usual and customary fees, relative value schedule reimbursement, or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan’s payment arrangement shall be the Allowable Expense for all plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan’s payment arrangement and if the Provider’s contract permits, that negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

When a plan provides benefits in the form of services, the reasonable cash value of each service provided will be considered both an Allowable Expense and a benefit paid.

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

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

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

- Individual and group accident and health insurance and subscriber contracts.
- Uninsured arrangements of group or Group-Type Coverage.
- Group-Type Coverage.
- Coverage through closed panel plans (a plan that provides coverage primarily in the form of services through a panel of Providers that have contracted with or are employed by a plan and

that excludes benefits for services provided by other Providers, except in the cases of emergency or referral by a panel member).

- Medical care components of long-term care contracts, such as skilled nursing care.
- Medicare and other governmental coverages, as permitted by law.

Other Plan does not include:

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

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

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

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

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

Order of Benefit Determination

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

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

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

- When Your parents are married or living together (whether or not they have ever been married), the plan of the parent whose Birthday falls earlier in the Year is the Primary Plan. If both parents have the same Birthday, the plan that has covered a parent longer is the Primary Plan.
- When Your parents are divorced or separated or are not living together (if they have never been married) and a court decree states that one of Your parents is responsible for Your health care expenses or health care coverage, the plan of that parent is primary to the plan of Your other parent. If the parent with that responsibility has no health care coverage for Your health care

expenses, but that parent's spouse does, the plan of the spouse shall be primary to the plan of Your other parent.

- If a court decree states that both parents are responsible for Your health care expenses or health care coverage, or if a court decree states that the parents have joint custody of You, without specifying that one of the parents is responsible for Your health care expenses or health care coverage, the provisions of the first bullet above (based on parental Birthdays) shall determine the order of benefits.
- If there is no court decree allocating responsibility for Your health care expenses or health care coverage, the order of benefits is as follows:
  - The plan of Your custodial parent shall be primary to the plan of Your custodial parent's spouse;
  - The plan of Your custodial parent's spouse shall be primary to the plan of Your noncustodial parent; and
  - The plan of Your noncustodial parent shall be primary to the plan of Your noncustodial parent's spouse.

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

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

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

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

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

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

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

Primary Health Plan Benefits

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

Secondary Health Plan Benefits

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

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

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

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

Right to Receive and Release Needed Information

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

Right of Recovery/Subrogation

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

- From You, if payment was made to You. Recovery would be by reversal of payments and be limited to a period within 12 months of the amount improperly paid for a coordination of benefits error, 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. 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. If a third-party collection agency or attorney is used to collect the overpayment, You agree to pay collection fees incurred, including, but not limited to, any court costs and attorney fees. If You do not pay, future benefits under this Plan may be withheld to offset the amount owing to it. We are responsible for making proper adjustments between insurers and Providers.

- From Providers, if payment was made to them. Recovery would be by reversal of payments and be limited to a period within 24 months of the amount improperly paid for a coordination of benefits error, or within 12 months of the amount improperly paid for any other reason, 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 11 – 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 level You may pursue. Certain matters requiring quicker consideration qualify for a level of expedited Appeal and are describer separately later in this section.

First-level Appeals

Initial Appeals must be submitted within 180 days of Our origional adverse decision. If You don't Appeal within this time period, You will not be able to continue to pursue the Appeal process and may jeapordize Your ability to pursue the matter in any forum. When an Appeal request is received We will send a written acknowledgement and information describing the entire Appeal process and Your rights.

First-level Appeals are reviewed by an employee or employees who were not involved in the inital decision that you are appealing. In Appeals that involve issues requiring medical judgement, the decision is made by our staff of health care professionals.

Appeal decisions will be provided within the following time frames:

- **Pre-service Appeal:** within 30 calendar days of receipt of the request
- **Post-service Appeal:** within 45 calendar days of receipt of the request

Expedited 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. Please see Expedited Appeals later in this section for more information. 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 a panel of our employees who were not involved in, or subordinate to anyone involved in the initial denial determination. You, or Your Representative on your behalf will be given the opportunity (within the constraints of the expedited Appeals timeframe) to participate via telephone and/or provide written materials. A verbal notice of the decision will be provided to You and Your Representative as soon as possible after the decision, but no later than 72 hours of the receipt of the appeal. A written notification of the decision will be mailed to You within three calendar days of the determination.

Voluntary External Appeal - IRO

A voluntary external Appeal to an Independent Review Organization (IRO) is available for issues involving medical judgment (including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service); or the determination that a treatment is Investigational, but only after You have exhausted all of the applicable non-voluntary levels of Appeal, or if We have failed to adhere to all claims and internal Appeal requirements. Voluntary external Appeals must be requested within 180 days of the notice of the prior adverse decision.

University of Utah Health Plans coordinates voluntary external Appeals, but the decision is made by an IRO at no cost to You. We will provide the IRO with the Appeal documentation. The IRO will make its decision and provide You with its written determination within 45 days after receipt of the request. Choosing the voluntary external Appeal as the final level to determine an Appeal will be binding in accordance with the IRO's decision and this section, except to the extent other remedies are available under State or Federal law. To request an IRO Members, of their authorized representative, fill out the Independent Review Request Form through the Utah Department of Insurance website at www.insurance.utah.gov. They may also contact the DOI by phone at 801-538-3077 or electronically at healthappeals.uid@utah.gov.

The voluntary external Appeal by an IRO is optional and you should know that other forums may be utilized as the final level of Appeal to resolve a dispute you have under the Plan.

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

- Voluntary External Appeal: within 45 days of the receipt of the request
- Voluntary Expedited External Appeal: within 72 hours of the receipt of the request

Expedited Voluntary Appeal - IRO

If You disagree with the decision made in the First Level Appeal and You or Your Representative reasonably believes that preauthorization remains clinically urgent (Pre-Service), You may request a voluntary expedited Appeal to an IRO.

You are not required to exhaust other levels of appeal before this level of appeal is filed, or You can 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 of 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 or 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 it's 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.

Information

If You have any questions about the Appeal process outlined here, You may contact Our Customer Service department at: 801-213-4008 or You can write to Our Customer Service department at the following address: University of Utah Health Plans, P.O.Box 45180, SLC, UT 84145.

Definitions Specific to the Appeal Process

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

- access to health care benefits, including an adverse determination made pursuant to utilization management;
- claims payment, handling or reimbursement for health care services;

- matters pertaining to the contractual relationship between a Claimant and the Plan;
- unresolved member complaints; and
- other matters as specifically required by state law or regulation.

Independent Review Organization (IRO) is an independent Physician review organization which acts as the decision-maker for voluntary expedited Appeals and voluntary external Appeals, through an independent contractor relationship with University of Utah Health Plans and/or through assignment to Us via state regulatory requirements. The IRO is unbiased and is not controlled by the Plan.

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

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

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

Representative means someone who represents You for the purpose of the Appeal. The Representative may be Your personal Representative or a treating Provider. It may also be another party, such as a family member, as long as You or Your legal guardian authorize in writing, disclosure of personal information for the purposes of the Appeal. No authorization is required from the parent(s) or legal guardian of a Claimant who is unmarried and less than 13 years old. For expedited Appeals only, a health care professional with knowledge of Your medical condition is recognized as Your Representative. Even if You have previously designated a person as Your Representative for a previous matter, an authorization designating that person as Your Representative in a new matter will be required (but re-designation is not required for each Appeal level). If no authorization exists and is not received in the course of the Appeal, the determination and any personal information will be disclosed to You or Your treating Provider only.

SECTION 12 – GENERAL PROVISIONS

Choice of Forum

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

Payment of Claims

90% of valid insurance claims submitted by a provider will be paid or denied within 30 days of the day on which we receive the claims. If we deny the claim, we will provide a written explanation for the denial. We may extend this time period by 15 days if we:

- determine that the extension is necessary due to matters beyond our control; and
- notify the provider and insured in writing of:
    - the circumstances requiring the extension; and
    - the date by which we expect to pay or deny the claim.

If an extension is necessary due to a failure of the provider or insured to submit the information necessary to decide the claim, the notice of extension will describe the information needed, and we will give the provider or the insured at least 45 days to provide the information before we deny the claim. We will process the claim and provide a written explanation of our decision regarding any part of the claim that is denied within 20 days.

When any claim is paid to a provider or denied under this plan, the insured will receive an explanation of benefits.

Claims Older Than One Year

Claims will be denied if submitted more than one year after the services were provided, unless the insured shows that it was not reasonably possible to give notice of the loss or file the proof of loss within one year.

Entire Contract; Changes

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

Incontestability

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

Representations

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

What Are the Time Limits on Legal Actions?

Legal Actions: No action will be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action will be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

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

Can this Policy be Assigned?

This Policy cannot be assigned.

Third Party Payments for Premiums. Copayments, Coinsurance

Providers may not waive, rebate, give, pay, or offer to waive, rebate, give or pay all or part of the Insured's deductible or other out-of-pocket costs, including copayments, coinsurance, or premiums. We will accept third party payments of premiums and 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

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

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

We do not count any financially interested third party cost-sharing payments toward deductible 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 13 – GENERAL EXCLUSIONS AND LIMITATIONS

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

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

Waiting Period For Preexisting Conditions

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

Specific Exclusions and Limitations

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

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

Advanced Direct Midwife

Services from an Advanced Direct Midwife are not covered.

Allergy Services
Sublingual or colorimetric allergy testing and sublingual antigens.

Covered allergy tests, treatment and serum must be administered by a provider with documented training in diagnosing and managing immunological conditions. Oral food challenge testing is only covered when administered by a provider who is board certified in allergy and/or immunology.

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

- acupuncture, 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.
- In addition, the Plan does not cover laboratory testing, imaging or other diagnostic services/procedures used to determine patient's eligibility for or to monitor response to alternative therapies

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

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

Billing of Services
The following improper billing practices:

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

Birthing Centers and Home Births
Services and supplies related to birthing centers and home births.

Cardiac Rehabilitation
Phases 3 and 4 associated with cardiac rehabilitation, which involve independent and group exercise programs.

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 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 that prohibits operating a motor vehicle in a state other than Utah, while exceeding the legal limit of concentration of alcohol, drugs, or a combination of both in the blood. Any violation shall be established in a criminal proceeding in which You or Your Dependent is found guilty, enters a no contest plea, or a plea in abeyance, or enters into a diversion agreement; or U of U Health Plans requests and independent review where the findings support a decision to deny coverage.

Clinical Trials
Investigational items, devices or services being used in a Clinical Trial, except for Approved Clinical Trials, including items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient, or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

- to treat a congenital anomaly for Claimants;
- to restore a physical bodily function lost as a result of Injury or Illness;

- required as a result of an Accidental Injury, Illness, or therapeutic intervention and services are rendered or planned (as specifically documented in the Claimant's medical record) within 12 months of the cause or onset of the Injury or as soon as reasonably possible, Illness or therapeutic intervention (generally performed to restore function, but may also be done to restore a normal appearance); or
- related to breast reconstruction following a Medically Necessary mastectomy.

Cosmetic means services or supplies that are applied to normal structures of the body primarily to improve or change appearance.

Reconstructive means services, procedures or surgery performed on abnormal structures of the body, caused by congenital anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance. Services specifically excluded include, but are not limited to, the following:

- services not medically necessary;
- complications from cosmetic surgery, except in cases of reconstructive surgery following a trauma;
- breast reduction;
- mastectomy for gynecomastia;
- blepharoplasty;
- capsulotomy, replacement, removal or repair of breast implant originally placed for cosmetic purposes;
- rhinoplasty, except when related to an accident;
- rhytidectomy;
- injection of collagen;
- lipectomy, abdominoplasty, panniculectomy;
- repair of diastasis recti;
- hair transplants;
- treatment for spider or reticular veins;
- liposuction;
- chin implant, genioplasty or horizontal symphyseal osteotomy;
- otoplasty; unless performed as a part of a stage procedure intended to restore hearing
- Procedures to treat varicose veins except when associated with ulceration or bleeding with significant comorbid complications; and
- chemical peels

Counseling
Charges for counseling a Claimant, including the following:

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

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

Court Ordered Treatment
Treatment ordered by a court unless both medically necessary and performed at a participating provider.

Dental Services
Dental Services provided to prevent, diagnose, or treat diseases or conditions of the teeth and adjacent supporting soft tissues, and treatment that restores the function of teeth, including dental hospitalization and pediatric dental anesthesia; and orthodontic treatment in conjunction with jaw surgery. Treatment for Temporomandibular Joint Disorder (TMJ) is limited to $2,000 per lifetime.

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 condition:
    - Is developmentally delayed to the point supporting documentation demonstrates the member is unable to cooperate with necessary services regardless of chronological age
    - 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
3. 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

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.

Expenses Before Coverage Begins or After Coverage Ends
Services and supplies incurred before Your Effective Date under the Plan or after the termination of Your enrollment under the Plan.

Fees, Taxes, Interest
Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. The Plan also does not cover excise, sales or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state or local government or by another entity, unless required by law.

Foot Care (Routine)
Routine foot care, including, but not limited to: treatment of corns and calluses and trimming of nails, except as medically necessary, determined in accordance with Medicare guidelines; visits in conjunction with palliative care or metatarsalgia or bunions, etc; and subtalar implants.

Genetic Testing

Genetic Testing is covered Only in the following circumstances and according to University of Utah Health Plans criteria or state or federal law:

- Prenatal testing when performed as part of an amniocentesis to assess specific chromosomal abnormalities in women at high risk for inheritable conditions that can lead to significant immediate and/or long term health consequences to the child after birth;
- Neonatal testing for specific inheritable metabolic conditions (e.g., PU);

- When the Member has a more than five percent probability of having an inheritable genetic condition and has signs or symptoms suggestive of a specific condition or a strong family history of the condition (defined as two or more first-degree relatives with the condition) and results of the testing will directly affect the patient's treatment; or
- Pre-implantation embryonic genetic testing performed to identify an inherited genetic condition known to already exist in either parent's family which has the potential to cause serious and impactful medical conditions for the child.

Government Programs

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

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

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

Home Health Care
Services including, but not limited to, the following:

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

Infertility
Unless specified in your schedule of benefits 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 (IUI), intrafallopian transfer, Gamete intrafallopian transfer (GIFT) or pronuclear stage transfer (PROST), or natural cycle IVF, In vitro fertilization with embryo transfer (IVF-ET), in vitro fertilization (IVF), and Zygote intrafallopian transfer (ZIFT)) 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 include but are not limited to the following:

- 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;

If your schedule of benefits specifies infertility as a covered benefit certain services may be covered up to the annual limits listed.

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

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

Medical Prescription Drugs

Medical drugs are those drugs administered either by intravenous (in a vein), intra-arterial (in an artery) infusion or injection most commonly administered by a qualified healthcare provider typically in an inpatient or outpatient hospital, stand-alone infusion center, skilled nursing facility, office or home health agency. Self-injectable drugs are not considered medical drugs.

Certain medical prescription drugs require prior authorization. For a list of medical drugs that require prior authorization or that are not covered, please refer to the Plan website found on your SBC.

Medication Samples

Including any corresponding administration requirements such as intravenous infusion therapy and office visits for administration.

Mental Health
The following disorders and mental health-related treatment:

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

Motor Vehicle Coverage and Other Insurance Liability
Expenses for services and supplies that are payable under any automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage or similar contract or insurance. This applies when the contract or insurance is either issued to, or makes benefits available to a Claimant, whether or not the Claimant makes a claim under such coverage. Further, the Claimant is responsible for any cost-sharing required by the motor vehicle coverage, unless applicable state law requires otherwise. Once benefits under such contract or insurance are exhausted or considered to no longer be Injury-related under the no-fault provisions of the contract, Benefits will be provided according to the Policy.

Non-Covered Services in conjunction with a Covered Service

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

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

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

Organ and Tissue Donation
Organ and tissue donor charges are not covered.

Other Specific Services

- Computer-assisted navigation for orthopedic procedures;
- Cryoablation therapy for plantar fasciitis and Morton's neuroma;
- Platelet Rich Plasma or other blood derived therapies for orthopedic procedures;
- Extracorporeal shock wave therapy for musculoskeletal indications;
- Infrared light coagulation for the treatment of hemorrhoids;
- Intimal Media Thickness (IMT) testing to assess risk of coronary disease;
- Magnetic Source Imaging (MSI);
- Manipulation under anesthesia for treatment of back and pelvic pain;
- Mole mapping;
- Radiofrequency ablation for lateral epicondylitis;
- Virtual colonoscopy as a screening for colon cancer; and
- Whole body scanning.

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.

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, and heat lamps are not covered.

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

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

- childbirth education classes;
- epidemiological and predictive genetic screening, except genetic evaluations for pregnancy at high risk of genetic disease;

- amniocentesis or chorionic villi sampling, except for high risk pregnancy; and
- medical services for surrogate mothers.

Pain Management Therapies
Prolotherapy, stem cell therapy, proliferation therapy or regenerative injection therapy for pain management.

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

Pulmonary Rehabilitation
Phase four associated with pulmonary rehabilitation, which includes an independent exercise program.

Reversals of Sterilizations
Services and supplies related to reversals of sterilization.

Robot-Assisted Surgery
Direct costs for the use of the robot are not covered.

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

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

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

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

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

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

Services and Supplies Provided by a School or Halfway House
Services and supplies provided by any public or private school or halfway house, or by their employees and services provided solely to satisfy institutional requirements.

Services and Supplies that are not Medically Necessary
Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury, except for preventive care benefits specifically provided under the Plan. 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;
- physical or occupational therapy primarily for maintenance care;
- evaluations not required for health reasons, such as employment or insurance examinations;
- autopsy procedures;
- charges for independent medical evaluations and testing for the purpose of legal defense;
- autologous blood storage for future use;
- probability and predictive analysis and testing; and
- hair or dental filling analysis to assess for trace elements or toxicity.

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

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

Sleep Studies
Sleep Studies are covered only when provided by:

- A board-certified sleep specialist or at a Participating Facility certified as a sleep center/lab by the American Board of Sleep Medicine; or
- A board-certified sleep specialist in your home and you or your Dependent is 18 or older.

Termination of Pregnancy
Services and supplies in connection with the performance of any induced abortion services except in the following circumstances in accordance with the 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.

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

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

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

Uniformed Services
The treatment of any Claimant's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

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

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

Vision services, except for Pediatric Vision services as required by PPACA and an annual routine adult eye exam and refraction, including, but not limited to, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, reversals or revisions of surgical procedures which alter the refractive character of the eye.

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

Weight Reduction/Control
Medical or surgical treatment (including reversals), programs, or supplies that are intended to result in weight reduction, regardless of diagnosis or psychological conditions. Except:

- certain counseling required under PPACA.
- Medically supervised weight loss performed in a program affiliated with an American Society for Metabolic and Bariatric Surgery certified center.

Bariatric surgery is not covered by the Plan. Specifically excluded are:

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

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

Durable Medical Equipment
This Plan provides coverage for DME only in the following circumstances:

1. When used in conjunction with an otherwise covered condition and ALL the Following Conditions are met:

    - It is only available by a Provider prescription;
    - Provides a therapeutic benefit to the member and is NOT primarily used for non-medical purposes;
    - Required for Activities of Daily Living;
    - Are Reusable and not disposable
    - Can stand repeated use for prolonged period
    - Is usable only for member with specific health condition
    - 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)
    - Not for duplication or replacement of lost, damaged, or stolen items; and
    - Not attached to a home or vehicle.

2. Batteries only when used to power a wheelchair or other medical devices in which a specially configured proprietary battery is necessary to power the covered device, additionally batteries for insulin pumps and insulin infusion pump
3. Repair of DME is only covered if pre-approved and estimated costs are less than replacement costs
4. 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.
5. Training and testing in conjunction with DME and prosthetics
6. Equipment purchased from non-licensed DME vendor unless approved prior to purchase by the Plan
7. Specifically Excluded DME include but are not limited to the following:

    - Transcutaneous electrical or neurostimulation
    - Incontinence supplies such as diaper, incontience pads
    - Functional Neurostimulation
    - Home whirlpool or SPA equipment
    - DME to allow participation in sporting activities
    - Continuous Passive Motion Devices
    - Custom Foot orthotics/inserts/heal pads except for specific custom shoes or inserts for diabetics which are prior authorized.

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

SECTION 14 – PRESCRIPTION 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 for information and assistance regarding your Prescription Drug coverage at the number on the back of your Health Plan ID Card. To fill your prescriptions, use your Health Plan ID Card at participating network pharmacies. You can obtain additional information regarding covered medications, limits, and over the counter drugs at the University of Utah Health Plans website customized for your group, found on your SBC or back of your ID card, or through the pharmacy web portal.

Definitions

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

Brand Name Drug is a drug that has a trade name and is protected by patent, meaning it can only be manufactured and produced by the company holding the patent. Brand name drugs may require step therapy or prior authorization. If a brand name drug has a generic equivalent, a brand-generic charge will apply.

Brand Generic Drug Charge is applied if you receive a Brand name drug, regardless of reason or medical necessity, when a generic is available. A Brand-Generic charge is the difference in cost between the generic and the brand name drug. This charge is added to the generic cost sharing outlined in your benefits summary. The Brand-Generic charge does not apply towards your Deductible or Out-of-Pocket Maximum and continues to apply after Deductible and Out-of-Pocket Maximum are met.

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

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

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

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

Prior Authorization is required before some brand and generic drugs, as well as all specialty drugs, are eligible for coverage under The Plan. The Pharmacy and Therapeutics (P&T) Committee establishes the Prior Authorization criteria. In order for a member to receive coverage for a medication requiring Prior Authorization, the member or member’s provider should contact Pharmacy Customer Service at the number listed on the back of your ID Card. Your provider will be required to complete a prior authorization form and provide clinical documentation to show why this medication is needed for treatment of your disease state or medical condition. A letter of medical necessity is also recommended. Your provider should also include in his/her letter your diagnosis and previous therapies that have failed. If Prior Authorization is not received or if the medication is filled prior to approval, the cost of the medication will be full member responsibility. In addition, Prior Authorizations are not back-dated.

Quantity Limits ensure members do not receive a prescription for a quantity that exceeds recommended Plan or safety limits. Limits are set because some medications 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 schedules, current medical practices, evidence-based clinical guidelines, and peer-reviewed medical literature related to a particular drug. Prior Authorization is required for any quantities that exceed Plan limits.

Specialty Drugs are high risk, high-cost drugs that are used to treat complex conditions that may require special handling and administration. Specialty drugs generally require prior authorization and are limited to a 30-day supply. All Specialty drugs must be filled through a designated specialty pharmacy. Please call University of Utah Health Plans Pharmacy Customer Service at the number found on the back of your ID Card for additional information.

Step Therapy is a program for prescription drugs developed around safety, cost, and a member's health. In Step Therapy, the covered drugs are arranged in a series of "steps". The program typically starts with generic drugs as the "first step." These generics are rigorously tested and approved by the FDA and allow you to have safe, effective treatment with medication that is more affordable. More expensive brand-name drugs are usually considered in the "second step" if your provider determines the "second step" products are medically necessity for your treatment. Step Therapy is developed under the guidance and direction of the Pharmacy and Therapeutics (P&T) Committee. They review the most current research on thousands of drugs tested and approved by the FDA for safety and effectiveness. The first time you submit a prescription that requires Step Therapy, your pharmacist will receive a message to tell you that the Plan requires Step Therapy. 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 Step Therapy, 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.

Pharmacy Coverage

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

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

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

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

- ACA – Preventive Drugs required by the Affordable Care Act
- 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

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

- When you use your Health Plan Identification Card at a Participating Network Pharmacy, you will be required to pay the applicable Deductible, Copay, or Coinsurance amounts specified in the Summary of Benefits and Coverage (SBC) at the time of purchase;
- When you do not use your Health Plan Identification Card, you will be required to pay the entire cost of the prescription drug. You can submit a paper claim with University of Utah Health Plans Pharmacy Customer Service within 365 days of fill date for reimbursement of eligible expenses, not to exceed the amount the Plan would have paid a Participating Pharmacy if you had used your Health Plan Identification Card. Claims are denied if submitted more than one year after the services were provided.
- If you fill a prescription order at an Out-of-Network Pharmacy you will be required to pay the entire cost of the prescription drug, unless it is related to a medical emergency. There is no reimbursement for prescription claims processed by an Out-of-Network Pharmacy.
- You are able to fill a 30 day supply at any In-Network Pharmacy. The Plan uses a Nationwide Network of Pharmacies. You can locate a network pharmacy through the pharmacy web portal. 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) through the Designated Mail Order program. Contact University of Utah Health Plans Pharmacy Customer Service at the number found on the back of your ID Card to see if your drug is eligible for the mail order or 90 day at Retail program.
- Lost/Damaged/Stolen prescription replacements are not covered by the plan. The member will have access to the network discounts, but the cost for replacement will be member responsibility. If a medication is stolen, the plan will review for replacement only when accompanied by a police report and if the provider is willing to write a new prescription. In the case a stolen replacement is approved, it will be limited to one incident per year.

Third Party Payments

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

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

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

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

Third party cost-sharing payments from the approved Third Parties identified above will accumulate towards Deductibles and/or Out-of-Pocket Maximum. All other Third party payments are not allowed under The Plan and would not apply to a member's Deductible and/or Out-of-Pocket Maximum. If a

financially interested third party payments of this type are identified after the fact, the Plan has the right to remove from the accumulation toward the Deductible and/or Out-of-Pocket Maximum.

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 become 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.utah.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 are limited and may not be covered if a commercial product is available. Prior Authorization may be required.
- 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.
- Food Supplements, Special Formulas, and Special Diets
- Homeopathic Medications
- Investigational, Experimental, Clinical Trial, or Unproven Drugs: Drugs labeled "Caution – limited by federal law to investigational use", or experimental drugs, even though a charge is made to the individual
- Medications for Cosmetic purposes (for example, but not limited to, cosmetic hair growth and removal Products)
- Medications or immunizations administered for the purpose of prevention of disease when traveling to other countries.
- Medication samples, including any corresponding administration requirements such as intravenous infusion therapy and office visits for administration
- Medication Taken or Administered While in an 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 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 used to treat or enhance fertility
- Medications used to treat sexual dysfunction or impotence
- Medications used to treat weight loss
- Off-label use of Medication; except as outlined in the Off-label Use Policy

- Over-the-Counter Medication (OTC) or other items purchased at a pharmacy other than Prescription Drugs whether or not there is a Prescription order for the item(s), except as required under PPACA
- Pigmenting/De-pigmenting Agents, except as required to treat photosensitive conditions, such as psoriasis
- Prescription Drugs in excess of a 90-day supply
- Prescription Order is in excess of the day's supply or Plan's quantity limit
- Refills in excess of the number specified by the Physician or any refill dispensed after one year from the Physician's original Prescription order
- Testopel pellets
- Therapeutic devices or appliances, including hypodermic needles, syringes (excluding insulin syringes), support garments, and other non-medicinal substances, regardless of intended use. (In some cases, items may be covered under the Medical Benefits portion of the Plan.)
- Vitamins and Minerals, except prenatal vitamins or vitamins as required under PPACA. Please note vitamins may be limited to coverage by age and specific dosing requirements.