# Medical Master Policy

## 2014

## State of Utah

This Medical Master Policy applies to only to the State of Utah risk pool.
Terms and conditions for other employer groups may vary.

9-12-13

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This Master Policy and corresponding Benefits Summary is the contract between Public Employees Health Program (PEHP) and its Members.

## Recitals

This Master Policy between PEHP and its Members is intended to comply with the provisions of Title 49, Chapter 20 of the Utah Code Annotated which creates the Public Employees Benefits and Insurance Program, also known as PEHP. The right and obligations of PEHP and its Members are set forth in this Master Policy. If any term of this Master Policy is found to be in violation of Title 49, Chapter 20 of the Utah Code Annotated or any other state or federal law, or is unenforceable for any reason, that term shall be null and void and severable from the Master Policy and shall not render the Master Policy null and void as a whole. This contract is governed by, and will be interpreted and enforced according to the laws of the State of Utah.

This contract, including all matters incorporated herein, including, but not limited to, benefit summaries and Enrollment forms, contains the entire agreement and it is binding upon Subscribers, Members and their heirs, successors, personal representatives and assignees in regard to their applicable Employer benefit plan. There are no promises, terms, conditions, or obligations other than those contained herein. This contract supersedes all prior communications, representations, or agreements, either verbal or written, between the parties. In the event there has been a written proposal supplied to the Employer by PEHP, the compliance by the Employer and its Employees with all minimum Enrollment and underwriting factors set forth in the proposal is a condition to the effectiveness of this Contract.

Upon renewal of this contract, PEHP may modify rates, benefits, Exclusions, Limitations, and/or service by providing Employer with advance notice of change.

Paragraph headings appearing in this contract are not to be construed as interpretation of the text, but are only for the convenience of reference for the reader.

## I. PEHP and Member Responsibilities

### 1.1 CONTRACT AMENDMENTS

PEHP may unilaterally change this contract upon plan renewal and upon 30 days written notice to PEHP Subscribers.

### 1.2 NON-ASSIGNABILITY

The parties to this contract may not transfer or assign their rights or obligations without the advance written approval of the other party except that PEHP may designate an affiliated company to administer some or all of the Employer's benefit plan.

### 1.3 AVAILABILITY OF CONTRACT FOR REVIEW

Members are entitled to review a copy of this contract at the offices of the Subscriber's Employer or at www.pehp.org. Members may also request a hard copy of this contract from PEHP.

### 1.4 NO VESTED RIGHTS

Members are only entitled to receive benefits from PEHP while this contract is in effect. Members do not have any permanent or vested interest in any benefits under this contract, and benefits may change or terminate as this contract is renewed, modified or terminated from year to year. Members only have rights to benefits under this contract when they are properly enrolled and recognized by PEHP as Members. Unless otherwise expressly stated in this contract, all benefits end when this contract ends. Members have no right to receive any care, services, treatments, drugs, medications, supplies, or equipment from or through PEHP except in strict compliance with this entire contract.

### 1.5 ACCEPTANCE OF THIS CONTRACT

As a condition to receiving Coverage from PEHP, Members are presumed and required to accept, comply with, and agree to, the terms of this contract. Subscribers are also presumed to agree to the terms of this contract on behalf of eligible Dependents who enroll as Members.

### 1.6 PEHP DETERMINES ELIGIBLE SERVICES

Merely because a physician or other Provider orders or recommends care, services, treatments, drugs, medications, supplies, or equipment for a Member does not mean that PEHP will recognize the procedure as being either Medically Necessary or covered by PEHP under this contract. This is true whether the physician or other Provider is a Contracted or non-Contracted Provider.

Benefits under the Master Policy will be paid only if PEHP decides in its discretion that the Member is entitled to them. PEHP also has discretion to determine eligibility for benefits, to require verification of any claim for Eligible Benefits and to interpret the terms and conditions of the benefit plan.

### 1.7 AGENCY

Neither the Employer, nor any Member has authority to act as agent for PEHP. PEHP is not the agent of Employer for any purpose. For purposes of this contract,

the Employer acts as the agent of its Subscribers (Employees) and Subscribers act as the agent of their eligible Dependent Members.

### 1.8 PROVIDER AGENCY

Providers contracting with PEHP are independent contractors and not Employees or agents of PEHP. PEHP does not control the manner in which Contracted Providers provide professional services. Such Providers are entitled and required to exercise independent professional medical judgment in providing care and services to Members.

PEHP does not promise, represent, warrant, or otherwise guarantee that care or services provided to Members by Providers will achieve any particular result or be provided in any particular manner or at any particular level of care.

It is understood and agreed that PEHP will not be liable for any claim or demand on account of injuries or damages of any kind arising out of or in any manner connected with any conditions or injuries suffered by a Member and resulting from care or services rendered, withheld, covered, limited, excluded, or otherwise provided or not under this Master Policy. Subscribers and Members agree that Providers are solely responsible to Members for care or services rendered, limited, or withheld by such Providers.

### 1.9 MANAGED CARE

Members agree to the managed care features that are a part of the health benefit program in which they are enrolled. For example, see Section 6.

### 1.10 BENEFITS ARE LIMITED

Coverage under this contract is limited in defined ways. It is the responsibility of each Member to know the requirements, conditions, Limitations and Exclusions that apply to their Coverage, and to know the Limitations and requirements that apply to their choice of Providers and Hospitals and the timing of their health care services.

Members are responsible for payment for any care, service, treatment, drug, medication, supply, or equipment that they obtain that is not covered or limited by this contract, or is obtained from Providers or Hospitals that are not authorized to be paid by PEHP. Members are not responsible to pay for claims that are the responsibility of PEHP.

### 1.11 ADMINISTRATIVE PROVISIONS

PEHP will from time to time adopt and enforce reasonable rules, regulations, policies, procedures, and protocols to help it in the administration of this Master Policy and in providing covered services to Members. Employers and Members are subject to such rules, regulations, policies, procedures, and protocols in connection with obtaining covered services and other matters under this Master Policy.

### 1.12 COMPLIANCE RESPONSIBILITIES

Each party is responsible for its own compliance with applicable laws, rules and regulations.

### 1.13 CHANGES IN MEMBER CONTACT INFORMATION

It is the Member's responsibility to keep PEHP informed of any change of address, phone number, and email address of the Subscriber or any eligible Dependent. Members should keep copies of any notices sent to PEHP.

### 1.14 REQUESTS FOR INFORMATION

As a condition of receiving benefits under this Master Policy, Members shall provide PEHP with all information at PEHP's request, including, but not limited to, providing releases for prior Medical Records. Failure by a Member to provide information to PEHP at PEHP's request under this section within a reasonable time, as determined by PEHP shall be a breach of this Master Policy and may result in forfeiture of benefits, termination of Coverage, or PEHP having the right to hold payment of claims for the Member or the Member's dependents until the requested information is received by PEHP.

### 1.15 NOTICES

Any notice required of PEHP under this Master Policy will be sufficient if mailed by first class mail to the Member or Subscriber at the address appearing on the records of PEHP. Notice to an eligible Dependent will be sufficient if given to the Subscriber under whom the Member is enrolled. Any notice to PEHP will be sufficient if mailed to the principal office of PEHP in Salt Lake City, Utah. Each Subscriber agrees to promptly notify his/her Dependents of all benefit and other plan changes.

### 1.16 RATE CHANGES

PEHP reserves the right to change premiums at any time, when actuarially indicated.

### 1.17 PEHP EMPLOYEE RESPONSES

Without the consent of PEHP Administration, individual Employees of PEHP do not have the authority to:

1. Modify the terms and conditions of this Master Policy;
2. Extend or modify the benefits available under this

Master Policy, either intentionally or unintentionally;

3. Waive or modify any Exclusion or Limitation; or
4. Waive compliance with PEHP requirements, such as the use of Contracted Providers or the necessity of obtaining Pre-authorizations.

Benefits under this Master Policy are determined by and limited to provisions stated in this Master Policy. In the event that PEHP chooses to honor any Coverage or pay for any service mistakenly authorized or provided, such Coverage or payment will be limited to a maximum period of not more than thirty (30) days.

### 1.18 NOTICE OF COBRA RIGHTS

PEHP is providing you and your Dependents notice of your rights and obligations under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") to temporarily continue health Coverage if you are an Employee of an Employer with 20 or more Employees and you or your eligible Dependents, (including newborn and /or adopted children) in certain instances would lose PEHP Coverage. Both you and your spouse should take the time to read this notice carefully. If you have any questions please call the PEHP Office at 801-366-7555 or refer to the Benefits Summary and/or the PEHP Master Policy at www.pehp.org.

#### Qualified Beneficiary

A Qualified Beneficiary is an individual who is covered under the Employer group health plan the day before a COBRA Qualifying Event.

#### Who is Covered

**»Employees**

If you have group health Coverage with PEHP, you have a right to continue this Coverage if you lose Coverage or experience an increase in the cost of the premium because of a reduction in your hours of employment or the voluntary or involuntary termination of your employment for reasons other than gross misconduct on your part.

**»Spouse of Employees**

If you are the spouse of an Employee covered by PEHP, and you are covered the day prior to experiencing a Qualifying Event, you are a "Qualified Beneficiary" and have the right to choose COBRA Coverage for yourself if you lose group health Coverage under PEHP for any of the following Qualifying Events:

1. The death of your spouse;
2. The termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse;
4. Your spouse becoming entitled to Medicare; or
5. The commencement of certain bankruptcy proceedings, if your spouse is retired.

**»Dependent Children**

A Dependent child of an Employee who is covered by PEHP on the day prior to experiencing a Qualifying Event, is also a "Qualified Beneficiary" and has the right to COBRA Coverage if group health Coverage under PEHP is lost for any of the following Qualifying Events:

1. The death of the covered parent;
2. The termination of the covered parent's employment (for reasons other than gross misconduct) or reduction in the covered parent's hours of employment;
3. The parents' divorce or legal separation;
4. The covered parent becoming entitled to Medicare;
5. The Dependent ceasing to be a "Dependent child" under PEHP; or
6. A proceeding in a bankruptcy reorganization case, if the covered parent is retired.

A child born to, or placed for adoption with, the covered Employee during a period of COBRA Coverage is also a Qualified Beneficiary.

#### Secondary Qualifying Event

A Secondary Qualifying Event means one Qualifying Event occurring after another. It allows a Qualified Beneficiary who is already on COBRA to extend COBRA Coverage under certain circumstances, from 18 months to 36 months of Coverage from the date of the original Qualifying Event.

#### Separate Election

If there is a choice among types of Coverage under the plan, each of you who is eligible for COBRA Coverage is entitled to make a separate election among the types of Coverage. Thus, a spouse or Dependent child is entitled to elect COBRA Coverage even if the covered Employee does not make that election. Similarly, a spouse or Dependent child may elect a different Coverage from the Coverage that the Employee elects.

#### Your Duties Under The Law

It is the responsibility of the covered Employee, spouse, or Dependent child to notify the Employer or Plan Administrator in writing within sixty (60) days of a divorce, legal separation, child losing Dependent status or secondary qualifying event, under the group health plan in order to be eligible for COBRA Coverage. PEHP can be notified at 560 East 200 South, Salt Lake City,

UT, 84102. PEHP Customer Service: 801-366-7555; toll free 800-765-7347. Appropriate documentation must be provided, such as: divorce decree, marriage certificate, etc.

Keep PEHP informed of address changes to protect you and your family's rights. It is important for you to notify PEHP at the above address if you have changed marital status, or you, your spouse or your Dependents have changed addresses.

In addition, the covered Employee or a family Member must inform PEHP of a determination by the Social Security Administration that the covered Employee or covered family Member was disabled during the 60-day period after the Employee's termination of employment or reduction in hours, within 60 days of such determination and before the end of the original 18-month COBRA Coverage period. (See "Special rules for disability," below.) If, during continued Coverage, the Social Security Administration determines that the Employee or family Member is no longer disabled, the individual must inform PEHP of this redetermination within 30 days of the date it is made.

### Employers' Duties Under The Law

Your Employer has the responsibility to notify PEHP of the Employee's death, termination of employment, reduction in hours, or Medicare eligibility. Notice must be given to PEHP within 60 days of the occurrence of the above-listed events. When PEHP is notified that one of these events has happened, PEHP in turn will notify you and your Dependents that you have the right to choose COBRA Coverage. Under the law, you and your Dependents have up to 60 days from the date you would lose Coverage because of one of the events to inform PEHP that you want COBRA Coverage or 60 days from the date of your Election Notice.

### Election of COBRA Coverage

Members have 60 days from either termination of Coverage or date of receipt of COBRA election notice to elect COBRA. If no election is made within 60 days, COBRA rights are deemed waived and will not be offered again. If you choose COBRA Coverage, your Employer is required to give you Coverage that, as of the time Coverage is being provided, is identical to the Coverage provided under the plan to similarly situated Employees and their family Members. If you do not choose COBRA Coverage within the time period described above, your group health insurance Coverage will end.

### Premium Payments

Payments must be made retroactively to the date of the qualifying event and paid within 45 days of the date of election. There is no grace period on this initial premium. Subsequent Payments are due on the first of each month with a thirty (30) day grace period. Delinquent Payments will result in a termination of COBRA Coverage.

The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA Coverage due to a disability, 150 percent) of the cost to the group health plan (including both Employer and Employee contributions) for Coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA Coverage. Claims paid in error by ineligibility under COBRA will be reviewed for collection. Ineligible premiums paid will be refunded.

### How Long Will Coverage Last?

The law requires that you be afforded the opportunity to maintain COBRA Coverage for a maximum of 36 months, unless you lose group health Coverage because of a termination of employment or reduction in hours. In that case, the required COBRA Coverage period is 18 months. Additional qualifying events (such as a death, divorce, legal separation, or Medicare entitlement) may occur while the COBRA Coverage is in effect. Such events may extend an 18-month COBRA period to a maximum of 36 months, but in no event will COBRA Coverage extend beyond 36 months from the date of the event that originally made the Employee or a qualified beneficiary eligible to elect COBRA Coverage. You should notify PEHP if a second Qualifying Event occurs during your 18-month COBRA Coverage period.

### Special Rules For Disability

If the Employee or covered family Member is disabled at any time during the first 60 days of COBRA Coverage, the COBRA Coverage period may be extended to 29 months for all family Members, even those who are not disabled.

**The criteria that must be met for a disability extension is:**

1. Employee or family Member must be determined by the Social Security Administration to be disabled.
2. Must be determined disabled during the first 60 days of COBRA Coverage.
3. Employee or family Member must notify PEHP of the disability no later than 60 days from the later of:
    a. the date of the Social Security Administration disability determination;
    b. the date of the Qualifying Event;
    c. the loss of Coverage date; or

   d. the date the Qualified Beneficiary is informed of the obligation to provide the disability notice.

4. Employee or family Member must notify Employer within the original 18 month COBRA period.
5. If an Employee or family Member is disabled and another qualifying event occurs within the 29-month COBRA period (other than bankruptcy of your Employer), then the COBRA Coverage period may continue up to a maximum of 36 months after the termination of employment or reduction in hours.

**Special Rules For Retirees**

In the case of a retiree or an individual who was a covered surviving spouse of a retiree on the day before the filing of a Title 11 bankruptcy proceeding by your Employer, Coverage may continue until death and, in the case of the spouse or Dependent child of a retiree, 36 months after the date of death of a retiree.

**COBRA Coverage May Be Terminated**

The law provides that your COBRA Coverage may be terminated prior to the expiration of the 18-, 29-, or 36-month period for *any* of the following reasons:

1. Your Employer no longer provides group health Coverage to any of its Employees.
2. The premium for COBRA Coverage is not paid in a timely manner (within the applicable grace period).
3. The individual becomes covered, after the date of election, under another group health plan (whether or not as an Employee) that does not contain any Exclusion or Limitation with respect to any preexisting condition of the individual.
4. The date in which the individual becomes entitled to Medicare, after the date of election.
5. Coverage has been extended for up to 29 months due to disability (see "Special rules for disability") and there has been a final determination that the individual is no longer disabled.
6. Coverage will be terminated if determined by PEHP that the Employee or family Member has committed any of the following: fraud upon PEHP or Utah Retirement Systems, forgery or alteration of prescriptions; criminal acts associated with COBRA Coverage; misuse or abuse of benefits; or breach of the conditions of the Plan Master Policy.

You do not have to show that you are insurable to choose COBRA Coverage. However, under the law, you may have to pay all or part of the premium for your COBRA Coverage plus two percent.

This notice is a summary of the law and therefore is general in nature. The law itself and the actual Plan provisions must be consulted with regard to the application of these provisions in any particular circumstance.

**Questions**

If you have any questions about continuing Coverage, please contact PEHP at 560 East 200 South, Salt Lake City, UT, 84102. Customer Service: 801-366-7555; toll free 800-765-7347.

### 1.19 NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT

In accordance with The Women's Health and Cancer Rights Act of 1998, PEHP 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 PEHP's Medical Case Management criteria and in a manner determined in consultation with the attending physician and the patient, for:

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

Coverage of mastectomies and breast reconstruction benefits are subject to applicable Deductibles and Copayment Limitations consistent with those established for other benefits.

Following the initial reconstruction of the breast(s), any additional modification or revision to the breast(s), including results of the normal aging process, will not be covered.

All benefits are payable according to the schedule of benefits, based on this plan. Regular Pre-authorization requirements apply.

### 1.20 NOTICE OF NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance Coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery; or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Provider (e.g. physician, nurse midwife or physicians

assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

## II. Definitions

### 2.1 ACCIDENT, ACCIDENTAL

A single unpremeditated event of violent and external means, which happens suddenly, is unexpected, and is identifiable as to time and place. Injuries resulting from a willful action including lifting, pushing, pulling, bending, or straining are not considered within the definition of an Accident. Life-threatening conditions may not be considered within the meaning of an Accident.

### 2.2 AMBULATORY SURGICAL FACILITY

Any licensed establishment with an organized medical staff of physicians, with permanent facilities equipped and operated primarily for the purpose of performing Ambulatory Surgical Procedures and with continuous physician services whenever a Member is in the facility but does not provide services or other accommodations for Members to stay overnight.

### 2.3 CERTIFICATION AND DISCLOSURE OF COVERAGE

A certificate describing an individual's Creditable Coverage as prior Coverage, beginning and termination dates of prior Coverage, and applicable Pre-existing Condition waiting periods. Certification shall specify any Pre-existing Condition waiting periods imposed on an individual for any Coverage. A new enrollee must present PEHP with a Certification and Disclosure at the time of Enrollment.

### 2.4 COMMUNITY STANDARD

The standard accepted for consensus decisions will be determined by published medical data, in journals sponsored by professional societies and associations, patterns of care within PEHP database, professional review organizations, and consultations with experts who are Board Certified by the American Board of Medical Specialists. The Community Standard is not necessarily a prevailing level of practice.

### 2.5 COMPLICATION(S)

A medical condition, illness, or injury related to, or occurring as a result of another medical condition, illness, injury, Surgical Procedure, device, or drug.

### 2.6 CONTRACTED HOSPITAL

A Hospital with whom PEHP has a current contractual agreement to render care to covered Members for a specific fee.

### 2.7 CONTRACTED PROVIDER

A Provider with whom PEHP has a current contractual agreement to render care to covered Members for a specific fee.

### 2.8 COORDINATION OF BENEFITS

The Coordination of Eligible Benefits between two or more plans under which an individual is covered after primary and secondary Coverage determination is made.

### 2.9 COPAYMENT

The portion of the cost of Eligible Benefits that a Member is obligated to pay under the plan(s), including Deductibles. A Copayment may be either a fixed dollar amount or a percentage of the allowable medical expense.

### 2.10 COSMETIC PROCEDURE

Any procedure performed to improve appearance or to correct a deformity without restoring a physical bodily function.

### 2.11 COVERAGE

The eligibility of a Member for benefits provided under this Master Policy, subject to the terms, conditions, Limitations and Exclusions of this Master Policy.

Benefits must be provided:

1. When this Master Policy is in effect; and
2. Prior to the date that termination occurs.

### 2.12 CREDITABLE COVERAGE

Any comprehensive health insurance plan such as: a group health plan; health insurance Coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act; Chapter 55 of Title 10 of the United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 of the United States Code; a public health plan; or, a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e). Creditable Coverage does not include Excepted Benefits. (Excepted Benefits defined below).

### 2.13 CUSTODIAL CARE

Services, supplies, or accommodations for care rendered which:

1. Do not provide treatment of injury or illness;
2. Could be provided by persons without professional skills or qualifications;
3. Are provided primarily to assist a Member in daily living;
4. Are for convenience, contentment, or other non-therapeutic purposes; or
5. Maintain physical condition when there is no prospect of affecting remission or restoration of the Member to a condition in which care would not be required.

### 2.14 DEDUCTIBLE

The amount paid by a Member for eligible charges before any benefits will be paid under the plan.

### 2.15 DEPENDENT

"Dependent" means:

1. The Subscriber's lawful spouse under Utah State Law. Adequate legal documentation may be required. A person of the opposite sex to whom you are not formally married is your lawful spouse only if he or she qualifies as a common law spouse under Utah State Law. In Utah, you must obtain a court or administrative agency order establishing the common law marriage. Eligibility may not be established retroactively. In cases of court or administrative orders purporting to retroactively either establish or annul/declare void a marriage or divorce, PEHP will consider the change effective on the date the court or administrative order was signed by the court or administrative agency, or the date the order is received by PEHP, whichever is later.
2. Adult designee and their Dependents as defined by the Employer (if applicable).
3. Children or stepchildren of the Subscriber up to the age of 26 who have a Parental Relationship with the Subscriber. Adequate legal documentation may be requested.
4. Legally adopted children, who are adopted prior to turning 18 years old, foster children up to age 19, and children through legal guardianship up to the age of 19 are eligible subject to PEHP receiving adequate legal documentation. (Legal guardianship must be court appointed.)
5. Children who are incapable of self support because of an ascertainable mental or physical impairment, and who are claimed as a Dependent on the Subscriber's federal tax return, upon attaining age 26, may continue Dependent Coverage, while remaining Totally Disabled, subject to the Subscriber's Coverage continuing in effect. Periodic documentation is required. Subscriber must furnish written notification of the disability to PEHP no later than 31 days after the date the Coverage would normally terminate. In the notification, the Subscriber shall include the name of the Dependent, date of birth, a statement that the Dependent is unmarried, and details concerning:
   a. The condition that led to the Dependent's physical or mental disability;
   b. Income, if any, earned by the Dependent; and
   c. The capacity of the Dependent to engage in employment, attend school, or engage in normal daily activities.

   If proof of disability is approved, the Dependent's Coverage may be continued as long as he/she remains Totally Disabled and unable to earn a living, and as long as none of the other causes of termination occur.

   At the time of a Dependent's approval for continued PEHP Coverage, PEHP shall provide the Subscriber with a date of renewal for their Dependent. At the time of their renewal, the Subscriber shall provide proof of Dependent's continued disability 30 days prior to the renewal date. If the Subscriber fails to provide proof of disability 30 days prior to the date of renewal, the Dependent's Coverage will terminate on the renewal date.
6. When you or your lawful spouse are required by a court or administrative order to provide health coverage for a child, the child will be enrolled in your coverage according to PEHP guidelines and only to the minimum extent required by applicable law. A Qualified Medical Child Support Order (QMCSO) can be issued by a court of law or by a state or local child welfare agency. If ordered, you and your Dependent child may be enrolled without regard to annual enrollment restrictions and will be subject to applicable PEC waiting period. The effective date for a qualified order will be the start date indicated in the order
7. In the event of divorce, Dependent children for whom the Subscriber is required to provide medical insurance as ordered in a divorce decree may continue Coverage. The former spouse and/or stepchildren may not continue Coverage but may

be eligible to convert to a COBRA plan. PEHP will not recognize Dependent eligibility for a former spouse or stepchildren as a result of a court order or divorce decree.

8. Stepchildren who no longer have a Parental Relationship with a Subscriber will no longer be eligible to receive benefits under PEHP.
9. Dependent does not include an unborn fetus.

### 2.16 DEVICE

Any instrument, apparatus, appliance, material, or other article, whether used alone or in combination, including the software necessary for its proper application intended by the manufacturer to be used for the purpose of:

1. Diagnosis, prevention, monitoring, treatment, or alleviation of illness or injury;
2. Diagnosis, monitoring, treatment, alleviation, or compensation for a handicap;
3. Investigation, replacement, or modification of the anatomy or of a physiological process, or;
4. Which does not achieve its principal intended action in or on the human body by pharmacological, immunological, or metabolic means, but which may be assisted in its function by such means.

### 2.17 DURABLE MEDICAL EQUIPMENT

Medical equipment that is all of the following:

1. Used only to benefit in the care and treatment of an illness or injury;
2. Durable and useful over an extended period of time;
3. Used only for a medical purpose rather than convenience or contentment;
4. Is prescribed by a Provider; and
5. Not used by other family members for non-therapeutic purposes.

### 2.18 ELECTIVE TREATMENT

Non-emergency services that can be scheduled 48 hours after diagnosis.

### 2.19 ELIGIBLE BENEFIT

Medical expenses which are covered under this Master Policy. If a group is a grandfathered plan under the Affordable Care Act, Preventive care services (Section 6.14) are covered in accordance with the applicable Benefits Summary.

### 2.20 EMERGENCY MEDICAL CONDITION

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. A determination of emergency will be made by PEHP on the basis of the final diagnosis.

### 2.21 EMPLOYEE

An Employer's Employee who is eligible for Coverage in the Group Insurance Program of Title 49, Chapter 20 of the Utah Code Annotated.

### 2.22 EMPLOYER

The State, its educational institutions and political subdivisions that are eligible to participate and have elected to participate in the Group Insurance Program of Title 49, Chapter 20 of the Utah Code Annotated.

### 2.23 ENROLLMENT

The process whereby an Employee makes written or online application for Coverage through PEHP, subject to specified time periods and plan provisions.

### 2.24 EXCEPTED BENEFITS

Benefits not subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). They are as follows: Coverage for Accident, or disability income insurance; Coverage issued as a supplement to liability insurance; liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; Coverage for on-site medical clinics; similar insurance Coverage under which benefits for medical care are secondary or incidental to other insurance benefits. The following benefits are not subject to requirements if offered separately: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination; other similar limited benefits. The following benefits are not subject to requirements if offered as independent non-coordinated benefits: Coverage only for a specified disease or illness; Hospital indemnity or other fixed indemnity insurance. The following benefits are not subject to requirements if offered as a separate insurance policy: Medicare supplemental Health insurance (as defined under section 1882(g)(1) of the Social Security Act), Coverage supplemental to the Coverage provided under Chapter 55 of Title 10, United States Code, and similar supplemental Coverage provided.

### 2.25 EXCLUSIONS
Those services or supplies incurred by the Member, which are not eligible under this policy.

### 2.26 EXPERIMENTAL, INVESTIGATIONAL, OR UNPROVEN
Those services, supplies, devices, or pharmaceutical (drug) products which are not recognized or proven to be effective for treatment of illness or injury in accordance with generally accepted standards of medical practice as solely determined by PEHP.

### 2.27 FDA APPROVED
Pharmaceuticals, Devices, or Durable Medical Equipment which have been approved by the FDA for a particular diagnosis.

### 2.28 FORMULARY
A list of selected prescription medications reviewed by an independent Pharmacy and Therapeutics (P&T) Committee. The P&T Committee is an independent group of accomplished health care professionals comprised of physicians with various medical specialties and clinical pharmacists who assist in developing the Formulary. The P&T Committee reviews medications in all therapeutic categories relevant to the prescription drug benefit and evaluates them based on safety and efficacy. The Committee reviews new and existing drugs on a regular basis and the Formulary is revised accordingly.

### 2.29 GLOBAL FEE
An amount negotiated for a specific procedure (such as an organ transplant) including multiple Providers, within a specified time frame.

### 2.30 GROUP INSURANCE PROGRAM
The program of Coverage created by Title 49, Chapter 20 of the Utah Code Annotated.

### 2.31 HIGH DEDUCTIBLE HEALTH PLAN
A plan with a lower premium and higher deductible than a traditional health plan, which is compatible with a Health Savings Account as defined by and in accordance with Federal Law.

### 2.32 HOLIDAY
Holiday is defined as any legal holiday of the State of Utah as defined in Utah Code Annotated § 63G-1-301(1).

### 2.33 HOSPICE CARE
A program of supportive care that addresses the spiritual, social, and psychological needs of terminally ill patients and their families. The Global per diem benefit for Hospice includes: home care nursing, nursing aides, oral medication, Durable Medical Equipment, social worker, counseling, respite care, physical, occupational, and speech therapies provided for purposes of symptoms control or to enable the patient to maintain activities of daily living and basic functional skills.

### 2.34 HOSPITAL
1. An institution which is licensed by the state in which it resides and maintains Medicare and Medicaid approval for services.
2. Any other institution which is operated pursuant to law, under the supervision of a staff of physicians and with twenty-four hour per day nursing service, which is primarily engaged in providing:
   a. General inpatient medical care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, all of which facilities must be provided on its premises or under its control; or
   b. Specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including x-ray and laboratory) on its premises, under its control, or through a written agreement or with a specialized Provider of those facilities.

In no event shall the term Hospital include a facility operated primarily as an outpatient or free standing unit, or a convalescent nursing home or an institution or part thereof which is used principally as a convalescent, rest, or nursing facility or facility for the aged, or which furnishes primarily domiciliary or Custodial Care, including training in the routines of daily living, or which is operated primarily as a school. Hospitals are considered Providers in accordance with this Master Policy.

### 2.35 IMMEDIATE FAMILY MEMBER
Immediate Family Members are considered to be (for purposes of this policy): spouse, children, son-in-law, daughter-in-law, brother, sister, brother-in-law, sister-in-law, mother, father, mother-in-law, father-in-law, step-parents, stepchildren, grandparents, grandchildren, uncles, aunts, nieces, nephews, domestic partners, and adult designees of any subscriber or dependent covered under the subscriber's plan.

### 2.36 INDUSTRIAL CLAIM
An illness or injury arising out of or in the course of employment covered by the Worker's Compensation Fund or Employer Liability laws.

### 2.37 LIFE-THREATENING
The sudden and acute onset of an illness or injury where delay in treatment would jeopardize the Member's

life or cause permanent damage to the Member's health such as, but not limited to, loss of heartbeat, loss of consciousness, cessation or severely obstructed breathing, massive and uncontrolled bleeding. The determination of a Life-threatening event will be made by PEHP on the basis of the final diagnosis and medical review of the records. PEHP reserves the right to solely determine whether or not a situation is Life-threatening.

### 2.38 LIFETIME MAXIMUM BENEFITS OR LIFETIME LIMITS

Eligible benefits that have a Lifetime Maximum Benefit apply to the Lifetime of the Member, and apply when a Member terminates and reinstates Coverage with the same employer who offers Coverage through PEHP.

### 2.39 LIMITATIONS

Provisions in the plan indicating services or supplies that are not fully covered or covered only when specific criteria is met, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

### 2.40 ALLOWED AMOUNT

The maximum fee allowable for a given procedure, test, device, or drug established by PEHP and accepted by Contracted Providers.

### 2.41 MEDICAL CASE MANAGEMENT

The active involvement by request of PEHP of a nurse coordinator or case manager working with the Member, Member's family and Provider(s) to coordinate a comprehensive, medically appropriate treatment plan with prudent use of benefit dollars.

### 2.42 MEDICAL RECORDS

Medical reports, clinical information, and Hospital records relating to the care, treatment, and relevant medical history of the Member.

### 2.43 MEDICALLY NECESSARY/ MEDICAL NECESSITY

Any healthcare services, supplies or treatment provided for an illness or injury which is consistent with the Member's symptoms or diagnosis provided in the most appropriate setting that can be used safely, without regard for the convenience of a Member or Provider. However, such healthcare services must be appropriate with regard to standards of good medical practice in the state of Utah and could not have been omitted without adversely affecting the Member's condition or the quality of medical care the Member received as determined by established medical review mechanisms, within the scope of the Provider's licensure, and/or consistent with and included in policies established and recognized by PEHP. Any medical condition, treatment, service, equipment, etc. specifically excluded in the Master Policy is not an "Eligible Benefit" regardless of Medical Necessity.

### 2.44 MEMBER

A Subscriber, a Subscriber's spouse, a Subscriber's Dependents who are enrolled in active Coverage or individuals who have converted to COBRA Coverage, Utah mini-COBRA Coverage, or a retired individual who is eligible for Coverage and has continued to pay contributions.

### 2.45 MENTAL HEALTH

Mental Health Coverage shall include diagnosis code as described in the International Classification of Disease code books, except where otherwise described or excluded in the policy.

### 2.46 PACKAGE FEE

The cost benefit of "package" surgical services, which include the operation per se; local infiltration, metacarpal/digital block or topical anesthesia when used and normal, uncomplicated follow-up care. Normal, uncomplicated follow-up care would cover the period of Hospitalization and office follow-up for progress checks or any service directly related to the Surgical Procedure as per standard medical guidelines. The only exception would be if the service relates to Complications, exacerbations or recurrences of other diseases or injuries requiring additional or separate services. When an additional Surgical Procedure(s) is carried out within the listed period of follow-up care for a previous Surgery, the follow-up periods will continue concurrently to their normal termination.

### 2.47 PARENTAL RELATIONSHIP

The relationship between a natural child or stepchild and a parent while the child or stepchild is dependent on the parent for Coverage. Stepchildren will no longer be eligible to receive benefits when the marriage between their natural parent and the subscriber step-parent is terminated for any reason.

### 2.48 PAYMENT

Amount paid by the Subscriber for the purchase of a medical benefits plan.

### 2.49 PBM

Pharmacy Benefit Manager.

### 2.50 PRE-AUTHORIZATION

The process, prior to service, that the Member and the

treating Provider must complete in order to obtain authorization for specified benefits of this Master Policy which may be subject to Limitations and to receive the maximum benefits of this Master Policy for Hospitalization, Surgical Procedures, Durable Medical Equipment, pharmaceutical drug products, or other services as required. Pre-authorization does not guarantee payment should Coverage terminate, should there be a change in benefits, should benefit limits be used by submission of claims in the interim, or should actual circumstances of the case be different than originally submitted.

### 2.51 PRE-NOTIFICATION

The process the Member must follow in order to notify PEHP of any impending Hospital admission as required by this Master Policy.

### 2.52 PRIMARY CARE PHYSICIAN

A Provider acting within the scope of the Provider's practice limited to the following:

- Family Practice (FP)
- Internal Medicine (IM)
- Pediatrician (MD)
- Obstetrics and Gynecology (OBGYN)
- Gynecologist (GYN)
- Geriatrician (MD)
- Osteopath (DO)

and other Providers performing services for Members for the above Provider types including:

- Registered Nurse (RN)
- Advanced Practical Registered Nurse (APRN)
- Nurse Practitioner (NP)
- Certified Nurse Midwife (CNM)
- Physician's Assistant (PA)

### 2.53 PROVIDER

A licensed practitioner of the healing arts acting within the scope of the Provider's practice, limited to the following: Medical Doctor (MD), Chiropractor (DC), Osteopath (DO), Podiatrist (DPM), Psychologist (PhD), Licensed Clinical Social Worker (LCSW), Psychiatric Nurse Specialist (RN, NS), Doctor of Medical Dentistry (DMD), Dentist (limited) (DDS), Registered Nurse (RN), Advanced Practical Registered Nurse (APRN), Nurse Practitioner (NP), Physician Assistant (PA), Licensed Practical Nurse (LPN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife (CNM), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), Optometrist (limited [OD]), Audiologist, Licensed Professional Counselor (LPC), and Registered Dietician.

### 2.54 RECONSTRUCTIVE SURGERY

Non-Cosmetic Surgery performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, which restores bodily function.

### 2.55 REHABILITATION THERAPY

The treatment of disease or injury by physical agents and methods to assist in the Rehabilitation and restoration of normal physical bodily function, that is goal oriented and where the Member has the potential for functional improvement and ability to progress.

### 2.56 SKILLED NURSING FACILITY

An institution, or distinct part thereof, that is licensed pursuant to state law and is operated primarily for the purpose of providing skilled nursing care for individuals recovering from illness or injury 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.

### 2.57 SPECIALIST

A Provider acting within the scope of the Provider's practice, limited to all other provider types not defined as Primary Care Physicians.

### 2.58 SPECIALTY DRUG

Drugs determined by PEHP and its PBM to be payable only through the Specialty Drug Program based on one or more of the following:

1. Special administration requirements.

2. Special handling requirements.
3. Special clinical support requirements.
4. Product accessibility.
5. High cost of medication.
6. Availability of medication through PEHP's Specialty Drug vendor.
7. Other drugs at PEHP's discretion.

#### 2.59 STAR PLAN
Self-directed Tax Advantage Resource. A HSA-qualified High Deductible Health Plan offered by PEHP.

#### 2.60 SUBROGATION
PEHP's right to recover payments it has made on behalf of a covered Member because of an injury caused by a liable party.

#### 2.61 SUBSCRIBER
An Employer's Employee who has enrolled for Coverage in the Group Insurance Program of Title 49, Chapter 20 of the Utah Code Annotated.

#### 2.62 SURGICAL PROCEDURE OR SURGERY
Cutting, suturing, treating burns, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electrocauterizing, tapping (paracentesis), applying plaster casts, treating pneumothorax, venipunctures, or endoscopy.

#### 2.63 TOTALLY DISABLED
The complete inability, due to medically determinable physical or mental impairment, to engage in any gainful occupation.

#### 2.64 UNBUNDLING
The practice of using numerous procedure codes to identify procedures that normally are covered by a single code. (Also known as "fragmentation," "exploding," or "a la carte" medicine.)

#### 2.65 URGENT CONDITION
An acute health condition with a sudden, unexpected onset, which is not Life-threatening but which poses a danger to the health of the Member if not attended by a physician within 24 hours; e.g., serious lacerations, fractures, dislocations, marked increase in temperature, etc.

#### 2.66 VERBAL PRE-AUTHORIZATION
Prior approval obtained by calling PEHP in advance of treatment as required for some specific services and as documented by PEHP.

## III. Enrollment, Eligibility & Termination

#### 3.1 GENERAL
Employees and their Dependents are eligible for Coverage as set forth herein. All Employees are required to enroll by completing and submitting a PEHP Enrollment form or by completing an electronic Enrollment form through PEHP's online Enrollment portal. All information gathered and the information contained on the Enrollment form is incorporated into this contract. Any Enrollment or Coverage changes must be done in writing, by completing and submitting a PEHP Enrollment form or by completing an electronic Enrollment form through PEHP's online Enrollment portal.

#### 3.2 ELIGIBILITY
The eligibility of Employees and eligible Dependents is determined based on the Employer's personnel policies and the Employee's representations made on their verified individual Enrollment form, which form is a part of this contract. Copies of Member's completed Enrollment forms are available upon request. Members who commit fraud or any other crime against PEHP are not eligible for Coverage.

##### 3.2.1 ENROLLMENT PERIOD
An Employee has 60 days from his/her hire date to enroll for Coverage. Coverage will be effective in accordance with the Employer's personnel policies. If the Employee fails to enroll during this time period, he/she is a late enrollee and must wait until the next annual Enrollment period to enroll and Coverage will become effective on the Employer's annual renewal date.

Newly eligible Dependents may be enrolled within 60 days from the date of birth, or placement in your home, or from the date of marriage. For such Dependents, Coverage will become effective on the date of birth, placement in home, or the date of marriage. If not enrolled during this time period, Dependents are late enrollees and must wait until the next annual Enrollment period to enroll and Coverage will become effective on the Employer's annual renewal date. See Section 3.2.3 for special Enrollment exceptions.

##### 3.2.2 LATE ENROLLEES
An eligible Employee or eligible Dependent who is not enrolled with PEHP at the time of initial eligibility or due to a special Enrollment event, as described in Section 3.2.3, is a late enrollee. A late enrollee is not eligible to enroll until his/her Employer's next annual Enrollment period and is subject to any Pre-existing Condition waiting period specified by the Employer's

health plan(s) and allowed by Federal Law. Any previous period of Creditable Coverage, not separated by a Break-in-Coverage of 63 consecutive days or more, is applied toward satisfying all or part of the Pre-existing Condition waiting period.

#### 3.2.3 SPECIAL ENROLLMENT

Eligible Employees who do not enroll themselves or their eligible Dependents during the initial Enrollment period may enroll in Coverage prior to the next annual Enrollment period if they meet the qualifications for a special Enrollment period. PEHP shall allow special Enrollment in the following circumstances:

**Loss of Other Coverage**

Eligible Employees and/or their eligible Dependents who do not initially enroll in Coverage may enroll at a time other than annual Enrollment only if:

The eligible Employee and/or their eligible Dependents declined to enroll in this Coverage due to the existence of other health plan Coverage; or

Involuntary loss of the other health plan Coverage (special Enrollment will not be allowed if the other Coverage is lost due to the Member's non-Payment of rates or cost-sharing).

The eligible Employee and/or eligible Dependents who lost the other Coverage must enroll in this Coverage within 60 days after the date the other Coverage is lost.

Proof of loss of the other Coverage (Certificate of Creditable Coverage) must be submitted to PEHP at the time of application. Proof of loss of other Coverage or other acceptable documentation, must be submitted before any benefits will be paid on applicable Members. In the absence of a Certificate of Creditable Coverage, PEHP will accept the following:

1. A letter from a prior employer indicating when group coverage began and ended;
2. Any other relevant documents that evidence periods of Coverage; or;
3. A telephone call from the other Insurer to PEHP verifying dates of Coverage.

**Family Status Change**

PEHP shall also allow an Employee and/or Dependents to enroll if the Employee gains an eligible Dependent through marriage, birth, adoption or placement for adoption. At the time the Employee enrolls his/her Dependents, the Employee may also be enrolled. In the case of birth or adoption of a child, the Employee may also enroll the Employee's eligible spouse, even if he/she is not newly eligible as a Dependent. However, special Enrollment is permitted only when the Enrollment takes place within 60 days of the marriage, birth, adoption or placement for adoption. PEHP must receive a copy of the adoption/placement papers before a Dependent who has been adopted or placed for adoption can be enrolled in Coverage.

If a divorce decree is set aside by a court of competent jurisdiction, PEHP shall treat the Dependent(s) as eligible for re-Enrollment on the date the decree was set aside. Dependent(s) shall not be eligible during the time the divorce decree was in effect.

#### 3.2.4 LEGAL GUARDIANSHIP

Dependent children who are under age 19 and who are placed under the legal guardianship (through testamentary appointment or court order) of the Subscriber or the Subscriber's lawful spouse are eligible to be enrolled for Coverage. The Subscriber must enroll any such children within 60 days of receiving legal guardianship.

#### 3.2.5 TRANSFER OF COVERAGE

Should Coverage be transferred from one PEHP plan to another, or should Coverage terminate and at a later date be reinstated, plan provisions for limited benefits, yearly maximum benefits, and Lifetime Limits will be maintained and be continuous from the point of transfer or termination.

#### 3.2.6 CERTIFICATIONS AND DISCLOSURE OF COVERAGE

At the time of Enrollment, the Employee must provide to PEHP a Certification and Disclosure of Coverage, or other acceptable documentation of Creditable Coverage. If no Certification or other documentation of Creditable Coverage is provided, the Pre-existing Condition waiting period will automatically be applied. PEHP shall provide a Certificate of Creditable Coverage in the following circumstances:

1. When a Member loses active group Coverage with PEHP;
2. When a Member loses COBRA Coverage; or
3. When a Member requests a Certificate of Creditable Coverage from PEHP within 24 months of the date of termination of Coverage.

### 3.3 COVERAGE WHILE ON LEAVE

#### 3.3.1 LEAVE OF ABSENCE

Except as allowed under federal law, when a Subscriber is on temporary leave of absence approved by the Employer, Coverage may be maintained for maximum period of six months. Coverage may continue for an unpaid leave of absence beyond six months only in limited situations (e.g. extended

investigation) and must be specifically requested by the Employer and approved by PEHP. PEHP shall approve continued coverage only for good cause as to why the employment relationship has continued. In order to continue Coverage, the Subscriber must remit the Payment for Coverage directly to PEHP. Upon Employer notification that the Subscriber is on leave, PEHP will establish a billing cycle for the Subscriber to remit payment directly to PEHP.

Should a Subscriber be granted an unpaid leave of absence and neglect to remit the Payment within 30 days, Coverage will be canceled retroactively to the end of the day through which Payment has been made.

**Military Leave**
Members called to active duty in the military are excluded from Coverage under this Master Policy, unless proper application for continuation of Coverage is made pursuant to the Uniformed Services Employment and Re-employment Act of 1994.

Subscribers may elect to continue Coverage for Dependents that were covered under the plan at the time of the Subscriber's call to active duty at the group rate. The Subscriber is responsible to ensure that the Subscriber's share of Payment for Coverage is made in a timely manner to PEHP. If Payment is not received by the date it is due or during the allowed grace period, Coverage will be cancelled. The Employer must continue paying the Employer share of the group rate.

If the Subscriber elects not to continue Coverage for themselves in whole or for their Dependents, Coverage may be reinstated within 90 days of discharge.

**Family and Medical Leave Act of 1993 (FMLA)**
The Employer shall maintain Coverage during periods of Leave approved pursuant to the Family and Medical Leave Act of 1993. The Subscriber is responsible to ensure that Subscriber's share of Payment for Coverage is made in a timely manner to PEHP. If Payment is not received by the date it is due or during the allowed grace period, Coverage will be cancelled. The Employer must continue paying the Employer share of the group rate. If the Subscriber elects not to continue Coverage for themselves in whole or for their Dependents, Coverage may be reinstated within 60 days of returning to work.

**Personal Leave (Leave without Pay)**
Members who have exhausted their annual FMLA allowance, sick and annual time, may continue PEHP coverage during their leave of absence by paying the full cost of Coverage. Upon Employer notification that the Subscriber is on personal leave, PEHP will establish a billing cycle for the Subscriber to remit 100% of the group rate directly to PEHP.

Should a Subscriber be granted an unpaid leave of absence and neglect to remit the Payment within 30 days, Coverage will be cancelled retroactively to the end of the day through which Payment has been made. Medical re-enrollment will be limited to the Employer group's next annual enrollment following return to work.

### 3.4 TERMINATION OF COVERAGE

Coverage for a Member will terminate if the Member ceases to be eligible for the following reasons:

1. Termination of employment – Coverage is terminated according to the Employer's internal policies.
2. Dependent child turns age 26 – Coverage will terminate at the end of the day prior to the 26th birthday.
3. Divorce – Coverage will terminate for ex-spouses and stepchildren at the end of the day prior to the date on the court-signed divorce decree.
4. Death of Subscriber – Coverage will terminate at the end of last day of work, the end of the last day of Employer's payroll period or the end of the last day of the month, according to the Employer's internal policies.
5. Failure to make timely premiums to PEHP – Coverage will terminate at the end of the day through which previous premium has been received by PEHP.
6. Employer group terminates PEHP group coverage.

The Subscriber may not terminate coverage for Dependents anytime during the year unless one of the following conditions are met:

a. Dependent enrolls in other group coverage;
b. Commencement or termination of employment of Dependent;
c. A change from part-time to full-time status (or vice versa) by the Subscriber or the Dependent, only if the change results in loss of coverage;

   or

d. A significant change in the health Coverage of the Subscriber, Subscriber's spouse or Dependent attributable to their employment.

It is the Subscriber's responsibility to make written notification when a Dependent is no longer eligible for Coverage. PEHP will not refund Payments made for ineligible Dependents. The Subscriber will be held responsible to reimburse PEHP for the claims processed beyond eligible service dates.

Pursuant to Section 76-6-521 of the Utah Code Annotated, anyone who fails to notify PEHP of Dependents ineligibility for Coverage is committing insurance fraud, a Class B Misdemeanor, punishable by fines or imprisonment.

PEHP shall have the right to deny claims, terminate any or all Coverages of a Member and seek reimbursement of claims paid upon the determination by PEHP that the Member has committed any of the following:

1. Fraud upon PEHP or Utah Retirement Systems;
2. Forgery or alteration of prescriptions;
3. Criminal acts associated with Coverage;
4. Misuse or abuse of benefits; or
5. Breached the conditions of this Master Policy.

#### 3.4.1 LIABILITY FOR SERVICES AFTER TERMINATION

All care, services, treatments, drugs, medications, supplies, or equipment obtained after the date of termination are the responsibility of the Member or the subsequent carrier or other Provider of Coverage, and not the responsibility of PEHP, no matter when the condition arose and despite care or treatment anticipated or already in progress.

### 3.5 EXTENSION OF BENEFITS

#### 3.5.1 COBRA COVERAGE

PEHP shall provide COBRA Coverage to Members originally enrolled through an Employer group who become entitled to such Coverage by operation of law. To be eligible for such Coverage a Member must strictly comply with all applicable deadlines and notice requirements in accordance with Section 1.15. COBRA Coverage will only be provided during the term of this Master Policy, and unless otherwise expressly stated in the Master Policy, and only for the minimum time and only to the minimum extent required by applicable state and federal law. COBRA Coverage will run concurrently with any other extension of Coverage, such as early retirement Coverage.

It is the responsibility of the covered Employee, spouse, or Dependent child to notify the Employer or PEHP in writing within 60 days of a divorce, legal separation, child losing Dependent status or secondary qualifying event, under the group health plan in order to be eligible for COBRA Coverage. Notice should be sent to:

**PEHP**
**560 East 200 South**
**Salt Lake City, Utah, 84102**

Appropriate documentation must be provided as determined by PEHP. When PEHP is notified of a Qualifying Event, PEHP in turn will notify the Member that they have 60 days from either termination of Coverage or the date of COBRA election notice to elect COBRA. If no election is made within 60 days, COBRA rights are deemed waived and will not be offered again.

**Premium Payments**

Payments must be made by the Member retroactively to the date of the qualifying event and paid within 45 days of the date of election of COBRA Coverage. There is no grace period on this initial premium. Subsequent Payments are due on the first of each month with a 30-day grace period. Delinquent Payments will result in a termination of Coverage. PEHP will collect on claims paid in error because of ineligibility for COBRA Coverage. Ineligible rates paid by the Member for COBRA Coverage will be refunded.

#### 3.5.2 UTAH MINI-COBRA

Under state law, health Coverage may be extended to Members, if Coverage is provided by an Employer group with fewer than 20 Employees and the Member has been continuously covered by PEHP for at least three months immediately prior to the date of termination. A right to continue coverage through Utah Mini-COBRA will occur if a Member experiences:

a. Voluntary or involuntary termination;
b. Retirement;
c. Death;
d. Divorce or legal separation;
e. Loss of dependent status;
f. Sabbatical;
g. A disability;
h. Leave of absence;
i. Reduction of hours.

The Coverage shall be extended for a period of 12 months from the date of termination, unless employment was terminated due to gross misconduct of the Subscriber, or the Member is eligible for any extension of Coverage required by federal law. The cost for Utah Mini-COBRA may not exceed 102% of the group rate in effect for a group Member, and is paid entirely by the Member electing Mini-COBRA Coverage.

Utah Mini-COBRA Coverage will terminate on the earliest of:

1. The date 12 months after the Utah Mini-COBRA

Coverage begins;

2. The date the Member fails to make timely Payments;
3. The date the Member violates a material term of the contract;
4. The date the Member becomes covered under another group health plan (whether or not as an Employee);
5. The date the Member becomes entitled to Medicare;
6. The date the Employer Coverage is terminated;
7. The date the Member performs an act or practice that constitutes fraud in connection with the coverage; or
8. The date the Member makes an intentional misrepresentation of material fact under the terms of the Master Policy.

The Utah Mini-COBRA Coverage will be administered in accordance with Utah State Law (Utah Code Annotated § 31A-22-722).

#### 3.5.3 DISABILITY WAIVER

To the extent allowed under State Law, Subscribers who are approved for long-term disability benefits under either the Public Employees Long-Term Disability Program under Utah Code Annotated Title 49, Chapter 21, or from another Employer-sponsored long-term disability program substantially similar to the Public Employees Long-Term Disability Program, are eligible to continue Coverage with PEHP until the earlier of:

1. The Subscriber no longer receiving long-term disability benefits;
2. The Subscriber's failure to make the required Payment to PEHP each month as set forth below;
3. Group cancellation of medical Coverage with PEHP;
4. The Subscriber or Subscriber's spouse reaching the first of the month in which the Subscriber or Subscriber's spouse attains the age of 65; or
5. The Subscriber or Subscriber's spouse turning 65 will be eligible to continue with a PEHP-sponsored Medicare Supplement plan.

The Subscriber or the Subscriber's spouse who is younger than 65, or any other Dependents covered on the plan younger than 65, will remain eligible for PEHP Coverage until they meet one of the other criteria listed above or no longer meet Dependent eligibility criteria.

The Payment for each disabled Subscriber who qualifies for PEHP Coverage shall be 102% of the regular active Employee Payment. Each disabled Subscriber must pay all or a portion of the monthly PEHP Payment to remain eligible for PEHP benefits as set forth below. The remainder of the monthly Payment, if any, shall be waived by PEHP. The disabled Subscriber shall pay 10% of the monthly PEHP Payment for the first year of eligibility beginning the day after the last day of actual work or last day on Family Medical Leave, 20% for the second year of disability, and 30% thereafter. The monthly PEHP Payment shall be set by PEHP. Notwithstanding the above percentages, if the disabled Subscriber is more than 30 days in arrears on paying money owed to the Public Employees Long-Term Disability Program, the disabled Subscriber shall pay the full monthly Payment to PEHP.

#### 3.5.4 EARLY RETIREMENT

Subscribers who retire prior to age 65 may continue Coverage with PEHP until they reach age 65 provided that their Employer has adopted an early retiree program in the Employer contract with PEHP and all Payment for Coverage is made as set forth in the Employer's contract with PEHP. If Payment is not received by PEHP, Coverage will terminate at the end of the day through which previous Payment has been received by PEHP. Early retiree Coverage runs concurrently with COBRA.

### 3.6 COORDINATION OF BENEFITS

#### 3.6.1 COORDINATION OF BENEFITS WITH OTHER CARRIERS

The Coordination of Benefits provision applies when a Subscriber or the Subscriber's covered eligible Dependents have health care Coverage under more than one health benefit plan, except those specifically excluded in Section 3.6.6. Coordination of Benefits will be administered in accordance with Utah Insurance Code rules. When a Subscriber or Subscriber's covered Eligible Dependents have health Coverage under more than one benefit plan, one plan shall pay benefits as the primary plan and the other plan shall pay benefits as the secondary plan.

The Subscriber must inform PEHP of other medical Coverage in force by completing a Duplicate Coverage Inquiry Form. If applicable, the Subscriber will be required to submit court orders or decrees. Subscribers must also keep PEHP informed of any changes in the status of other Coverage.

#### 3.6.2 ORDER OF BENEFIT DETERMINATION

PEHP determines the order of benefits using the first of the following rules that applies:

1. The benefits of the plan that covers the person as an Employee, or Subscriber, are determined before those of the plan that covers the person as a Dependent.
2. *Dependent Child—Parents not Separated or Divorced*

   The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are as follows:

   a. The benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in the year. (The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.)

   b. If both parents have the same birthday, benefits of the plan that covered the parent longer are determined before the shorter Coverage.

3. *Dependent Child— Parents Separated or Divorced*

   If two or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

   a. First, the plan of the parent who is ordered by divorce decree to maintain Coverage. If neither or both parents are ordered, the plan of the Subscriber whose birthday falls earlier in the calendar year;

   b. Then, the plan of the spouse of the parent who is ordered by divorce decree to maintain Coverage. If neither or both parents are ordered, the plan of the Subscriber whose birthday falls second among Subscribers in the calendar year;

   c. Then the plan of the parent who is not ordered by divorce decree to maintain coverage. If neither or both parents are ordered, the plan of the Subscriber whose birthday falls third among Subscriber in the calendar year;

   d. Finally, the plan of the spouse of the parent who is not ordered by divorce decree to maintain Coverage. If neither or both parents are ordered, the plan of the Subscriber whose birthday falls last among Subscribers in the calendar year.

After the Dependent turns 18, the plan of the parent with whom the Dependent resides shall be the primary payer. If the Dependent does not reside with either parent, all Subscriber's birthdates will be considered. Please refer to 3.6.2.3 a-d above. A copy of the divorce decree may be requested for file documentation.

There are many circumstances that affect order of benefit determination. Please contact PEHP Customer Service for further clarification.

### 3.6.3 COORDINATION OF BENEFITS RULES

When PEHP is the primary plan, its Eligible Benefits are paid before those of the other health benefit plan and without considering the other health plan's benefits. When PEHP is the secondary plan, its Eligible Benefits are determined after those of the other health benefit plan and may be reduced to prevent duplication of benefits.

When secondary, PEHP calculates the amount of Eligible Benefits it would normally pay in the absence of the primary plan coverage, including Deductible, Copayments, coinsurance, and the application of credits to any policy maximums. PEHP then determines the amount the Member is responsible to pay after the primary carrier has applied its allowed contracted amount. PEHP will then pay the amount of the Member's responsibility after the primary plan has paid, up to the maximum amount it would have paid as the primary carrier. In no event will PEHP pay more than the Member is responsible to pay after the primary carrier has paid the claim.

Medical and pharmacy claims will be subject to all plan provisions as described in this Master Policy, including, but not limited to, Pre-authorization/Pre-notification requirements, benefit Limitation, step therapy requirements, quantity level rules, etc., regardless of whether PEHP is the primary or secondary payer.

Coverage under this Master Policy is primary only when required to be primary by law or by this Master Policy. If the other health benefit plan does not have rules for Coordination of Benefits, then Coverage under the other plan will be primary to Coverage under this Master Policy.

When a payment between PEHP and a Provider/facility has been coordinated incorrectly, PEHP will make proper payment adjustment if the request is submitted to PEHP within 12 months from the date of adjudication.

### 3.6.4 DUAL COVERAGE

When a Dependent enrolls on a second PEHP plan creating "dual Coverage" (a combination of two or more PEHP plans) eligible Benefits will be adjudicated in the same order as any other Coordination of Benefits.

For plans with limited benefits, the plan covering the patient as primary will pay up to the plan allowance. The secondary plan will pay Eligible balances not to exceed Allowed Amount. Dual Coverage does not extend or increase limits above what is allowed on the primary plan, unless the benefits on the secondary plan exceeds the primary plan's limits and then only up to

the secondary plan's maximum. Limits are not doubled under Dual Coverage.

#### 3.6.5 CORRECTION OF PAYMENT IN ERROR

PEHP shall have the right to pay to any organization making payments under other plans that should have been made under this Master Policy, any amount necessary to satisfy the payment of claims under this Master Policy. Amounts so paid by PEHP shall be considered benefits paid under this Master Policy, and PEHP shall be fully discharged from liability under this Master Policy to the extent of such payments. Corrections will be made a maximum of 24 months from date of service except in the cases of Medicaid, Medicare, or when ordered by a hearing officer or court of competent jurisdiction.

#### 3.6.6 NO COORDINATION OF BENEFITS WITH OTHER TYPES OF PLANS

PEHP does not coordinate with school plans, sports plans, Accident only Coverage, specified disease Coverage, nursing home or long term care plans, disability income protection Coverage, or Veterans Administration plans.

#### 3.6.7 COORDINATION OF BENEFITS WITH MEDICARE

PEHP's Coordination of Benefits with Medicare and its status as primary or secondary payer shall be determined in accordance with applicable Medicare laws and regulations. Benefits shall be considered payable by Medicare for purposes of this provision whether or not the individual eligible for Medicare benefits has enrolled in or applied for Medicare Parts A and B, or has failed to take any other action required by Medicare to qualify for benefits, or would have received benefits payable by Medicare as if the individual received services in a facility to which Medicare would have paid benefits.

When PEHP is secondary to Medicare, benefits otherwise payable under PEHP shall be reduced so that the sum of benefits payable under PEHP and Medicare shall not exceed the total allowable expenses of the primary plan.

## IV. General Provisions

### 4.1 MASTER POLICY

This Master Policy, with a complete description of benefits, is maintained by PEHP solely for use by its Members. PEHP does not authorize any other use of this Master Policy.

This Master Policy and the applicable Benefits Summary for your Employer group's Eligible Benefits are intended to work in conjunction with one another. If there is any conflict regarding Eligible Benefits, the Benefits Summary supersedes the Master Policy.

### 4.2 AUTHORIZATION TO OBTAIN/RETAIN/SHARE INFORMATION

By enrolling with PEHP and accepting or receiving services and/or benefits through PEHP, all Members agree that PEHP and healthcare Providers are authorized to obtain, retain and share information (including but not limited to sensitive medical information contained in Medical Records) necessary or reasonably believed to be necessary to properly diagnose and treat Members, in order to process and evaluate claims for services rendered. PEHP will maintain the confidentiality of such information in its possession as regulated by 45 CFR 160 and 164 as amended, Utah Code Annotated § 49-11-618 and applicable Utah State Retirement Board resolution(s).

Upon receiving appropriate documentation, PEHP may provide a custodial parent information regarding claims payment and benefit information for the covered Dependent.

## V. Conditions of Service

### 5.1 EXCESS PAYMENT OR MISTAKEN PAYMENTS

PEHP will have the right at any time to recover any payment made in excess of PEHP's obligations under this Master Policy or Benefits Summary, whether such payment was made in error or otherwise. Such right will apply to payments made to Members, Providers or Facilities. If an excess payment is made by PEHP, the Member agrees to promptly refund the amount of the excess. PEHP may, at its sole discretion, offset any future payment against any excess or mistaken payment already made to a Member or for a Member to a Provider or Facility. The making of a payment in error or under a mistaken understanding of the relevant facts is not recognition by PEHP that the service in question is covered under this Master Policy. If a claim incurred due to false pretenses, whether intentional or not, false representation, or actual fraud is discovered, PEHP may deny or seek reimbursement for payment, including associated costs and legal fees made in association with such claim.

### 5.2 MEDICAL CASE MANAGEMENT

Medical Case Management is designed to enhance the value of medical care in cases of complex medical conditions or injudicious use of medical benefits. Under Medical Case Management, a nurse case manager

will work with the Member, the Member's family, Providers, outside consultants and others to coordinate a comprehensive, medically appropriate treatment plan.

Failure to abide by the treatment plan may result in a reduction or denial of benefits. Claims will be paid according to CPT, RBRVS, global fee, and industry standards and guidelines.

PEHP, at its own discretion, may require a Member to obtain Pre-authorization for any and all benefits in coordination with Medical Case Management, if PEHP has determined such action is warranted by the Member's claims history.

## VI. Covered Benefits

The information contained herein applies only to proven and currently available services as of the start of the Member's plan year.

### 6.1 CONTRACTED PROVIDERS

PEHP offers quality medical care in the state of Utah through Contracted Providers. For emergencies and some limited benefits outside the state of Utah, PEHP has Contracted with a network administrator to secure discounts with Provider networks.

It is the Member's responsibility to use Contracted Providers. Failure to use Contracted Providers may result in a reduction or denial of benefits. PEHP will make available a current list of Contracted Providers at www.pehp.org or by contacting PEHP. PEHP reserves the right to make changes to the Provider list at any time during a plan year without notice.

In general, the Member is responsible to pay the specified Copayment(s) at the time of service and the balance will be paid by PEHP according to plan benefits.

The Member's PEHP Identification card must be presented at each visit.

The Provider will have a release form that authorizes PEHP to obtain necessary information. This form must be signed by the Member.

### 6.2 OUT-OF-STATE/OUT-OF-NETWORK/ OUT-OF-COUNTRY COVERAGE

Medical Services received from non-Contracted Providers will not be paid by PEHP, except under the following circumstances:

1. If a Member receives medical services to treat a Life-threatening condition from a non-Contracted Provider outside of Utah, the services will be allowed by PEHP at the Allowed Amount by State average as determined by the National Access Program for the state in which the services are being performed, or negotiated fees and paid by PEHP at the amount specified for Contracted Providers by the Member's applicable Benefits Summary.

   If a Member receives medical services to treat a Life-threatening condition from a non-Contracted Provider in Utah, the services will be allowed up to the Allowed Amount and paid by PEHP at the amount specified for Contracted Providers by the Member's applicable Benefits Summary.

   In the case of in-patient hospitalization in a non-Contracted medical facility, the Member will be transferred to a Contracted medical facility as soon as medically possible, in coordination with PEHP's Medical Case Management.

2. Medical services received by a Member from a non-Contracted provider outside of Utah to treat an Urgent Condition will be allowed up to the Allowed Amount and paid by PEHP at the amount specified for non-Contracted Providers by the Member's applicable Benefits Summary, if the Member's plan allows the use of Non-Contracted Providers. If the Member's plan does not allow the use of Non-Contracted Providers, the services will be paid by PEHP at 50% of the Allowed Amount.

   Medical services received by a Member from a non-Contracted provider in Utah to treat an Urgent Condition will be allowed up to the Allowed Amount and paid by PEHP at the amount specified for non-Contracted Providers by the Member's applicable Benefits Summary, if the Member's plan allows the use of Non-Contracted Providers. If the Member's plan does not allow the use of Non-Contracted Providers, the services will be denied by PEHP.

3. Medical services not available in Utah and performed by non-Contracted out-of state Providers will be allowed by PEHP at the Allowed Amount by State average as determined by the National Access Program for the state in which the services are being performed or negotiated fees, only if PEHP pre-authorizes Coverage for Medical Services in writing prior to the medical services being received. Whether Eligible Benefits are available in Utah is solely determined by PEHP; or

   Medical services received by a Member outside of the United States will be allowed by PEHP at billed charges or negotiated fees if the member provides PEHP with a copy of the original foreign claim and

provides PEHP with acceptable documentation of the claim. PEHP will translate the claim into English and convert the charges to United States Currency.

## 6.3 HOSPITAL BENEFITS

See your specific Benefits Summary for applicable Copayment amounts.

### 6.3.1 INPATIENT HOSPITALIZATION

Charges for eligible Medically Necessary inpatient Hospitalization are payable after applicable Copayment. Hospital admissions require Pre-notification. See Section 7.1.

When a Hospital stay spans an old and new plan year, charges billed on the hospital claim will be based on the old plan year provisions. Eligible ancillary services such as Inpatient Physician visits, diagnostic tests, laboratory tests, etc. performed during the hospital stay but billed separately from the hospital will apply to the benefits in effect under the plan year on the actual date of service billed. When Coverage terminates during a hospital stay, it will be necessary to convert to a COBRA policy to continue Coverage for the completion of the stay beyond the termination date.

For out-of-state Coverage for inpatient Hospital admissions, see Section 6.2.

### 6.3.2 OUTPATIENT FACILITY BENEFITS

Charges for eligible Medically Necessary Surgical Procedures performed in an Ambulatory Surgical Facility, whether free-standing or Hospital based, are payable after applicable Copayment. For out-of-area Coverage for outpatient facility admission, see Section 6.2.

### 6.3.3 EMERGENCY ROOM SERVICES

Eligible Medically Necessary emergency room facility services are payable after applicable Copayment. Each follow up visit in the emergency room is payable as a separate benefit and will require an additional emergency room Copayment. When emergency room treatment results in an inpatient admission (within 24 hours), or an outpatient hospital service, benefits are payable as an inpatient or outpatient stay.

### 6.3.4 URGENT CARE FACILITY

Eligible Medically Necessary Urgent care facility services are payable, after applicable Copayment.

### 6.3.5 LIMITATIONS RELATING TO ALL INPATIENT AND OUTPATIENT HOSPITAL/FACILITY AND EMERGENCY ROOM SERVICES

The following are Limitations of the policy:

1. Charges for ambulance services, physician's Hospital or emergency room visits, specialty medications, and Durable Medical Equipment billed on the Hospital bill are payable separately, subject to applicable plan provisions and specified Copayments.
2. Newborn nursery room charges are separate from the mother's claim and the child must be enrolled to be eligible.
3. When an eligible Surgical Procedure is performed in conjunction with other ineligible Surgery, benefits will be prorated and only Eligible Benefits will be payable per Allowed Amount. All procedures must be disclosed for proper adjudication.
4. When an inpatient Hospital stay can be shortened or charges reduced by transfer to a transitional care unit or Skilled Nursing Facility, PEHP may require the patient to be transferred for Coverage to continue. This benefit is only available through concurrent Medical Case Management and approval by PEHP.
5. Hospital treatment for the following conditions or procedures, including Complications, are payable at 50% of Allowed Amount:
   a. Breast reduction;
   b. Eligible tests and treatment for infertility;
   c. Blepharoplasty (or other eyelid Surgery);
   d. All facility claims related to a Hospital stay when the Member is discharged against medical advice;
   e. Sclerotherapy of varicose veins except for spider and reticular veins;
   f. Microphlebectomy (stab phlebectomy); and
   g. Eligible expenses related to Spinal Cord Stimulators. Requires written Pre-authorization through Medical Case Management.
6. Inpatient benefits for Mental Health and/or substance abuse require Pre-authorization. See Section 6.8 for more information about Mental Health and substance abuse benefits.
7. Only acute Emergency Care for Life-threatening injury or illness is covered in conjunction with attempted suicide or anorexia/bulimia. Other services require Pre-authorization through the inpatient Mental Health benefits.
8. If the Member is six years of age or older, and is at high risk due to medical diagnoses which make it necessary to have a dental procedure performed in an outpatient surgical facility, benefits may be

payable with Pre-authorization.

9. Human Pasteurized Milk is a covered benefit for Newborn ICU babies whose mother's milk supply is inadequate, and in cases of extreme immaturity. Requires Pre-authorization.

### 6.3.6 EXCLUSIONS FROM COVERAGE RELATING TO ALL INPATIENT AND OUTPATIENT HOSPITAL/FACILITY AND EMERGENCY ROOM SERVICES

The following are Exclusions of the policy:

1. Ineligible Surgical Procedures or related Complications.
2. Treatment programs for enuresis or encopresis for Members age 18 and over.
3. Services or items primarily for convenience, contentment, or other non-therapeutic purpose, such as: guest trays, cots, telephone calls, shampoo, toothbrush, or other personal items.
4. Occupational therapy for activities of daily living, academic learning, vocational or life skills, developmental delay.
5. Care, confinement or services in a nursing home, rest home or a transitional living facility, community reintegration program, vocational rehabilitation, services to re-train self care, or activities of daily living.
6. Recreational therapy.
7. Autologous (self) blood storage for future use.
8. Organ or tissue donor charges, except when the recipient is an eligible Member covered under a PEHP plan, and the transplant is eligible.
9. Nutritional analysis or counseling, except in conjunction with diabetes education, anorexia, bulimia, or as covered under the Affordable Care Act (Preventive Services under Section 6.14).
10. Custodial Care and/or maintenance therapy.
11. Take-home medications.
12. Additional fees charged for a robotic surgical system used during surgery.
13. Mastectomy for gynecomastia.

## 6.4 SURGICAL BENEFITS

See applicable Benefits Summary for specific Copayment amounts.

Medically Necessary Surgical Procedures are payable, after applicable Copayment when performed in a physician's office, in a Hospital, or in a freestanding Ambulatory Surgical Facility.

PEHP pays for an assistant surgeon when Medically Necessary. Services of a co-surgeon, when required and in the absence of an assistant surgeon, are payable up to the combined total amount eligible per Allowed Amount for the surgeon and an assistant's fee, divided equally. Charges for an assistant surgeon (MD) are allowable up to 20% of Allowed Amount. Charges for a certified assistant surgical nurse, or physician's assistant at Surgery in lieu of an assistant surgeon (MD) are allowable up to 10% of Allowed Amount.

PEHP pays a Global Fee for maternity charges for normal delivery, C-section, and Complications. With exception of the pre-natal lab charge and RhoGam injection, Global Fee benefits are payable at time of delivery. If the Member changes physicians during pregnancy or changes Coverage prior to delivery, benefits will be paid for services rendered according to the applicable procedure code as described in the AMA CPT manual. Applicable Copayments will apply for the specific service(s) rendered. If Coverage under PEHP terminates during a pregnancy and Member wishes Coverage for delivery, continued Coverage through COBRA must be purchased to receive those benefits.

### 6.4.1 SECOND OPINION AND SURGICAL REVIEW

A second opinion evaluation for Surgery is payable (office consultation only). Available Medical Records, including x-rays, should be forwarded to the Provider for the second opinion evaluation.

### 6.4.2 LIMITATIONS RELATING TO SURGERY

The following are Limitations of the policy:

1. Multiple Surgical Procedures during the same operative session are allowable at 100% of Allowed Amount for the primary procedure and 50% of Allowed Amount for all additional eligible procedures. Incidental procedures are excluded.
2. Surgical benefits are payable based on surgical Package Fees to include the Surgery and post-operative care per CPT guidelines and RBRVS guidelines.
3. Eligible Surgical Procedures for the treatment of infertility are payable according to plan specifications. (See applicable Benefits Summary for details.)
4. When an eligible Surgical Procedure is performed in conjunction with other ineligible Surgery, benefits will be prorated per Allowed Amount and CPT guidelines for primary and secondary procedures. Only Eligible Benefits will be payable. Provider's Pre-authorization must disclose all proposed

procedures and implantable Devices to allow for accurate adjudication.

5. The following surgeries, when Medically Necessary, are payable at 50% of Allowed Amount:
    a. Breast Reduction;
    b. Blepharoplasty (or other eyelid Surgery);
    c. Eligible infertility surgery;
    d. Sclerotherapy of varicose veins except for spider and reticular veins;
    e. Microphlebectomy (stab phlebectomy); and
    f. Eligible expenses related to Spinal Cord Stimulators. Requires written Pre-authorization through Medical Case Management.
6. Breast Reconstructive Surgery is an Eligible Benefit as allowed under WHCRA. Requires written Pre-authorization through Medical Case Management.
7. Maxillary/Mandibular bone or Calcitite augmentation Surgery is covered when a Member is edentulous (absence of all teeth) and the general health of the Member is at risk because of malnutrition or possible bone fracture. If the Member elects a more elaborate or precision procedure, PEHP may allow payment for the standard Calcitite placement towards the cost and the Member will be responsible for the difference. Quadrant or individual tooth areas or osseous implants are not eligible.
8. Maternity and related medical services for surrogate mothers shall only be Covered by PEHP if the surrogate mother meets the requirements of Utah law and provides PEHP a copy of the surrogate agreement. Pursuant to Section 7.5 of this Master Policy, PEHP maintains the right to subrogate against or the member shall contractually reimburse PEHP for any payment or amounts received by the surrogate mother due to the pregnancy.

### 6.4.3 EXCLUSIONS FROM COVERAGE RELATING TO SURGERY

The following are Exclusions of the policy:

1. Breast Reconstructive Surgery, augmentation or implants solely for Cosmetic purposes.
2. Capsulotomy, replacement, removal or repair of breast implant originally placed for Cosmetic purposes or any other Complication(s) of Cosmetic or non-covered breast Surgery.
3. Obesity Surgery such as Lap Band, gastric bypass, stomach stapling, gastric balloons, etc., including any present or future Complications.
4. Any service or Surgery that is solely for Cosmetic purposes to improve or change appearance or to correct a deformity without restoring a physical bodily function, with the following exceptions:
    a. Breast Reconstructive Surgery as allowed under WHCRA for Cosmetic purposes: and
    b. Reconstructive Surgery made necessary by an Accidental injury in the preceding five years.
5. Rhinoplasty for Cosmetic reasons is excluded except when related to an Accidental injury occurring in the preceding five years.
6. Assisted reproductive technologies: invitro fertilization; gamete intra fallopian tube transfer; embryo transfer; zygote intra fallopian transfer; pre-embryo cryopreservation techniques; and/or any conception that occurs outside the woman's body. Any related services performed in conjunction with these procedures are also excluded.
7. Surgical treatment for correction of refractive errors.
8. Expenses incurred for Surgery, pre-operative testing, treatment, or Complications by an organ or tissue donor, where the recipient is not an eligible Member, covered by PEHP, or when the transplant for the PEHP Member is not eligible.
9. Reversal of sterilization.
10. Gender reassignment Surgery.
11. Rhytidectomy.
12. Surgery that is dental in origin, including care and treatment of the teeth, gums, or alveolar process, extraction of teeth; dental implants and crowns or pontics over implants, re-implantation or splinting, endodontia, periodontia, and orthodontia, including anesthesia or supplies used in such care.
13. Complications as a result of non-covered or ineligible Surgery.
14. Injection of collagen, except as approved for urological procedures.
15. Lipectomy, abdominoplasty, panniculectomy, unless any of these procedures are medically necessary to treat an unintended adverse event of an eligible surgery.
16. Repair of diastasis recti.
17. Sperm banking system, storage, treatment, or other such services.
18. Non-FDA Approved or Experimental or Investigational procedures, drugs and Devices.
19. Hair transplants or other treatment for hair loss or

restoration.

20. Chemical peels.
21. Treatment for spider or reticular veins.
22. Liposuction.
23. Orthodontic treatment or expansion appliance in conjunction with jaw Surgery.
24. Chin implant, genioplasty or horizontal symphyseal osteotomy.
25. Unbundling or fragmentation of surgical codes.
26. Any Surgery solely for snoring.
27. Otoplasty.
28. Abortions, except if the pregnancy is the result of rape or incest, or if necessary to save the life of the mother.
29. Surgical treatment for sexual dysfunction.
30. Subtalar implants.
31. Additional fees charged because a robotic surgical system was used during surgery.
32. Mastectomy for gynecomastia.
33. Elective home delivery for childbirth.

### 6.5 ANESTHESIA BENEFITS

See applicable Benefits Summary for specific Copayment amounts.

The charges for Medically Necessary anesthesia administered by a Provider (MD or CRNA) in conjunction with Medically Necessary Surgery are payable, after applicable Copayment.

#### 6.5.1 LIMITATIONS RELATING TO ANESTHESIA

The following are Limitations of the policy:

1. Anesthesia must be administered by a qualified licensed practitioner other than the primary surgeon. Exceptions:
   a. A Provider in a rural area, when an anesthesiologist is not available, may administer anesthesia and will be paid up to 20% of the eligible Surgery fee.
   b. Anesthesia performed by an oral surgeon in conjunction with an eligible medical Surgical Procedure.
2. Anesthesia in conjunction with a Surgery that is payable at 50%, will also be payable at 50% of Allowed Amount.
3. When an eligible Surgical Procedure is performed in conjunction with other ineligible Surgery, anesthesia benefits will be prorated and only Eligible Benefits will be payable per Allowed Amount. All procedures must be disclosed for proper adjudication.
4. Anesthesia for labor and delivery is payable on a sliding scale with one base rate (first hour— full time, second hour—half time, quarter time for every hour thereafter).
5. An epidural block during labor is not payable to the delivering Provider in addition to an anesthesiologist fee.
6. If the Member is six years of age or older, and is at high risk due to medical diagnoses which make it necessary to have a dental procedure performed under general anesthesia, benefits may be payable with Pre-authorization.
7. Eligible expenses related to Spinal Cord Stimulators are payable at 50% of Allowed Amount. Requires written Pre-authorization through Medical Case Management.
8. Moderate sedation (conscious sedation) is included in standard colonoscopy and EGD surgery and shall not be reimbursed separately.
9. Manipulation under anesthesia for knees and shoulders requires written Pre-authorization through Medical Case Management.

#### 6.5.2 EXCLUSIONS FROM COVERAGE RELATING TO ANESTHESIA

The following are Exclusions of the policy:

1. Anesthesia in conjunction with ineligible Surgery.
2. Anesthesia administered by the primary surgeon.
3. Monitored anesthesia care or on-call time for consultant.
4. Additional charges for supplies, drugs, equipment, etc.
5. Manipulation under anesthesia for any body part other than knees or shoulders.

## 6.6 MEDICAL VISIT BENEFITS

See applicable Benefits Summary for specific Copayment amounts.

Medically Necessary medical visits, including visits in the Provider's office, urgent care facility, emergency room, Hospital, or the Member's home, are payable, after applicable Copayments. PEHP pays for other outpatient or office services such as: chemotherapy, office Surgery, labs and x-rays, blood "factor" replacement, etc., after applicable Copayments.

### 6.6.1 LIMITATIONS RELATING TO MEDICAL VISITS

The following are Limitations of the policy:

1. Physical therapy visits and outpatient occupational therapy for fine motor function may be payable up to plan limits when Medically Necessary. Pre-authorization is required after the 12th visit per plan year. Benefits allow up to three units per visit. See applicable Benefits Summary for plan limits.
2. Pelvic floor therapy requires Pre-authorization.
3. Only one medical, psychiatric, chiropractic, physical therapy or osteopathic manipulation visit per day for the same diagnosis when billed by Providers of the same specialty for any one Member is allowable. Same-day visits by a multi-disciplinary team are eligible with applicable Copayment(s) per Provider.
4. Eligible Benefits for TMJ/TMD/Myofacial Pain are limited to the following services: initial diagnostic exam, TMJ/TMD radiographs, range of motion measurements, TMJ/TMD appliance and appliance adjustments, and physical therapy. See Benefits Summary for Eligible Benefits.
5. Therapeutic injections in the Provider's office will not be eligible if oral medication is an effective alternative or if only covered through the Specialty Pharmacy Program.
6. Gamma globulin injections are only eligible for documented immunosuppression with absence of Gamma globulin. Depending on the diagnosis, these drugs may be required to be obtained through the Specialty Drug Program. No benefits are payable for prophylactic purposes or other diagnoses.
7. Speech therapy by a qualified speech therapist requires Pre-authorization. Eligible Benefits are payable up to plan limits.

   Therapy or evaluation provided by speech therapists for dysphagia (difficulty in swallowing) is payable separate from the speech therapy limit as a medical visit.
8. Voice therapy is eligible for selected criteria. Pre-authorization is required.
9. Eligible services in conjunction with diagnosing and treating infertility are payable at 50% of Allowed Amount. See applicable Benefits Summary for Eligible Benefits.
10. Medical services to treat or diagnose enuresis and/or encopresis as a physical organic illness are eligible on an outpatient basis. If determined to be psychological, outpatient Mental Health benefits are payable.
11. After hours and/or holidays are payable only when special consultation is Medically Necessary beyond normal business hours or "on-call" or shift work requirements.
12. Cardiac Rehabilitation, Phase 2, is payable following heart attack, cardiac Surgery, severe angina (chest pain), etc. for up to 24 visits per plan year.
13. Pulmonary Rehabilitation, Phase 2, resulting from chronic pulmonary disease or Surgery is payable for up to 24 visits per plan year.
14. Eligible expenses related to Spinal Cord Stimulators are payable at 50% of Allowed Amount. Requires written Pre-authorization through Medical Case Management.
15. Hepatitis B immunoglobulin is covered if there is a documented exposure or if in conjunction with an eligible liver transplant.
16. Predictive genetic counseling except in conjunction with the Affordable Care Act (Preventive Services under Section 6.14) or as Medically Necessary, as determined by PEHP.

### 6.6.2 EXCLUSIONS FROM COVERAGE RELATING TO MEDICAL VISITS

The following are Exclusions of the policy:

1. Hospital visits the same day as Surgery or following a Surgical Procedure except for treatment of a diagnosis unrelated to the Surgery.
2. Examinations made in connection with a hearing aid unless specifically covered as indicated in your Benefits Summary.
3. Services for weight loss or in conjunction with weight loss programs regardless of the medical indications except as allowed under the Affordable Care Act (Preventive Services under Section 6.14).
4. Sublingual antigens.
5. Services that are dental in origin, including care and treatment of the teeth, gums, alveolar process, extraction of teeth, re-implantation or splinting, endodontia, periodontia, orthodontia, prosthetics,

dental implants, crowns or pontics over implants, anesthesia or supplies used in such care.

6. Charges in conjunction with ineligible procedures, including pre- or post-operative evaluations.
7. Acupuncture treatment unless specifically covered in your Benefits Summary.
8. Chiropractic, physical or occupational therapy primarily for maintenance care unless specifically excluded in your Benefits Summary.
9. Occupational therapy for activities of daily living, academic learning, vocational or life skills, drivers evaluation or training, developmental delay and recreational therapy.
10. Speech therapy for educational purposes or delayed development, or speech therapy that does not qualify within the criteria previously stated in Limitations.
11. Functional or work capacity evaluations, impairment ratings, work hardening programs or back school.
12. Hypnotherapy or biofeedback.
13. Hair transplants or other treatment for hair loss or restoration.
14. Study models, panorex, eruption buttons, orthodontics, occlusal adjustments or equilibration, crowns, photos, and mandibular kinesiograph are some, but not necessarily all, ineligible services for the treatment of TMJ/TMD or myofacial pain.
15. Vision therapy.
16. Testing and treatment therapies for developmental delay or child developmental programs.
17. Rolfing or massage therapy.
18. Training and testing in conjunction with Durable Medical Equipment or prosthetics.
19. Nutritional analysis or counseling, except in conjunction with diabetes education, anorexia, bulimia, or as allowed under the Affordable Care Act (Preventive Services under Section 6.14).
20. Reports, evaluations, examinations not required for health reasons, such as employment or insurance examinations, or for legal purposes such as custodial rights, paternity suits, sports physicals, etc.
21. Visits in conjunction with palliative care of metatarsalgia or bunions; corns, calluses or toenails, except removing nail roots and care prescribed by a licensed physician treating a metabolic or peripheral vascular disease. See applicable Benefits Summary for Eligible Benefits.
22. Cardiac Rehabilitation, Phases 3 and 4.
23. Pulmonary Rehabilitation, Phase 3.
24. Office visits in conjunction with allergy, contraception, hormone, or repetitive therapeutic injections when the only service rendered is the injection.
25. Fitness programs.
26. Charges for special medical equipment, machines, or Devices in the Provider's office used to enhance diagnostic or therapeutic services in a Provider's practice.
27. Childbirth education classes.
28. Topical hyperbaric oxygen treatment.

## 6.7 DIAGNOSTIC TESTING, LAB AND X-RAY BENEFITS

See applicable Benefits Summary for specific Copayments.

Benefits for Medically Necessary laboratory, x-ray, CT, MRI, MRA, and ultrasound services are payable. A fee for transportation of x-ray equipment is payable when appropriate.

Lab and x-ray in conjunction with office Surgery are payable after applicable Copayments.

### 6.7.1 LIMITATIONS RELATING TO DIAGNOSTIC TESTING, LAB AND X-RAY

The following are Limitations of the policy:

1. Sleep Studies for sleep disorders are payable up to a maximum benefit of $2,000 in a three-year period.
2. Lab and x-rays are only eligible for diagnosing or treating symptomatic illness and must be specific to the potential diagnosis.
3. Eligible services in conjunction with diagnosing infertility are payable at 50% of Allowed Amount. See applicable Benefits Summary for plan limits.
4. Laboratory typing/testing for organ transplant donors is eligible only when recipient is an eligible Member, covered under a PEHP plan, and the transplant is eligible.
5. Molecular diagnostic (genetic testing) in the course of evaluating a Member for genetic or congenital disease must be Pre-authorized.
6. Eligible expenses related to Spinal Cord Stimulators are payable at 50% of Allowed Amount. Requires written Pre-authorization through Medical Case Management

### 6.7.2 EXCLUSIONS FROM COVERAGE RELATING TO DIAGNOSTIC TESTING, LAB AND X-RAY

The following are Exclusions of the policy:

1. Charges in conjunction with ineligible procedures, including pre- or post- operative evaluations.
2. Routine drug screening, except when ordered by a treating physician.
3. Sublingual or colorimetric allergy testing.
4. Charges in conjunction with weight loss programs regardless of Medical Necessity.
5. Epidemiological counseling and testing.
6. Unbundling of lab charges or panels.
7. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations.
8. Hair analysis, trace elements, or dental filling toxicity.
9. Assisted reproductive technologies, including but not limited to: invitro fertilization; gamete intra fallopian tube transfer; embryo transfer; zygote intra fallopian transfer; pre-embryo cryopreservation techniques; and/or any conception that occurs outside the woman's body. Any related services performed in conjunction with these procedures are also excluded.

## 6.8 MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Some plans may be exempt from The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and may limit the number of visits or benefits for Mental Health and Substance Abuse services. (See applicable Benefits Summary for details.)

### 6.8.1 FACILITY AND HOSPITAL SERVICES

Medically Necessary services from Contracted Hospitals, inpatient treatment centers, inpatient pain clinics, day treatment facilities or intensive outpatient programs are payable after applicable Copayments and must be Pre-authorized through PEHP. See applicable Benefits Summary for further details. Failure to Pre-authorize will result in denial of benefits. Charges for the full Hospital stay will be prorated into a per diem rate, or as Contracted with specific Providers, for adjudication of daily benefits.

Day treatment or intensive outpatient program may be considered in lieu of inpatient care with two or more days applicable to one inpatient day based on Provider agreements or Pre-authorization. If program is not completed, benefits revert to outpatient coverage.

Electro Convulsive Therapy is eligible under Medical benefits.

Eating disorders, such as anorexia and/or bulimia, are payable under medical benefits while Life-threatening, as determined by PEHP. When the condition is no longer Life-threatening, benefits are payable under Mental Health and require Pre-authorization.

### 6.8.2 INPATIENT PROVIDER VISITS

Eligible Hospital visits are payable after applicable Copayment(s).

### 6.8.3 OUTPATIENT PROVIDER VISITS

Outpatient treatment by a licensed psychologist, licensed clinical social worker, medical Provider or licensed psychiatric nurse specialist is eligible. See applicable Benefits Summary for further details.

Eligible neuropsychological evaluations and testing are payable as medical benefits.

Eligible medical management to monitor use of psychotropic drugs is payable as a medical benefit.

### 6.8.4 LIMITATIONS RELATING TO MENTAL HEALTH AND SUBSTANCE ABUSE

The following are Limitations of the policy:

1. Benefits for group family counseling will be payable under Mental Health for the primary patient. Benefits will not be considered separately for each individual family Member.
2. When a Hospital stay spans an old and new plan year, charges billed on the hospital claim will be based on the old plan year provisions. Eligible ancillary services such as Inpatient Physician visits, diagnostic tests, laboratory tests, etc. performed during the hospital stay but billed separately from the hospital will apply to the benefits in effect under the plan year on the actual date of service billed. When Coverage terminates during a hospital stay, it will be necessary to convert to a COBRA policy to continue Coverage for the completion of the stay beyond the termination date.
3. Inpatient Provider visits are payable only in conjunction with authorized inpatient days, and will apply to benefits in effect under the plan year on the actual date of service billed.
4. Only one visit per Provider of the same specialty per day is payable.

### 6.8.5 EXCLUSIONS FROM COVERAGE RELATING TO MENTAL HEALTH AND SUBSTANCE ABUSE

The following are Exclusions of the policy:

1. Inpatient or outpatient treatment for Mental Health and/or substance abuse without Pre-authorization, if required by the Member's plan.

2. Milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances.
3. Mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.
4. Wilderness programs.
5. Inpatient treatment for behavior modification, enuresis, or encopresis.
6. Psychological evaluations or testing for legal purposes such as custodial rights, etc., or for insurance or employment examinations.
7. Occupational or recreational therapy.
8. Hospital leave of absence charges.
9. Sodium amobarbital interviews.
10. Residential treatment programs.
11. Tobacco abuse.
12. Routine drug screening, except when ordered by a treating physician.

### 6.9 AMBULANCE BENEFITS

See applicable Benefits Summary for specific Copayments. Benefits for eligible ambulance services, including air transport, are payable after applicable Copayment.

#### 6.9.1 LIMITATIONS RELATING TO AMBULANCE BENEFITS

The following are Limitations of the policy:

1. Benefits are only eligible when ambulance services are necessary due to a medical emergency and only to transport to the nearest Hospital where the appropriate level of care is available.
2. Benefits will be payable for air ambulance only in Life-threatening emergencies when a Member could not be safely transported by ground ambulance, and only to the nearest facility where the appropriate level of care is available.

If emergency is considered to be non-Life-threatening by PEHP, otherwise eligible air ambulance charges will be payable at ground transport rates.

#### 6.9.2 EXCLUSIONS FROM COVERAGE RELATING TO AMBULANCE BENEFITS

The following are Exclusions of the policy:

1. Charges for common or private aviation services.
2. Services for the convenience of the patient or family.
3. After-hours charges.
4. Charges for ambulance waiting time.

### 6.10 HOME HEALTH AND HOSPICE CARE BENEFITS

See applicable Benefits Summary for specific Copayments.

When Pre-authorized, Medically Necessary skilled home health, home IV therapy and Hospice services are payable at plan benefits.

Hospice benefits may be approved when a Member is no longer receiving any curative treatment, and is only receiving palliative care for pain relief, symptom control and comfort.

#### 6.10.1 LIMITATIONS RELATING TO HOME HEALTH AND HOSPICE CARE BENEFITS

The following are Limitations of the policy:

1. Total Enteral Nutrition (TEN) formula requires Pre-authorization and must be obtained through the pharmacy card.
2. Physical and/or occupational therapy performed in the home is subject to Pre-authorization. See Benefits Summary for details.
3. A home visit by a Licensed Clinical Social Worker is payable from outpatient Mental Health benefits, if applicable. See Benefits Summary for details.
4. Skilled Nursing visits are subject to plan Limitations. See applicable Benefits Summary for details.
5. Hospice services are subject to plan Limitations. See applicable Benefits Summary for details.

#### 6.10.2 EXCLUSIONS FROM COVERAGE RELATING TO HOME HEALTH AND HOSPICE CARE

The following are Exclusions of the policy:

1. Nursing or aide services which are requested by or for the convenience of the Member or family, which do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such services. This Exclusion applies even when services are recommended by a Provider.
2. Private duty nursing.
3. Home health aide.
4. Custodial Care.
5. Respite Care.
6. Travel or transportation expenses, escort services to Provider's offices or elsewhere, or food services.
7. Total Parenteral Nutrition through Hospice.
8. Enteral Nutrition, unless obtained through the

pharmacy card.

### 6.11 ADOPTION BENEFITS

Adoption benefits for legal or agency fees may be available, subject to plan Limitations. (See applicable Benefits Summary for details.)

In order to be eligible for adoption benefits, the adopting parent must have been a Subscriber for three months prior to the placement of the child. At the time of placement, the child must be 17 years of age or younger.

These adoption benefits will not be payable until the adoption becomes final and proper documentation is provided.

The Adoption benefits eligible under the Benefits Summary are the maximum (but not the minimum) benefits PEHP will allow per adoption, even if the Member is enrolled in more than one plan (Dual Coverage), or is also insured by another health insurance policy. If more than one child (ex. twins or siblings) is placed simultaneously for adoption with the Subscriber, only one Adoption benefit is payable.

#### 6.11.1 EXCLUSIONS FROM COVERAGE RELATING TO ADOPTION BENEFITS

The following are Exclusions of the policy:

1. Expenses incurred for the adoption of nieces, nephews, brothers, sisters, grandchildren, cousins, stepchildren, children of adult designees or in-laws of any of the above.
2. Transportation, travel expenses or accommodations, passport fees, translation fees, photos, postage etc.
3. Living expenses, food, and/or counseling for the birth mother.

### 6.12 PRESCRIPTION AND SPECIALTY DRUG BENEFITS

See applicable Benefits Summary for specific Copayments. The PEHP pharmacy benefit provides pharmacy and injectable Coverage through our pharmacy network.

The PEHP Pharmacy and Specialty Drug benefit is categorized by the following tiers:

- » **Tier 1:** Preferred generic drugs that are available at the lowest Copayment.
- » **Tier 2:** Preferred brand name drugs that are available at the intermediate Copayment.
- » **Tier 3:** Non-Preferred medications that are available at the highest Copayment.
- » **Tier A:** Preferred Specialty oral and injectable medications available at the lowest specialty Copayment listed in your Benefit Summary.
- » **Tier B:** Non-preferred Specialty medications available at the highest specialty Copayment listed in your Benefit Summary.

Go to www.pehp.org or contact PEHP Customer Service for the tier placement of your medication.

PEHP Members will receive a pharmacy Identification card upon Enrollment in the PEHP's Pharmacy program. The Identification card will only list the Subscriber's name but will provide Coverage for each enrolled family Member. Members need to present their pharmacy card or provide their PEHP Identification number to a participating pharmacy along with an eligible prescription and any applicable Copayment to receive their prescription medication. Prescription drugs purchased through PEHP's Pharmacy program are exempt from any Pre-existing Condition waiting period.

#### 6.12.1. COVERED FORMULARY DRUGS

1. FDA legend medications approved by PEHP and allowed by the PEHP Master Policy.
2. Insulin and diabetic supplies.
3. Select asthma spacers.
4. Select injectables and Specialty Drugs.
5. Select prescription pre-natal vitamins.
6. Select birth control pills.
7. Select prescription creams and ointments.
8. Select asthma drugs.
9. Select cholesterol and blood pressure medications.
10. Select antidepressants.
11. Select anticonvulsants.

#### 6.12.2 PRE-AUTHORIZATION FOR PRESCRIPTION AND SPECIALTY MEDICATIONS

PEHP has chosen specific prescription drugs, Specialty medications and injectables to require Pre-authorization. These medications were chosen with consideration for their potential for safety issues, adverse reactions, contraindications, misuse, opportunity to use first line therapy and cost. Go to www.pehp.org or contact PEHP's Customer Service for a complete listing of medications that require Pre-authorization.

To obtain Pre-authorization, a Member's physician may obtain a Pre-authorization form at www.pehp.org or may contact PEHP's Customer Service to start the Pre-authorization process. The Provider will be directed to PEHP's pharmacy Pre-authorization phone line. Approval or denial will be communicated to the Provider's office. Members may also phone the PEHP Customer Service Department for a status of

the physician's request. Pre-authorization does not guarantee payment. Coverage is subject to eligibility, benefit Coverage and Pre-authorization requirements.

### 6.12.3 QUANTITY LEVELS AND STEP THERAPY

Medications may have specific limits on how much of the drug Members can receive with each prescription or refill to ensure that Members receive the recommended and appropriate dose and length of therapy. PEHP establishes quantity levels based on criteria that includes the maximum dosage levels indicated by the drug manufacturer, duration of therapy, FDA, and the cost of the drug. Members must obtain Pre-authorization for any quantity that exceeds a PEHP quantity level limit. PEHP may require an additional Copayment if Pre-authorization is granted. Go to www.pehp.org for a complete list of medications that require a quantity level.

For some disease states and some drug categories, one or more medications must be tried before a drug will be covered under the pharmacy or injectable benefit.

Step therapy ensures that a Member receives the most clinically appropriate and cost-effective medication. Step therapy is based on current medical studies, generic availability, cost of the medication and FDA recommendations.

### 6.12.4 PHARMACY COORDINATION OF BENEFITS WITH OTHER CARRIERS

PEHP will coordinate pharmacy benefits with other insurance carriers when claims meet the requirements listed in Section 3.6.

If PEHP is the secondary carrier, Members must purchase their prescription medications through their primary insurance carrier. PEHP will coordinate Coverage of eligible Copayments and unpaid claim amounts if the pharmacy claim meets PEHP's pharmacy benefit requirements, Coverage rules, Pre-authorization requirements and quantity levels. Most pharmacies have the ability to process the secondary pharmacy claims electronically at the point of sale. Members will be required to pay the applicable deductible and copayment amounts after both claims are processed. If the pharmacy is unable to coordinate electronically, the Member must submit an original itemized receipt (a pharmacy printout is not a valid receipt) and a claim form to Express Scripts. If the primary insurance did not provide any Coverage of the claim, the Member must pay for the prescription at the point of sale and provide an explanation of payment or denial from their primary insurance carrier. Members may obtain a claim form at www.pehp.org or by contacting PEHP's Customer Service. Reimbursement will not exceed PEHP's normal discounted rate or any Limitation required by the pharmacy benefit. If the primary insurance requires a Deductible or out-of-pocket maximum, PEHP will recognize the pharmacy claim as unpaid by the primary insurance until the Deductible or out-of-pocket maximum is met. PEHP will administer the claim as a primary insurance and reimburse minus the patient's required retail Copayment.

If your Coordination of Benefits request is for a Specialty medication, PEHP will administer your Coordination of Benefits claim under your retail or medical Specialty benefit. An out-of-pocket maximum may not apply.

### 6.12.5 OUT-OF-AREA PRESCRIPTIONS OR OTHER CASH PURCHASES

If Members are traveling outside the service area, they may contact PEHP's Customer Service Department for the location of the nearest Contracted pharmacy in the United States. In emergency situations, Members may pay for a prescription and mail a reimbursement form along with a receipt to Express Scripts for reimbursement. Reimbursement forms may be obtained from www.pehp.org.

Urgent and emergent medications will be covered if obtained outside the United States when the drug or class of medication is covered under the PEHP Pharmacy or Specialty benefit. PEHP will determine the Urgent or emergent status of each claim submitted for reimbursement. Cash paid and out-of-area claims will be subject to PEHP's Pre-authorization requirements and step therapy and quantity levels. PEHP will reimburse up to our normal discounted rate and benefit rules minus the required Copayment.

### 6.12.6 SPECIALTY AND INJECTABLE DRUGS

Specialty and injectable drugs are typically bio-engineered medications that have specific shipping and handling requirements or are required by the manufacturer to be dispensed by a specific facility. PEHP may require that specialty medications be obtained from a designated pharmacy or facility for coverage.

Our specialty pharmacy, Accredo, will coordinate with you or your physician to provide delivery to either your home or your provider's office. Sometimes Specialty Drugs may be available through both our specialty pharmacy and through your provider's office or facility. In these cases PEHP will offer your specialty medication for a lower copayment and/or a lower maximum out-of-pocket cost through our specialty pharmacy. Pre-authorization may be required, and you may also have a separate out-of-pocket maximum per member per year for medications you receive through a provider's office or facility.

Copayments through Accredo will not apply to the specialty out-of-pocket maximum on the Medical plan, if applicable. However, the overall out-of-pocket expense may be lower if Accredo is the pharmacy used for the Specialty Drug.

### 6.12.7 LIMITATIONS RELATING TO PRESCRIPTION DRUG BENEFITS

The following are Limitations of the policy:

1. Drug quantities, dosage levels and length of therapy may be limited to the recommendations of the drug manufacturer, FDA, clinical guidelines, or PEHP.
2. Anabolic steroid Coverage will be limited to hypogonadism or HIV and cancer wasting.
3. Inhalant spacers are limited to one unit per calendar year.
4. A medication in a different dosage form or delivery system that contains the same active ingredient as an already covered drug may be restricted from Coverage.
5. PEHP may classify an FDA-approved generic medication as non-Preferred or not covered.
6. When a medication is dispensed in two different strengths or dosage forms, a separate Copayment will be required for each dispensed prescription.
7. If a Member is required by the FDA to be enrolled in a manufacturer Access or Disease Management Program, Coverage may be limited to Member's participation.
8. Medication quantities and availability may be restricted to a lower allowed day supply when a manufacturers' package size cannot accommodate the normal allowed pharmacy benefit day supply.
9. If a medication is packaged in a day supply that is greater than a 30-day or 90-day supply, the Member's out-of-pocket responsibility may require a Copayment for each 30-day supply of the anticipated duration of the medication.
10. Cash paid and Coordination of Benefits claims will be subject to PEHP's Pre-authorization, step therapy, benefit Coverage and quantity levels. PEHP will reimburse up to the Contracted rate and PEHP's benefit rules.
11. PEHP will have the ability to limit the availability and filling of any medication, Device or supply. The Pharmacy or Case Management Department may require the following tools:
    a. Require prescriptions to be filled at a specified pharmacy.
    b. Obtain services and medications in dosages and quantities that are only Medically Necessary as determined by PEHP.
    c. Obtain services and medications from only a specified Provider.
    d. Require participation in a specified treatment for any underlying medical condition.
    e. Require completion of a drug treatment program.
    f. Adhere to a PEHP Limitation or program to help reduce or eliminate drug abuse or dependence.
    g. Deny medications or quantities needed to support any dependence, addiction or abuse if a Member misuses the health care system to obtain drugs in excess of what is Medically Necessary.
12. Pharmacy Copayments will not apply to medical out-of-pocket limits, except for STAR plans.
13. Fluoride tablets are limited to children up to the age of 12 years old.
14. Enteral formula requires Pre-authorization and is limited to the pharmacy network for Coverage.
15. If prescription mail service is included in the pharmacy benefit plan, Members must use Express Scripts' mail order facility for 90-day Coverage.
16. Retail and mail order prescriptions are not refillable until 75% of the total prescription supply within the last 180 days is used. Twenty-three days must pass at a local pharmacy and 68 days at the mail-order facility before a prescription can be refilled.
17. A separate Copayment may be required if Federal or state law, clinical guidelines, PEHP quantity levels or manufacturer's package size requires a prescription to be dispensed in a quantity less than a 30- or 90-day supply.

### 6.12.8 PRESCRIPTIONS BY MAIL

If the Member's benefit plan includes a mail order program, they can purchase a 90-day supply of a maintenance medication at Express Scripts' mail-order facility. Maintenance medications are the only drugs available through PEHP's mail-order program. Maintenance drugs are prescribed to treat chronic conditions as defined by the FDA or PEHP.

» Examples of maintenance medications available through the mail-order program include:

a. Diabetes medications.

b. Anticonvulsants.

c. Birth control pills.

d. Blood pressure drugs.

e. Asthma medications.

f. Antidepressants.

» Examples of medications not available through mail-order include:

a. Antibiotics.

b. Anti-anxiety.

c. Anti-migraine.

d. Injectables.

e. Pain medications.

f. Muscle relaxants.

Prescriptions must be for a 90-day supply to be filled at Express Scripts' mail-order facility.

The mail-order facility may also contact Providers to see if they may substitute a brand name prescription with an equivalent generic drug when one is available.

Members should reserve the mail-order for those medications that are used for a chronic disease. To ensure that a medication will work for our Members, PEHP recommends that first time prescriptions be filled at a local pharmacy to ensure that there are no adverse effects or Complications.

To use the mail-order program, Members should ensure that their medication is eligible for mail-order and all Pre-authorization requirements have been met before sending in a prescription. Members should obtain a 90-day prescription from their physician, complete a mail-order form and send the order along with payment to the address listed on the order form. Members should review their prescription for accuracy. PEHP's mail-order facility is unable to fill prescriptions for 30-day supplies and may have to delay an order if they must verify the strength, dosage or directions with the prescribing physician.

Mail-order prescriptions may also be delayed if a duplicate prescription is filled at a local pharmacy within 10 days of requesting a mail-order prescription. Members should also avoid ordering a refill before 75% (68 days) of their prescription is gone. The mail-order facility will view the order as too early to fill. A Member should always have a 2-week supply of medication on hand to allow time for delivery. Members should also take into consideration that the mail-order facility is unable to supply a medication if the manufacturer cannot supply the drug.

### 6.12.9 GENERIC SUBSTITUTION BENEFIT

If the Member's benefit plan includes the generic substitution benefit, Members will be required to pay the difference between a generic medication and a brand name drug plus a generic Copayment when the brand name drug is dispensed instead of a substitutable generic medication. If your benefit plan has a Deductible, the cost difference between a brand-name drug and a generic equivalent does not apply to meeting your Deductible.

### 6.12.10 EXCLUSIONS FROM COVERAGE RELATING TO PRESCRIPTION DRUG BENEFITS

The following are Exclusions of the policy:

1. A prescription that is not purchased from a designated pharmacy (if required) and/or exceeds any quantity levels or step therapy disclosed on PEHP's Preferred Drug List or website.
2. Vitamins, minerals, food supplements, homeopathic medicines and nutritional supplements (Prenatal vitamins and folic acid will be covered for pregnancy).
3. Dental rinses and fluoride preparations. (Fluoride tablets will be covered for children up to the age of 12 years old).
4. Hair growth and hair loss products.
5. Medications or nutritional supplements for weight loss or weight gain.
6. Investigational and non-FDA Approved medications.
7. Medications needed to participate in any drug research or medication study.
8. FDA-approved medication for Experimental or Investigational indications.
9. Non-approved indications determined by PEHP.
10. Drugs for athletic and mental performance.
11. New medications released by the FDA until they are reviewed for efficacy, safety and cost-effectiveness by PEHP.
12. Oral infant and medical formulas.
13. Therapeutic Devices or appliances unless listed in PEHP's Preferred Drug List.
14. Diagnostic agents.
15. Over-the-counter medications and products unless listed in PEHP's Preferred Drug List or covered under the Affordable Care Act (Preventive Services under Section 6.14).
16. Take-home prescriptions from a Hospital or Skilled Nursing Facility.
17. Biological serum, blood, or blood plasma.

18. Medications and injectables prescribed for Industrial Claims and Worker's Compensation.
19. Medications dispensed from an institution or substance abuse clinic when the Member does not use their pharmacy card at a PEHP Contracted pharmacy are not payable as a pharmacy claim.
20. Compounding fees, powders, and non-covered medications used in compounded preparations.
21. Medications used for Cosmetic indications.
22. Replacement of lost, stolen or damaged medications.
23. Nasal immunizations unless listed in the PEHP Preferred Drug List.
24. Medications for abortions except if the pregnancy is the result of rape or incest, or if necessary to save the life of the mother.
25. Drugs for the treatment of nail fungus.
26. Medications for sex change operations.
27. Medications needed to treat Complications associated with Elective bariatric Surgery or other non-covered services.
28. Hypodermic needles.
29. Oral and nasal antihistamines for allergies.
30. Medications obtained outside the United States that are not for Urgent or emergency use.
31. Drugs used for sexual dysfunction or enhancement.
32. Medications for the treatment of infertility unless listed in the Preferred Drug List.
33. An additional medication that may be considered duplicate therapy defined by the FDA or PEHP.
34. Specific medications not listed on the PEHP website, including but not limited to: Adoxa, ammonium lactate, Avidoxy DK, Avita, Doryx, Doxal, Dynacin, Doxycycline monohydrate, Fortamet, Glumetza, Oracea, Oraxyl, Riomet, Solodyn, Symbyax, Sarafem, DMSO (Dimethylsulfoxide). For a complete list of covered drugs, refer to the PEHP website.
35. Drugs purchased from non-participating Providers online.

## 6.13 DURABLE MEDICAL EQUIPMENT/SUPPLY BENEFITS

See applicable Benefits Summary for specific Copayments.

Refer to Durable Medical Equipment, Appendix A, for a partial list of Covered and Non-covered items and Durable Medical Equipment that require Pre-authorization. Any item not listed requires Pre-authorization.

Purchase or rental of Durable Medical Equipment may be eligible if the criteria below are met.

Coverage is provided when the equipment is:

1. Medically Necessary;
2. Prescribed by a Provider and approved by PEHP; and
3. Used for medical purposes rather than for convenience or comfort.

PEHP will allow the cost of standard conventional equipment or supplies necessary to treat the medical condition. Additional charges for more elaborate or precision equipment or supplies shall be the responsibility of the Member.

Except for sleep disorder equipment and oxygen, if medical equipment will be required for longer than 60 days, it requires Pre-authorization for review of continued rental versus purchase. The total benefits allowable for rental and/or subsequent purchase may not exceed 100% of the allowable purchase price of the equipment.

### 6.13.1 LIMITATIONS RELATING TO DURABLE MEDICAL EQUIPMENT/SUPPLY BENEFITS

The following are Limitations of the policy:

1. Machine rental or purchase for the treatment of sleep disorders is payable at plan benefits, up to $2,500 in a five-year period, including all related equipment and supplies.
2. One lens for the affected eye following eligible corneal transplant Surgery. Contact lenses for documented Keratoconus may be approved as Medically Necessary.
3. Two pair support hose per plan year for phlebitis or other eligible diagnosis.
4. One pair of ear plugs within 60 days following eligible ear Surgery.
5. Continuous Passive Motion (CPM) machine rentals may be approved for up to 21 days rental only for total knee or shoulder arthroplasty.
6. Artificial prosthetics, such as eyes or limbs, when made necessary by loss from an injury or illness, must be Pre-authorized. If approved, the maximum prosthetic benefit available is one in a five-year period. Breast prosthetics require Pre-authorization. If approved, the maximum breast prosthetic benefit available is one per affected breast in a two-year period.
7. Only conventional, body powered, cable-operated

prosthetics will be eligible for loss of a limb or congenitally missing limb(s). Additional charges for more elaborate or precision equipment will be the Member's responsibility.

8. Wheelchairs require Pre-authorization through Medical Case Management and are limited to one power wheelchair in any five-year period.
9. Knee braces are limited to one per knee in a three-year period.

#### 6.13.2 EXCLUSIONS FROM COVERAGE RELATING TO DURABLE MEDICAL EQUIPMENT/SUPPLY BENEFIT

The following are some, but not necessarily all, items not covered as a benefit, regardless of the relief they may provide for a medical condition. Refer to Durable Medical Equipment, Appendix A, for a more detailed list of Non-covered items.

1. Training and testing in conjunction with Durable Medical Equipment or prosthetics.
2. More than one lens for each affected eye following Surgery for corneal transplant.
3. More than two pair of support hose for a medical diagnosis per plan year.
4. Durable Medical Equipment that is inappropriate for the patient's medical condition.
5. Diabetic supplies, i.e. insulin, syringes, needles, etc., are a pharmacy benefit.
6. Equipment purchased from non-licensed Providers.
7. Used Durable Medical Equipment.
8. TENS Unit.
9. Neuromuscular Stimulator.
10. H-wave Electronic Device.
11. Sympathetic Therapy Stimulator (STS).

### 6.14 PREVENTIVE SERVICES

Under the Affordable Care Act, PEHP offers the following preventive services covered at no cost to you when received from a Contracted Provider. If these services are received from a non-Contracted Provider they will be allowed up to the Allowed Amount and paid by PEHP at the allowed amount specified for non-Contracted Providers by the Member's applicable Benefit Summary, if the Member's plan allows the use of non-Contracted Providers. If the member's plan does not allow the use of non-Contracted Providers, the services will be denied by PEHP.

We process claims based on your provider's clinical assessment of the office visit. If a preventive item or service is billed separately, cost-sharing may apply to the office visit. If the primary reason for your visit is seeking treatment for an illness or condition, and preventive care is administered during the same visit, cost sharing may apply.

Certain screening services such as a colonoscopy or mammogram may identify health conditions that require further testing or treatment. If a condition is identified through a preventive screening, any subsequent testing, diagnosis, analysis, or treatment are not considered preventive services and are subject to the appropriate cost sharing.

Also, it is important to note that the Department of Health and Human Services has defined the preventive services to be covered with no cost share as those services described in the U.S. Preventive Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by the Health Resources and Services Administration (HRSA) Guidelines including the American Academy of Pediatrics Bright Futures periodicity guidelines, therefore it is subject to change.

See Benefits Summary for coverage information.

#### 6.14.1 COVERED PREVENTIVE SERVICES FOR ALL ADULTS

- Preventive physical exam visits for adults, one time per plan year including:
  - Blood Pressure screening
  - Basic/Comprehensive metabolic panel
  - Complete blood count
  - Urinalysis
- Abdominal Aortic Aneurysm one-time screening for men aged 65-75 who have ever smoked.
- Alcohol Misuse screening and counseling.
- Aspirin use for men ages 45-79 and women ages 55-79, covered under the pharmacy benefit when prescribed by a physician.
- Cholesterol screening for adults of certain ages or at higher risk.
- Colorectal Cancer screening for adults ages 50 to 75 using fecal occult blood testing, sigmoidoscopy, or colonoscopy.

**Note:** Moderate sedation (conscious sedation) is included in standard colonoscopy and is not reimbursed separately. General anesthesia or Monitored Anesthesia Care (MAC) must be medically

necessary and requires Pre-authorization through PEHP.

- » Depression screening for adults.
- » Type 2 Diabetes screening for adults with high blood pressure.
- » Diet counseling for adults at higher risk for chronic disease including hyperlipidemia, obesity, diabetes, and cardiovascular disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists including registered dietitians.
- » HIV screening for all adults at higher risk.
- » Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
  - › Hepatitis A
  - › Hepatitis B
  - › Herpes Zoster (Shingles age 60 and above)
  - › Human Papillomavirus (HPV)
    - » males age 9-21 Gardasil
    - » females age 9-26 Gardasil or Cervarix
  - › Influenza (Flu Shot)
  - › Measles, Mumps, Rubella
  - › Meningococcal (Meningitis)
  - › Pneumococcal (Pneumonia)
  - › Tetanus, Diphtheria, Pertussis (Td or Tdap)
  - › Varicella (Chickenpox)

Learn more about immunizations and see the latest vaccine schedules at www.cdc.gov/vaccines/.

- » Obesity screening and counseling for all adults by Primary Care Clinicians to promote sustained weight loss for obese adults.
- » Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk.
- » Tobacco Use screening for all adults and cessation interventions for tobacco users.
- » Syphilis screening for all adults at higher risk.

### 6.14.2 COVERED PREVENTIVE SERVICES SPECIFICALLY FOR WOMEN, INCLUDING PREGNANT WOMEN

- » Anemia screening on a routine basis for pregnant women.
- » Bacteriuria urinary tract or other infection screening for pregnant women.
- » BRCA counseling about genetic testing for women at higher risk.
- » BRCA testing for women at higher risk, requires pre-authorization from PEHP.
- » Breast Cancer Mammography screenings one time per plan year for women over 40.
- » Breast Cancer Chemoprevention counseling for women at higher risk.
- » Breastfeeding comprehensive support and counseling from trained Providers, as well as access to breastfeeding supplies, for pregnant and nursing women.
  - › Coverage allows for either a manual or electric breast pump within 12 months after delivery. Hospital grade breast pumps when Medically Necessary and Pre-Authorized by PEHP are also included.
- » Cervical Cancer screening (pap smear) for women ages 21-65.
- » Chlamydia Infection screening for younger women and other women at higher risk.
- » Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.
  - › Covered services/devices include: One IUD every two years (including removal), generic oral contraceptives, NuvaRing, Ortho Evra, diaphrams, cervical caps, emergency contraceptives (Ella, and generics only), injections, hormonal implants (including removal), Essure, and tubal ligation.
- » Domestic and interpersonal violence screening and counseling for all women.
- » Folic Acid supplements for women who may become pregnant, covered under the pharmacy benefit when prescribed by a physician.
- » Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
- » Gonorrhea screening for all women at higher risk.
- » Hepatitis B screening for pregnant women at their first prenatal visit.
- » Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women.
- » Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older

in conjunction with cervical cancer screening (pap smear).

- Osteoporosis screening for women over age 60 depending on risk factors.
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
- Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users.
- Sexually Transmitted Infections (STI) counseling for sexually active women.
- Syphilis screening for all pregnant women or other women at increased risk.
- Well-woman visits to obtain recommended preventive services one time per plan year. Additional well-woman exams in the plan year will be reviewed and must be recommended by the provider.

### 6.14.3 COVERED PREVENTIVE SERVICES FOR CHILDREN

- Preventive physical exam visits throughout childhood as recommended by the American Academy of Pediatrics including:
  - Behavioral assessments for children of all ages;
  - Blood pressure screening for children;
  - Developmental screening for children under age 3 and surveillance throughout childhood;
  - Oral health risk assessment for young children;
  - Hearing screening one time between age 4 and 6.
- Alcohol and Drug Use assessments for adolescents.
- Autism screening for children at 18 and 24 months.
- Cervical Dysplasia (pap smear) screening for sexually active females.
- Congenital Hypothyroidism screening for newborns.
- Depression screening for adolescents.
- Dyslipidemia screening for children at higher risk of lipid disorders.
- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns.
- Hearing screening for all newborns, birth to 90 days old.
- Height, Weight and Body Mass Index measurements for children.
- Hematocrit or Hemoglobin screening for children.
- Hemoglobinopathies or sickle cell screening for newborns.
- HIV screening for adolescents at higher risk.
- Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
  - Diphtheria, Tetanus, Pertussis (Dtap);
  - Haemophilus influenzae type b (Hib);
  - Hepatitis A;
  - Hepatitis B;
  - Human Papillomavirus (HPV);
    - Males age 9-21 Gardasil;
    - Females age 9-26 Gardasil or Cervarix;
  - Inactivated Poliovirus;
  - Influenza (Flu Shot);
  - Measles, Mumps, Rubella;
  - Meningococcal (Meningitis);
  - Pneumococcal (Pneumonia);
  - Rotavirus;
  - Varicella (Chickenpox).

  Learn more about immunizations and see the latest vaccine schedules at www.cdc.gov/vaccines/.
- Iron supplements for children ages 6 to 12 months at risk for anemia.
- Lead screening for children at risk of exposure.
- Obesity screening and counseling.
- Phenylketonuria (PKU) screening for this genetic disorder in newborns.
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk.
- Tuberculin testing for children at higher risk of tuberculosis.
- Vision screening for all children one time between age 3 and 5.

### 6.14.4 COVERAGE FOR SPECIFIC DRUGS

Payable through the Pharmacy Plan when received at a participating pharmacy with a prescription from your doctor. Over the counter purchases are not covered.

See applicable Benefits Summary for coverage information.

- Aspirin use for men age 45-79 and women age 55-79.
- Folic acid supplements for women who may become pregnant.
- Fluoride chemoprevention supplements for children without fluoride in their water source.
- Iron supplements for children ages 6 to 12 months at risk for anemia.
- Tobacco use cessation interventions.

#### 6.14.5 PILOT PROGRAMS

PEHP, in conjunction with your employer, may participate in pilot programs for services to measure the effectiveness of such pilots prior to implementing broad changes to the Master Policy or payment contracts. For any pilot program, PEHP and your employer reserve the right to determine eligibility, benefits limits, member copayments, length of time the pilot program will continue, all other aspects of the pilot program and any other condition for participation. If a pilot program is available to your employer, the specific information will be included in your benefits summary document.

### 6.15 ADDITIONAL BENEFIT PROGRAMS

#### 6.15.1 HEALTHY UTAH PROGRAM

Subscribers and their spouses are eligible to attend one Healthy Utah testing session each plan year free of charge. Healthy Utah is offered at the discretion of the Employer.

### 6.16 NATIONAL ACCESS PROGRAM

The National Access Program is a value added addition to PEHP's Provider Network. This card allows in-network Coverage for only the following PEHP Members: 1) Members who are living outside the State of Utah (Members who are living outside the State of Utah must notify PEHP of their out-of-state address prior to receiving Coverage); 2) Members traveling outside the State of Utah who are in need of urgent or life-threatening services while traveling (Coverage is excluded for services outside the State of Utah when a Member is traveling for the purpose of seeking medical care or treatment.); or 3) Members that require medical services that are not available in Utah and that have been Pre-authorized by PEHP.

## VII. General Limitations and Exclusions

### 7.1 PRE-AUTHORIZATION LIMITATIONS

Certain medical services require Pre-notification or Pre-authorization by PEHP before being eligible for payment. While many Contracted and non-Contracted Providers will Pre-authorize or Pre-notify on your behalf, it is your responsibility to ensure that PEHP has received notice and/or granted approval for any service requiring Pre-notification or Pre-authorization prior to the services being received. If you do not Pre-authorize or Pre-notify services that require such approval, benefits may be reduced or denied by PEHP.

**The following services require Pre-notification by calling PEHP Customer Service:**

- All inpatient Hospital admissions
- All inpatient Hospital Rehabilitation admissions
- Skilled Nursing Facilities
- All inpatient mental health and substance abuse admissions

To receive maximum benefits, a Member must call for Pre-notification before being admitted to a Hospital as described below:

**Elective Treatment**

Treatment for a medical condition that can be scheduled in advance without causing harm or suffering to the Member's health. At least five working days before the admission date or Surgery, call PEHP at 801-366-7755 or 800-753-7754.

**Urgent Treatment**

Treatment for a medical condition that, if left untreated, may cause unnecessary suffering or prolonged treatment to restore Member's health. At least three working days before the admission date or Surgery, call PEHP at 801-366-7755 or 800-753-7754.

**Emergency Treatment**

Treatment for a medical condition of an unforeseen nature that, if left untreated, may cause death or permanent damage to the Member's health. Members do not have to call prior to admission. Member or a responsible person must contact PEHP within 72 hours following admission or Surgery (or, if during a weekend or holiday, the first working day following treatment) at 801-366-7755 or 800-753-7754.

Failure to call may result in a reduction or denial of benefits. See applicable Benefits Summary for specific penalties.

**Out-of-Area Hospital Admission**

Requires Pre-notification by the Member, the physician,

the Hospital, or, in an emergency, a responsible person. Call PEHP at 801-366-7755 or 800-753-7754 within the time specified above for the type of treatment. Failure to call will result in a reduction or denial of benefits. See applicable Benefits Summary for specific penalties.

**The following service requires verbal Pre-authorization by calling PEHP Customer Service:**

- Any inpatient maternity stay that exceeds 48 hours following a vaginal delivery or 96 hours following delivery by Cesarean section.

**The following is a list of the most common services requiring written Pre-authorization. It is not all inclusive. Call PEHP if you have any questions regarding Pre-authorization:**

- Eligible dental procedures performed in an outpatient facility for patients 6 years of age and older
- Organ or tissue transplants
- Surgery that may be partially or wholly Cosmetic
- Coronary CT angiography
- Surgery performed in conjunction with obesity Surgery
- Implantation of artificial Devices
- New and Unproven technologies
- Cochlear implants
- Molecular diagnostics (genetic testing)
- Durable Medical Equipment with a purchase price over $750 or any rental of more than 60 days, except for sleep disorder equipment and oxygen
- Botox injections
- Maxillary/Mandibular bone or Calcitite augmentation Surgery
- All out-of-state, out-of-network surgeries/procedures or inpatient admissions that are not Urgent or Life-threatening
- Pelvic floor therapy
- Wound care, except for the diagnosis of burns
- Home health and Hospice Care
- Hyperbaric oxygen treatments
- Intrathecal pumps
- Spinal cord stimulators
- Surgical Procedures utilizing robotic assistance
- Implantable medications, excluding contraception
- Certain prescription and Specialty Drugs
- Continuous glucose monitoring Devices and supplies
- Jaw surgery
- Dialysis when using non-Contracted Providers
- Breast pumps – Hospital grade
- Human pasteurized milk
- Physical or occupational therapy after 8 combined visits
- Speech therapy after initial evaluation
- Stereotactic radiosurgery
- Magnetoencephalography (MEG)/ magnetic source imaging
- Voice therapy
- Breast reconstruction surgery
- Virtual colonoscopy
- Transanal endoscopic microsurgery
- Artificial ankle prosthetic
- Endovenous ablation therapy (Radiofrequency or laser)
- Manipulation under anesthesia
- Anesthesia during standard colonoscopy or EGD surgery, other than moderate sedation (conscious sedation)
- Any Surgery for solely for snoring
- Chelation therapy
- Video EEG Monitoring (VEEG)

## 7.2 MAXIMUM OUT-OF-POCKET BENEFITS

PEHP has set limits for maximum out-of-pocket expense for Members. After the Member's share of eligible expenses exceeds specified amounts, PEHP will pay further Eligible Benefits incurred during the remaining plan year at 100% of Allowed Amount. See applicable Benefits Summary for specific out-of-pocket limits.

### 7.2.1 EXCLUSIONS FROM COVERAGE RELATING TO MAXIMUM OUT-OF-POCKET BENEFITS

Amounts paid by the Member for the following services will not apply to the Member's out-of-pocket maximum:

1. Inpatient or outpatient Mental Health or substance abuse treatment for plans that do not have Mental Health Parity or separate Mental Health or substance abuse yearly out-of-pocket maximums*;

2. Temporomandibular Joint (TMJ/TMD/Myofacial Pain) treatment*;
3. Sleep apnea testing or equipment*;
4. Infertility testing, Surgery*;
5. Surgeries or procedures payable at 50%*;
6. Adoption*;
7. Penalties for failing to obtain Pre-authorization or to complete Pre-notification;
8. Emergency room*;
9. Prescription drugs*;
10. Supplies obtained through the Pharmacy card*;
11. Any service or amount established as ineligible under this policy or considered inappropriate medical care;
12. Charges in excess of Allowed Amount or contract Limitations;
13. Charges applied to Member Deductibles*;
14. Charges for Hospital services when the patient was discharged against medical advice (AMA);
15. Specialty Drugs obtained through a Provider's office or outpatient facility will have a separate out-of-pocket maximum and will not apply to the medical out-of-pocket maximum*;
16. The cost difference between a brand name drug and a generic equivalent.

**Except for HSA-compatible STAR Plans*

### 7.3 SPECIFIC EXCLUSIONS

Specific Exclusions are listed under the most commonly applicable Benefit category, but are not necessarily limited to that category only.

### 7.4 GENERAL EXCLUSIONS FROM COVERAGE

1. Charges in excess of contract Limitations or Allowed Amount.
2. All charges for services received as a result of an Industrial Claim (on-the job) injury or illness, any portion of which is payable under Worker's Compensation or Employer's liability laws.
3. Charges in conjunction with a Pre-existing Condition, if applicable.
4. PEHP will only be liable for Eligible Benefits for which the Member is liable. Payment will not be made for any expense for which the Member is not legally bound.
5. Charges for educational material or literature.
6. Charges for nutritional counseling except for the benefits provided for diabetes education, anorexia, bulimia, or as allowed under the Affordable Care Act (Preventive Services under Section 6.14).
7. Charges for scholastic education, vocational training, learning disabilities, or behavior modification.
8. Charges for medical care rendered by an Immediate Family Member.
9. Charges prior to Coverage or after termination of Coverage even if illness or injury occurred while a Member.
10. Provider's telephone calls or travel time.
11. Charges for services primarily for convenience, contentment, or other non-therapeutic purpose.
12. Overutilization of medical benefits as determined by PEHP.
13. Charges that are not medically necessary to treat the condition, as determined by PEHP, or charges for any service, supply or medication not reasonable or necessary for the medical care of the patient's illness or injury.
14. Charges for Unproven medical practices or care, treatment, Devices or drugs that are Experimental or Investigational in nature or generally considered Experimental or Investigational by the medical profession as determined solely by PEHP.
15. Charges for services without adequate diagnosis or dates of service.
16. Charges for services, supplies or medications to the extent they are provided by any governmental plan or law under which the individual is, or could be covered.
17. Charges for services as a result of an auto related injury and covered under No-fault insurance or would have been covered if Coverage were in effect as required by law.
18. Services, treatments, or supplies furnished by a Hospital or facility owned or operated by the United States Government or any agency thereof while a member is on active duty.
19. Services or supplies received as a result of an act of war.
20. Any service or supply not specifically identified as a benefit.
21. Charges for commercial or private aviation services, meals, accommodations and car rental.
22. Charges for mileage reimbursement except for eligible ambulance service.
23. Charges by a Provider for case management.
24. Charges for independent medical evaluations and/or

testing for the purpose of legal defenses or disputes.

25. Charges for submission of Medical Records necessary for claims review.
26. Delivery, shipping, handling, sales tax, or finance charges.
27. PEHP is not responsible to pay any benefits given verbally or assumed except as written in a Pre-authorization, documented by Customer Service or Medical Case Management, or as described in this policy.
28. Charges for remote medical evaluation and management, including prescriptive services provided by the Internet, telephone or catalog.
29. Autopsy procedures.
30. Complications as a result of any non-covered service, procedure, or drug.
31. Treatment of obesity by means of Surgery, medical services, or prescription drugs, regardless of associated medical, emotional, or psychological condition.
32. Services incurred in connection with injury or illness arising from the commission of
    a. a felony;
    b. an assault, riot or breach of peace;
    c. a Class A misdemeanor;
    d. any criminal conduct involving the illegal use of firearm or other deadly weapon;
    e. other illegal acts of violence.
33. Charges incurred while a Member is incarcerated or in police custody.
34. Claims submitted past the timely filing limit allowed per Section 8.1 of this Master Policy.
35. Charges for expenses in connection with appointments scheduled and not kept.
36. Charges for the treatment of sexual dysfunction.
37. Charges for services received as a result of medical tourism, or for traveling out of the United States to seek medical services, drugs, or devices.
38. Medical services, procedures, supplies or drugs used to treat secondary conditions or Complications due to any non-covered medical services, procedures, supplies or drugs are not covered. Such Complications include, but are not limited to:
    a. Complications relating to services and supplies for or in connection with gastric bypass or intestinal bypass, gastric stapling, or other similar Surgical Procedure to facilitate weight loss, or for or in connection with reversal or revision of such procedures, or any direct Complications or consequences thereof;
    b. Complications as a result of a Cosmetic Surgery or procedure, except in cases of Reconstructive Surgery:
        1. When the service is incidental to or follows a Surgery resulting from trauma, infection or other diseases of the involved party; or
        2. Related to a congenital disease or anomaly of a covered Dependent child that has resulted in functional defect;
    c. Complications relating to services, supplies or drugs which have not yet been approved by the FDA or which are used for purposes other than its FDA-Approved purpose;
39. Pelvic or spinal manipulation under anesthesia.
40. Services, procedures, drugs, or devices received at or from a birthing center.

## 7.5 SUBROGATION AND CONTRACTUAL REIMBURSEMENT

### 7.5.1 CONTRACTUAL REIMBURSEMENT

The Member agrees to seek recovery from any person(s) who may be obligated to pay damages arising from occurrences or conditions caused by the person(s) for which Eligible Benefits are provided or paid for by PEHP and promises to keep PEHP informed of his/her efforts to recover from those person(s). If the Member does not diligently seek such recovery, PEHP, at its sole discretion, reserves the right to pursue any and all claims or rights of recovery on the Member's behalf.

In the event that Eligible Benefits are furnished to a Member for bodily injury or illness, the Member shall reimburse PEHP with respect to a Member's right (to the extent of the value of the Benefits paid) to any claim for bodily illness or injury, regardless of whether the Member has been "made whole" or has been fully compensated for the illness or injury. PEHP shall have a lien against any amounts advanced or paid by PEHP for the Member's claim for bodily injury or illness, no matter how the amounts are designated, whether received by suit, settlement, or otherwise on account of a bodily injury or illness. PEHP's right to reimbursement is prior and superior to any other person or entity's right to the claim for bodily injury or illness, including, but not limited to, any attorney fees or costs the Member chooses to incur in securing the amount of the claim.

### 7.5.2 SUBROGATION

The Member agrees to seek recovery from any person(s) who may be obligated to pay damages arising from

occurrences or conditions caused by the person(s) for which Eligible Benefits are provided or paid for by PEHP and promises to keep PEHP informed of his/her efforts to recover from those person(s). If the Member does not diligently seek such recovery, PEHP, at its sole discretion, reserves the right to pursue any and all claims or rights of recovery on the Member's behalf. The Member will cooperate fully with PEHP and will sign and deliver instruments and papers and do whatever else is necessary on PEHP's behalf to secure such rights and to authorize PEHP to pursue these rights.

In the event that Eligible Benefits are furnished to a Member for bodily injury or illness, PEHP shall be and is hereby subrogated (substituted) with respect to a Member's right (to the extent of the value of the Benefits paid) to any claim for bodily illness or injury, regardless of whether the Member has been "made whole" or has been fully compensated for the illness or injury. PEHP shall have a lien against any amounts advanced or paid by PEHP for the Member's claim for bodily injury or illness, no matter how the amounts are designated, whether received by suit, settlement, or otherwise on account of a bodily injury or illness. PEHP's right to reimbursement is prior and superior to any other person or entity's right to the claim for bodily injury or illness, including, but not limited to, any attorney fees or costs the Member chooses to incur in securing the amount of the claim.

#### 7.5.3 ACCEPTANCE OF BENEFITS AND NOTIFICATION

Acceptance of the benefits hereunder shall constitute acceptance of PEHP's rights to reimbursement or Subrogation rights as explained above.

#### 7.5.4 RECOUPMENT OF BENEFIT PAYMENT

In the event the Member impairs PEHP's reimbursement or Subrogation rights under this contract through failure to notify PEHP of potential liability, settling a claim with a responsible party without PEHP's involvement, or otherwise, PEHP reserves the right to recover from the Member the value of all benefits paid by PEHP on behalf of the Member resulting from the party's acts or omissions.

No judgment against any party will be conclusive between the Member and PEHP regarding the liability of the party or the amount of recovery to which PEHP is legally entitled unless the judgment results from an action of which PEHP has received notice and has had a full opportunity to participate.

## VIII. Claims Submission & Appeals

PEHP reserves the right at its discretion to determine whether a claim is an Eligible Benefit or to require verification of any claim for Eligible Benefits. In order to be considered for payment, expenses must be incurred while Member is eligible under the plan. The date the medical service is received shall be the date the medical expenses are incurred. PEHP shall not be responsible for any expenses that are not Eligible Benefits.

PEHP may request Medical Records, operative reports, pathology reports, x-rays, photos, etc. of a Member. PEHP may review the Medical Records or have the records reviewed by qualified healthcare Providers or other qualified entities to audit claims for eligibility, Pre-existing Condition, Medical Necessity, and appropriateness of services with the Community Standard or usual patterns of care as determined by PEHP.

Benefits are adjudicated in conjunction with the Allowed Amount and code review systems implemented by PEHP. Claims may be returned for incomplete or improper coding. If, after a second request, necessary records are not received, the claim(s) will be denied for insufficient documentation.

### 8.1 CLAIMS SUBMISSION

When a Contracted Provider is used, the Provider will submit the claims directly to PEHP. Payment will be made directly to the Contracted Provider. It is the Contracted Provider's responsibility to file the claim within 12 months from the date of service. Claims denied for untimely filing are not the Member's responsibility, unless one of the following exceptions is met:

a. When PEHP becomes the secondary payer, the Member is responsible to ensure timely filing from all Providers. Claims must be submitted to PEHP within 15 months from the date of service to be eligible.
b. When the Member provides inaccurate or incomplete information regarding Medical Plan Coverage to the Provider.

When a non-Contracted Provider is used, it is the responsibility of the Member to ensure that the claim is filed. PEHP accepts paper and electronic claims. Claims that are not received within the timely filing limits above will be Member's responsibility in full.

### 8.1.1 REQUIRED INFORMATION FOR CLAIMS SUBMISSION

The CPT (Current Procedural Terminology); HCPCS (Health Care Financing Administration's Common Procedural Coding System); ICD-9 (International Classification of Diseases) code(s) and NDC# (National Drug Code), if applicable, and the Providers charge must be provided.

Claims may be submitted electronically, or mailed to:

**PEHP**
**Claims Division**
**560 East 200 South**
**Salt Lake City, Utah 84102-2004**

### 8.2 CLAIMS APPEAL PROCESS

If a Member disagrees with a PEHP decision regarding benefits, the Member may request a full and fair review by completing the PEHP Appeal form located on each explanation of benefit statement, or available online at pehp.org, and returning the form to PEHP within 180 days after PEHP's initial determination. If the appeal form is not received by PEHP within 180 days, the appeal shall be denied. PEHP shall allow for expedited appeals only when required by federal law and at the request of the Member. The Member shall include with the appeal form all applicable information necessary to assist PEHP in making a determination on the appeal. Requests for a review of claims should be sent to one of the following addresses:

**Mail**

**PEHP Appeals and Policy Management Department**
**P.O. Box 3836**
**Salt Lake City, Utah 84110-3836**

**Fax: 801-320-0541**

PEHP shall review and investigate the appeal. If PEHP requires additional information to investigate the appeal, it shall inform the Member of what information is required, and the Member shall have 45 days to provide the information to PEHP. Unless an expedited appeal or unless PEHP requests additional information from the Member, PEHP shall decide the appeal and inform the Member of the decision within 60 days from its receipt of the appeal form. PEHP's investigation shall include a review by the Executive Director of Utah Retirement Systems in accordance with Utah Code Annotated § 49-11-613(1)(c).

In accordance with federal law, if PEHP's decision on the appeal involved a medical judgment, a member may request an external review of PEHP's decision by completing PEHP's external review form and returning the form to PEHP. The member shall pay $25 for filing a request for an external review unless the member provides evidence to PEHP that they are indigent (unable to pay). The request for external review and the $25 fee must be received by PEHP within 30 days of the date of PEHP's decision. Following the external reviewer's decision, PEHP shall notify the member of the decision. If PEHP's original decision is overturned by the external reviewer, PEHP shall refund the $25 filing amount to the Member.

If PEHP's decision on the appeal did not involve a medical judgment, or if a member contests the decision of the external reviewer, a member may, within 30 days of the denial, file a written request for a formal administrative hearing before the Utah State Retirement Board's hearing officer, in accordance with the procedure set forth in Utah Code Annotated § 49-11-613. The Member must file the petition to the hearing officer on a standard form provided by and returned to the Retirement Office. Once the hearing process is complete, the hearing officer will prepare an order for the signature of the Utah Retirement Board. See the Master Policy for a more complete list of definitions. Find the Master Policy at www.pehp.org or call PEHP.

# Appendix A

## Durable Medical Equipment

### COVERED EQUIPMENT

This is a general list of Covered, Pre-authorization Required, and Non-covered Durable Medical Equipment (DME) items. This list is not necessarily all DME items. Any further items not specifically listed are subject to review for eligibility. Equipment over $750 requires Pre-authorization, except sleep disorder equipment and oxygen.

Subject to all policy provisions, Medical Necessity, Limitations, etc., as well as the specific benefit Limitations noted in italics below. If medical equipment will be required for longer than 60 days, it requires Pre-authorization for review of continued rental versus purchase.

## Durable Medical Equipment (CONTINUED)

| Item | COVERED | NON-COVERED | PRE-AUTHORIZATION | PHARMACY CARD SYSTEM ONLY |
|---|---|---|---|---|
| Abdominal Binder/Support | ● | | | |
| Adaptive Devices or Aids to Daily Living | | ● | | |
| Aerochamber | | | | ● |
| Air Cleaner, Purifier | | ● | | |
| Air Conditioners | | ● | | |
| Alarm Systems | | ● | | |
| Allergy Free Blanket, Pillow Case, or Mattress Cover | | ● | | |
| Ankle Foot Orthotic (AFO) | | | ● | |
| Apnea Monitor (infant) | | | ● | |
| Arch Supports, Insoles, Heel Cushions, etc. | | ● | | |
| Automatic Blood Pressure Monitor | | ● | | |
| Automatic Blood Pressure Monitor (neonatal/pediatric) | | | ● | |
| Auto-Tilt Chair | | ● | | |
| Bandages | | ● | | |

## Durable Medical Equipment (CONTINUED)

| Item | COVERED | NON-COVERED | PRE-AUTHORIZATION | PHARMACY CARD SYSTEM ONLY |
|---|---|---|---|---|
| Bar Bell Set, Dumb Bells | | ● | | |
| Barrel Crawl | | ● | | |
| Bathtub Lifts | | ● | | |
| Bathtub Seat/Bench/Chair | | ● | | |
| Bathtub/Toilet Rails | | ● | | |
| Batteries, Replacement, any type<br>*Except power wheelchair batteries allowed once in 3 years* | | ● | | |
| Battery Charger | | ● | | |
| Bed, Air Fluidized | | | ● | |
| Bed Baths (home type) | | ● | | |
| Bed Board | | ● | | |
| Bed Cradle | | ● | | |
| Bed Pans | | ● | | |
| Bed Side Rails | | | ● | |
| Bed Wedges, Foam Slants | | ● | | |
| Bed, Hospital, standard, semi-electric | | | ● | |
| Bed, Hospital, total electric | | ● | | |
| Bed, non-Hospital, Adjustable | | ● | | |
| Bed, Oscillating | | ● | | |
| Bed, Pressure Therapy | | | ● | |
| Beeper | | ● | | |
| Bilirubin Lights (phototherapy)<br>*Up to seven days* | ● | | | |
| Biofeedback Device | | ● | | |
| BiPAP (including eligible attachments and supplies)<br>*Sleep disorder equipment is limited to $2,500 in a five-year period* | ● | | | |
| Blood Pressure Cuff and/or Kit | | ● | | |
| Bone Growth Stimulator (Osteogenesis) | | | ● | |

## Durable Medical Equipment (CONTINUED)

| Item | COVERED | NON-COVERED | PRE-AUTHORIZATION | PHARMACY CARD SYSTEM ONLY |
|---|---|---|---|---|
| Booster Chair, pediatric | | ● | | |
| Brace, back (see Corset) | ● | | | |
| Brace, knee<br>*Limited to one per knee in a three-year period* | ● | | | |
| Brace, leg (child) | ● | | | |
| Brace, scoliosis | | | ● | |
| Braille Teaching Texts | | ● | | |
| Brassiere/Bra (mastectomy) | | ● | | |
| Breast Pump — Manual or electric<br>*One per delivery* | ● | | | |
| Breast Pump — Hospital grade<br>*One per delivery* | | | ● | |
| Cane | | ● | | |
| Car Seat, adult or pediatric | | ● | | |
| Car/Van Lift, Car modifications | | ● | | |
| Carafe | | ● | | |
| Cast Boot (ambulatory surgical boot) | ● | | | |
| Cervical Collar | ● | | | |
| Cervical Pillow | | ● | | |
| Chair, adjustable (for dialysis only) | | ● | | |
| Chest Compression Vest, System Generator and Hoses | | | ● | |
| Circle Balance Discs | | ● | | |
| Cleaning Solutions | | ● | | |
| Coagulation Protime Self-Testing Device (CoaguChek) | | | ● | |
| Commode and accessories | | ● | | |
| Communicative Device, Equipment or Repair | | ● | | |
| Computer Systems or Components | | ● | | |

## Durable Medical Equipment (CONTINUED)

| Item | COVERED | NON-COVERED | PRE-AUTHORIZATION | PHARMACY CARD SYSTEM ONLY |
|---|---|---|---|---|
| Computerized Assistive Devices | | ● | | |
| Contact Lens | | ● | | |
| Contact Lens, following corneal transplant<br>*Limited to one lens per eye* | ● | | | |
| Contact Lens, for keratoconus | ● | | | |
| Continuous Hypothermia Machine | | ● | | |
| Continuous Passive Motion (CPM) Machine, including supplies<br>*Up to 21 days for Total Knee or Shoulder Replacement* | ● | | | |
| Continuous Passive Motion (CPM) Machine for toe/foot surgeries, including supplies | | ● | | |
| Continuous Passive Motion (CPM) Machine – other procedures | | | ● | |
| Continuous Positive Airway Pressure<br>(CPAP Machine—including eligible attachments and supplies)<br>*Sleep disorder equipment is limited to $2,500 in a five year period* | ● | | | |
| Contour Chair | | ● | | |
| Corset (lumbar), custom, orthopedic | ● | | | |
| Cranial Electro Stimulation (CES) | | ● | | |
| Crawler, height adjustable | | ● | | |
| Crawler, prone | | ● | | |
| Crawling Coordination Training Unit | | ● | | |
| Crutches—purchase | ● | | | |
| Crutches—rental | | ● | | |

## Durable Medical Equipment (CONTINUED)

| Item | COVERED | NON-COVERED | PRE-AUTHORIZATION | PHARMACY CARD SYSTEM ONLY |
|---|---|---|---|---|
| Crutches, Underarm Pad Replacement | | ● | | |
| Cuff Weights | | ● | | |
| Dehumidifiers (room or central heating system) | | ● | | |
| Deironizer, Water Purification System | | ● | | |
| Dialysis Equipment, home | | | ● | |
| Diabetic Supplies (syringes, needles) | | | | ● |
| Diapers | | ● | | |
| Drionic Machine | | | ● | |
| Dynasplint | | | ● | |
| Ear Plugs, molds<br>*Limited to one pair, following ear Surgery* | ● | | | |
| Electrodes and Accessories for stimulators | ● | | | |
| Electronic Controlled Thermal Therapy Devices | | ● | | |
| Electrostatic Machine | | ● | | |
| Elevators | | ● | | |
| Emesis Basins | | ● | | |
| EMG Machine (Biofeedback) | | ● | | |
| Enuresis Alarm Unit<br>*For Members up to age 18* | ● | | | |
| Environmental Control Systems | | ● | | |
| Erectile Aid System (vacuum system) | | ● | | |
| Exercise Equipment | | ● | | |
| Eyeglasses | | ● | | |
| Face Masks | | ● | | |
| Fracture Frame | ● | | | |
| Gel Flotation Pads and Mattresses | | | ● | |

## Durable Medical Equipment (CONTINUED)

| Item | COVERED | NON-COVERED | PRE-AUTHORIZATION | PHARMACY CARD SYSTEM ONLY |
|---|---|---|---|---|
| Glucometer (blood glucose monitor) | | ● | | |
| Glucose Monitor, Continuous | | | ● | |
| Grab Bars | | ● | | |
| Gym Mat | | ● | | |
| Hand Controls for Motor Vehicle | | ● | | |
| Handgrip Replacement (cane, crutch, walker, wheelchair, etc.) | | ● | | |
| Head Float | | ● | | |
| Health Spa | | ● | | |
| Hearing Aids, hearing Devices<br>*Except when covered by specific employer group* | | ● | | |
| Heat Lamps | | ● | | |
| Heating Pads, Hot Water Bottle | | ● | | |
| Helmet (cranial molding orthosis) | | | ● | |
| Home Modifications | | ● | | |
| Home Physical Therapy Kits | | ● | | |
| Hot Tub | | ● | | |
| Humidifier | | ● | | |
| Humidifier, room or central heating | | ● | | |
| Humidifier, only with IPPB or other respiratory equipment | ● | | | |
| H-Wave Electronic Device, including supplies | | ● | | |
| Hydraulic Patient Lifts | | | ● | |
| Hydrocollater Unit | | ● | | |
| Hydrotherapy Tanks | | ● | | |
| Ice Packs | | ● | | |
| Immobilizer, shoulder | ● | | | |
| Incontinence Treatment System | | | ● | |

## Durable Medical Equipment (CONTINUED)

| Item | COVERED | NON-COVERED | PRE-AUTHORIZATION | PHARMACY CARD SYSTEM ONLY |
|---|---|---|---|---|
| Infusion Pumps (ambulatory), Parenteral, Enteral | | | ● | |
| Insulin Pump, external, ambulatory | | | ● | |
| Interferential Nerve Stimulator | | ● | | |
| IPPB Machine | | | ● | |
| IV Pole | ● | | | |
| Kangaroo Pump/Kit | | | ● | |
| Lambswool Pads | ● | | | |
| Lift Platform, wheelchair, van or home | | ● | | |
| Lift, Chair (seat) | | ● | | |
| Light Box (seasonal) | ● | | | |
| Lumbosacral Support | ● | | | |
| Lymphedema Pump (pneumatic compressor) | | | ● | |
| Lymphedema Sleeves/Supplies | | | ● | |
| Maclaren Buggy, Stroller | | ● | | |
| Maintenance, Warranty or Service Contracts | | ● | | |
| Maintenance/Repair, Routine | | ● | | |
| Massage Devices | | ● | | |
| Mattress, Hospital bed | | | ● | |
| Mattress, inner spring or foam rubber | | ● | | |
| Mattress, pressure-reducing, including overlay | | | ● | |
| Motor Vehicle | | ● | | |
| Motor Vehicle Alterations, Conversions | | ● | | |
| Motor Vehicle Devices, Hand Controls, Lifts, etc. | | ● | | |
| Mouth Guard | | ● | | |
| Muscle Stimulator, including supplies | | ● | | |
| Myoelectric Prosthetics | | ● | | |

## Durable Medical Equipment (CONTINUED)

| Item | COVERED | NON-COVERED | PRE-AUTHORIZATION | PHARMACY CARD SYSTEM ONLY |
|---|---|---|---|---|
| Nebulizer, with compressor, ultrasonic, heater, etc. *Limited to one in five years* | ● | | | |
| Neo-control Chair | | ● | | |
| Neuromuscular Stimulator (NMES) | | ● | | |
| Oral appliance to treat Obstructive Sleep Apnea | | | ● | |
| Orthopedic Brace for sports activities | | ● | | |
| Orthotics, Shoe Inserts (any type) *Except when covered by specific Employer group up to two per plan year* | | ● | | |
| Overbed Tables | | ● | | |
| Oximeter (pulse oximeter) | | | ● | |
| Oxygen (contents), Cylinders, Carrier | ● | | | |
| Oxygen, Portable Systems | ● | | | |
| Oxygen Humidifier | ● | | | |
| Oxygen Regulators | ● | | | |
| Oxygen Systems, Concentrators and Accessories—purchase | | ● | | |
| Oxygen Systems, Concentrators and Accessories—rental | ● | | | |
| Oxygen Tent | ● | | | |
| Pager | | ● | | |
| Paraffin Bath Units (therabath) | | ● | | |
| Parallel Bars | | ● | | |
| Patient Lifts, Slings | | | ● | |
| Peak Flow Meter, handheld *Limited to one per plan year* | ● | | | |
| Pelvic Floor Stimulator | | | ● | |
| Percussor, Chest (with generator) | | | ● | |

## Durable Medical Equipment (CONTINUED)

| Item | COVERED | NON-COVERED | PRE-AUTHORIZATION | PHARMACY CARD SYSTEM ONLY |
|---|---|---|---|---|
| Polarcare (cold compression Device) | | ● | | |
| Portable Room Heaters | | ● | | |
| Postural Drainage Board | | ● | | |
| Posture Chair | | ● | | |
| Pressure Pads, Cushions and Mattresses (with or without pumps) | | | ● | |
| Prosthesis, Breast (non-implant), *One per affected breast in a two-year period* | | | ● | |
| Prosthesis, Eye, Limb *One per site in a five year period* | | | ● | |
| Prosthetic Socks (stump socks), and supplies | ● | | | |
| Protonics Knee Orthosis | | | ● | |
| Pulsed Galvanic Stimulator, including supplies | | ● | | |
| Quad-Cane | ● | | | |
| Raised Toilet Seats | | ● | | |
| Reflux Board, infant | ● | | | |
| Repairs, Non-Routine Performed by a skilled technician | ● | | | |
| Rib Belt | ● | | | |
| Rocking Bed | | ● | | |
| Roho Air Flotation System | | | ● | |
| Rollabout Chair | | ● | | |
| Rowing Machine | | ● | | |
| Safety Grab Bar, Rail, Bathroom, Toilet, Bed | | ● | | |
| Safety Rollers, with walkers | | | ● | |
| Sauna Baths | | ● | | |
| Scales | | ● | | |
| Scoliosis Orthotic Devices | | | ● | |

## Durable Medical Equipment (CONTINUED)

| Item | COVERED | NON-COVERED | PRE-AUTHORIZATION | PHARMACY CARD SYSTEM ONLY |
|---|---|---|---|---|
| Scooter Board | | ● | | |
| Seat Lift Mechanism | | ● | | |
| Shoes, Orthopedic or Corrective, Modifications, Lifts, Heels, Wedges, Inserts, etc. | | ● | | |
| Shower Bench | | ● | | |
| Sitz Bath | | ● | | |
| Sling, Arm | ● | | | |
| Spa Membership | | ● | | |
| Speech Augmentation Communication Device | | ● | | |
| Speech Generating Device | | ● | | |
| Speech Teaching Machines, Language Master | | ● | | |
| Sphygmomanometer with Cuff (blood pressure cuff) | | ● | | |
| Spinal Pelvic Stabilizers | | ● | | |
| Stairglide (Stairway Elevator Lift) | | ● | | |
| Stander | | | ● | |
| Standing Table | | ● | | |
| Stethoscope | | ● | | |
| Suction Pump, Aspirator | ● | | | |
| Sun Glasses | | ● | | |
| Support Hose (elastic stockings, surgical stockings) *Limited to four per plan year for eligible diagnosis* | ● | | | |
| Support Pillow | | ● | | |
| Swimming Pool | | ● | | |
| Sympathetic Therapy Stimulator (STS), including supplies | | ● | | |
| Telephone | | ● | | |
| Telephone Alert Systems | | ● | | |

## Durable Medical Equipment (CONTINUED)

| Item | COVERED | NON-COVERED | PRE-AUTHORIZATION | PHARMACY CARD SYSTEM ONLY |
|---|---|---|---|---|
| Telephone Arms | | ● | | |
| Theraband | | ● | | |
| Therapy Ball, Roll, Putty | | ● | | |
| Thermometer | | ● | | |
| Three-Wheeler<br>*Wheelchair benefits apply* | | | ● | |
| Tips, Replacement (wheelchair, walker, crutches, etc.) | | ● | | |
| Toddler Walkabout | | ● | | |
| Toileting Aids | | ● | | |
| Tool Kits | | ● | | |
| Tracheostomy Speaking Valve | | ● | | |
| Traction, Cervical, Extremity, Pelvic | | ● | | |
| Traction, Overdoor | | ● | | |
| Transcutaneous Electrical Nerve Stimulator<br>(TENS) Unit, including supplies | | ● | | |
| Transfer Board | | | ● | |
| Trapeze Bars | | | ● | |
| Tray, Desk, Drafting Table, Easel, Caddy Tray, Cup Holder, etc. (wheelchair) | | ● | | |
| Tricycle, Hip Extensor | | ● | | |
| Truss | ● | | | |
| Ultraviolet Cabinet | | ● | | |
| Ultraviolet Lamp, handheld | | ● | | |
| Upholstery, Reinforcement or Replacement | | ● | | |
| Urinals | | ● | | |
| Used Equipment | | ● | | |
| Uterine Activity Monitor, with pregnancy | | ● | | |
| Vacuum Assisted Closure (VAC) Wound Healing | | | ● | |

## Durable Medical Equipment (CONTINUED)

| Item | COVERED | NON-COVERED | PRE-AUTHORIZATION | PHARMACY CARD SYSTEM ONLY |
|---|---|---|---|---|
| Van, Van Conversion | | ● | | |
| Vaporizer, room type | | ● | | |
| Ventilator—rental | | | ● | |
| Ventilator—purchase | | ● | | |
| Vibrating Chair | | ● | | |
| Vibrators | | ● | | |
| Vision Aid or Device | | ● | | |
| Walkers and attachments, Basic—purchase | ● | | | |
| Walkers and attachments, Basic—rental | | ● | | |
| Walkers and attachments, Specialty—purchase | | | ● | |
| Walkers and attachments, Specialty—rental | | ● | | |
| Waterbed | | ● | | |
| Wheelchair<br>*Limited to one power wheelchair in a five-year period.* | | | ● | |
| Wheelchair, armrest replacements | ● | | | |
| Wheelchair, auto carrier | | ● | | |
| Wheelchair, backpacks, caddy, carrier, baskets, etc. | | ● | | |
| Wheelchair, caster replacement | ● | | | |
| Wheelchair, cushions | | | ● | |
| Wheelchair, footrest replacement | ● | | | |
| Wheelchair, heel, toe loops replacement | ● | | | |
| Wheelchair, Safety Equipment (belt, harness, vest) | | | ● | |
| Wheelchair, Seatbelts, Crossbar Replacement | ● | | | |
| Wheelchair, Seating System | | | ● | |
| Wheelchair, Spoke Protectors | | ● | | |

## Durable Medical Equipment (CONTINUED)

| Item | COVERED | NON-COVERED | PRE-AUTHORIZATION | PHARMACY CARD SYSTEM ONLY |
|---|---|---|---|---|
| Wheelchair, Stand-Up | | ● | | |
| Wheelchair, Strap/Belt Harness Replacement | ● | | | |
| Wheelchair, Tires/Tubes, Replacement | ● | | | |
| Wheelchair, Tune-up | | ● | | |
| Wheelchair, Utility Tray | | ● | | |
| Wheelchair Ramp | | ● | | |
| Wheelmobile | | ● | | |
| Whirlpool Bath Equipment | | ● | | |
| Whirlpool Pumps | | ● | | |
| White Cane | | ● | | |
| Wig, Hair Piece | | ● | | |
| Work Table | | ● | | |
| Wrist Alarm | | ● | | |

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