



Medical Master Policy

2022-2023

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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 60 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, 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 COVERED SERVICES

Merely because a physician or other Provider orders or recommends care, services, treatments, 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 an In-Network or out-of-network 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 Covered Services 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 In-Network 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, 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. Unless another time frame is specifically allowed in another section of this Master Policy, PEHP will only pay retroactive benefits for a limited period of time. Such retroactive benefits shall only be paid back to a) the start of the current plan year, or b) 90 days prior to the start of the current plan year if the request is made within 90 days of the current plan year. No retroactive benefits shall be paid for more than one calendar year.

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 In-Network Providers or the necessity of obtaining Preauthorizations.

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.

There may be other Coverage available through the Healthcare Marketplace Exchange. Please see the Coverage Alternatives information at the end of this section.

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 who meets the definition of Dependent, who is 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 are 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.

It is the responsibility of a Subscriber to inform PEHP if they are currently in the process of a divorce. If in the process of a divorce, a member may be prevented by court order from making changes to PEHP coverage, such as modifying or changing beneficiaries. To make changes to your coverage, you must certify that you are not a party to a Utah divorce proceeding and are not subject to an injunction/order which prevents you from modifying insurance or changing beneficiaries.

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 or loss of Coverage 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.

Coverage Alternatives

There may be other Coverage options for you and your family. You are now able to buy Coverage through the Health Insurance Marketplace, which may cost less than COBRA. In the Marketplace you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for Coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. Through the Marketplace you will also learn if you qualify for free or low-cost Coverage from Medicaid or the Children’s Health Insurance Program (CHIP).

You have 60 days from the time you lose your job-based Coverage to enroll in the Marketplace. After 60 days your special enrollment period will end and you may not be able to enroll, you should take action right away. In

addition, during an “open enrollment” period, anyone can enroll in Marketplace Coverage.

If you sign up for COBRA, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through a “special enrollment period.” If you terminate your COBRA early without a qualifying event, you will have to wait to enroll in Marketplace Coverage until the next open enrollment period, and could end up without any health Coverage in the interim.

If your COBRA ends you will be eligible to enroll in Marketplace Coverage through a special enrollment period event, if the Marketplace open enrollment has ended. If you sign up for Marketplace Coverage instead of COBRA, you cannot switch to COBRA under any circumstances.

You can access information regarding the Marketplace at [HealthCare.gov](https://www.healthcare.gov) or call 800-318-2596.

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 Preauthorization 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

ACCIDENT, DENTAL

A single unpremeditated event of violent or external means, which happens suddenly, is unexpected, and is identifiable as to time and place. Injuries resulting from the act of biting or chewing are not considered within the definition of an Accident.

ACCIDENT, MEDICAL

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.

ALLOWED AMOUNT

The maximum fee allowable for a given procedure, test, Device, or medication established by PEHP and accepted by In-Network Providers. Also referred to as "In-Network Rate." PEHP, in its discretion, may set an Allowed Amount at a lower rate than what is accepted by In-Network Providers when an Out-of-Network Provider is used.

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.

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.

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 medication.

CONSCIOUS (MODERATE) SEDATION

An induced state of sedation characterized by a minimally depressed consciousness such that the patient is able to continuously and independently maintain patent airway, retain protective reflexes, and remain responsive to verbal commands and physical stimulation.

CONTRACTED HOSPITAL

A Hospital with whom PEHP has a current contractual agreement to render care to covered Members for a specific fee. Also referred to as In-Network Hospital.

CONTRACTED PROVIDER

A Provider with whom PEHP has a current contractual agreement to render care to covered Members for a specific fee. Also referred to as In-Network Provider.

COORDINATION OF BENEFITS

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

COPAYMENT

The portion of the cost of Covered Services 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.

COSMETIC PROCEDURE

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

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.

COVERED SERVICES

Health care services and supplies as defined under PEHP's Master Policy(ies) that are eligible for reimbursement or Payment under a Plan.

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).

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.

DEDUCTIBLE

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

DEPENDENT

"Dependent" means:

1. a. The Subscriber's lawful spouse under Utah State Law. A valid marriage certificate and/or affidavit of marriage are required to demonstrate the validity of a marriage.
 - b. Common-law marriage. A common law spouse is a lawful spouse under Utah State law, but only if the Subscriber and spouse obtains a court order establishing the common law marriage. Eligibility for a common-law spouse may not be established retroactively.
 - c. General provisions relating to marriage. When a court purports to retroactively either establish or annul/declare void a marriage or divorce for Benefit eligibility, PEHP will consider the marriage or dissolution of the marriage effective on the date the court order was signed by the court, or the date the order is received by PEHP, whichever is later.
2. Domestic partner and their Dependents as defined by the Employer (if applicable).
3. Children or stepchildren of the Subscriber up to the end of the month in which they turn age 26 who have a Parental Relationship with the Subscriber. A valid birth certificate listing Subscriber or legal Spouse as parent is required.
4. Legally adopted children, foster children up to age 19, and children through legal guardianship up to the age of 26 are eligible subject to PEHP receiving adequate legal documentation. (Legal guardianship must be court appointed and must be obtained prior to the child turning 18 years old.)
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 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. 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.

DEPENDENT DISABILITY

A person age 26 or older who is incapable of self support due to a definable mental or physical impairment, who is not married or living independently, and is claimed as a Dependent on the Subscriber's income taxes.

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.

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.

ELECTIVE TREATMENT

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

EMERGENCY

A medical condition of sudden or acute onset and symptoms of sufficient severity that a Member could reasonably expect the absence of immediate medical attention to result in the health of the Member in serious jeopardy, or would result in significant impairment to a bodily organ or function. PEHP shall determine whether a situation is an emergency based on the final diagnosis and review of the medical records.

EMERGENCY SERVICES

Medical services provided for an Emergency, including services received at an emergency department at a hospital and subsequent medical examination and treatment at a hospital until the Member is medically stabilized.

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.

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.

ENROLLMENT

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

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 healthcare, 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.

EXCLUSIONS

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

EXPERIMENTAL, INVESTIGATIONAL, OR UNPROVEN

Except for routine patient care costs, services, drugs or Devices received as part of clinical trial, those services, supplies, Devices, or pharmaceutical (medication) 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.

FDA APPROVED

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

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 medication benefit and evaluates them based on safety and efficacy. The Committee reviews new and existing medications on a regular basis and the Formulary is revised accordingly.

GENERAL ANESTHESIA

Anesthesia affecting the entire body and accompanied by a loss of consciousness.

GENETIC TESTING

The sequencing of DNA to discover the presence or absence of a mutation.

GLOBAL FEE

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

GROUP INSURANCE PROGRAM

The program of Coverage created by Title 49, Chapter 20 of the Utah Code Annotated.

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.

HOLIDAY

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

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.

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.

IMMEDIATE FAMILY MEMBER

Immediate Family Members are considered to be (for purposes of this policy): the Subscriber, the spouse, child, parent, brother, sister, domestic partner or anyone that lives in the same home or for which one party is dependent on the other for financial support of any Subscriber or dependent covered under the Subscriber's plan. Immediate Family Member includes any step-relatives of the same types as are described above.

IN-NETWORK CONTRACTED PROVIDER

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

IN-NETWORK RATE

The maximum fee allowable for a given procedure, test, Device, or medication established by PEHP and accepted by In-Network Providers. Also referred to as "Allowed Amount." PEHP, in its discretion, may set an Allowed Amount at a lower rate than what is accepted by In-Network Providers when an Out-of-Network Provider is used.

INDUSTRIAL CLAIM

Charges for an illness or injury arising out of or in the course of employment which charges are determined by PEHP to be covered by a Workers' Compensation carrier under the Utah Workers' Compensation Act.

LIFETIME MAXIMUM BENEFITS OR LIFETIME LIMITS

Covered Services 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.

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.

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.

MEDICAL RECORDS

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

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.

MEMBER

A Subscriber, a Subscriber's spouse, or 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.

MENTAL HEALTH

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

MISUSE OR ABUSE OF BENEFITS OR FAILURE TO COOPERATE

Includes, but is not limited to, a pattern of benefit misuse where a Member overutilizes benefits or uses benefits to obtain services beyond what is necessary to most appropriately treat the Member's condition. E.g., receiving multiple emergency room visits in a short period of time for conditions and services that could have been provided by a Provider at a lower level of care; or failure to reasonably cooperate and appropriately reimburse PEHP following an industrial injury or when there is a third party liable for claims.

MOLECULAR DIAGNOSTICS

Analysis of biological markers regardless of source, to evaluate the genetic coding or expression of genes or proteins.

MONITORED ANESTHESIA CARE

Monitored Anesthesia Care (MAC) is the monitoring of a patient's physiological signs during a procedure in anticipation of the need for administration of general anesthesia or the development of adverse reactions to the procedure.

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.

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.

PAYMENT

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

PBM

Pharmacy Benefit Manager.

PHARMACY TOURISM BENEFIT

A program which allows PEHP members to obtain specific medications at an out-of-country pharmacy when preauthorized by PEHP.

PREAUTHORIZATION

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, out-of-state, out-of-network, at a Rehabilitation, long-term acute care or Skilled Nursing Center, Hospitalization for Mental Health or Substance Abuse, Surgical Procedures, Durable Medical Equipment, pharmaceutical medication products, or other services as required. Preauthorization 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. Preauthorization is valid only for the dates authorized, even if treatment has not been completed.

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)

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), Applied Behavior Analyst (ABA), Athletic Trainer, and Registered Dietician.

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.

RECREATIONAL THERAPY

A treatment philosophy and format used for patients with mental or physical conditions or injuries to improve or maintain functionality, self confidence, socialization and a sense of well-being. Including, but not limited to, animal-assisted therapy.

REHABILITATION THERAPY/HABILITATION 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.

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 medications; 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.

SPECIALIST

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

SPECIALTY MEDICATION

Medications determined by PEHP and its PBM to be payable only through the Specialty Medication 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 Medication vendor.
7. Other medications at PEHP's discretion.

STAR PLAN

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

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.

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.

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.

TOTAL DISABILITY

The inability to successfully complete regular education programs or maintain gainful employment or perform activities of daily living as a direct result of a defined mental or physical impairment.

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.)

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.

UTAH PREVAILING RATE

The allowed amount PEHP would pay to the most relevant corresponding In-Network Provider as determined by PEHP.

VERBAL PREAUTHORIZATION

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 must enroll for Coverage within the period of time and manner allowed by the Employer, but not longer than 60 days from his/her hire date. 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 the period of time and manner allowed by the Employer, but not longer than 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.

3.2.3 SPECIAL ENROLLMENT

Eligible Employees who do not enroll in or terminate Coverage on themselves or their eligible Dependents during the initial Enrollment period may enroll in or terminate Coverage prior to the next annual Enrollment period if they meet the qualifications for a special Enrollment period. Employees may also choose to change plan types and/or network at this time. 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 the period of time and manner allowed by the Employer, but not longer than 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 the period of time and manner allowed by the Employer, but not longer than 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.

Other Circumstances

Eligible Employees and/or their eligible Dependents may enroll or terminate Coverage at a time other than annual Enrollment if:

1. The eligible Employee had a permanent reduction in hours worked as certified by the Employer; or
2. On December 31 of any year if an enrolled Employee or Dependent certifies to PEHP within 15 days of the Marketplace open enrollment that the enrolled Employee or Dependent will enroll in a federal Marketplace plan at the next available Marketplace open enrollment.

3.2.4 LEGAL GUARDIANSHIP

Dependent children who are under age 26 who and who are placed under the legal guardianship (through testamentary appointment or court order) of the Subscriber or the Subscriber's lawful spouse prior to turning age 18, are eligible to be enrolled for Coverage. Dependent children who were placed under the legal guardianship of the Subscriber or the Subscriber's lawful spouse that were enrolled on the Subscriber's PEHP plan immediately prior to turning age 19, may elect to remain on the plan until age 26 like other dependent children if, and only if, the Employer elects to allow these individuals to remain enrolled on the plan and Employer imputes appropriate income to the Subscriber pursuant to applicable tax laws and rules. If Employer has elected this option, it shall be reflected in the Benefit Grid in the Employer's applicable Benefit Summary.

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.

3.3 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 OR LIMITATION 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 month in which the Dependent child turns age 26.
3. Dependent child (Legal Guardianship) turns age 19 – Coverage will terminate at the end of the month in which the Dependent child turns age 19. If Employer elects to provide continued guardianship benefits between ages 19-26, coverage will terminate as if the child was a natural child of Subscriber.
4. Dependent child (foster care) turns age 19 – Coverage will terminate at the end of the day prior to the 19th birthday.
5. 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.
6. 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 Employer's internal policies. Coverage for Dependents may be extended an additional one month if allowed by the applicable risk pool.
7. 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.
8. Employer group terminates PEHP group Coverage.

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.

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.

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. It is the Subscriber's responsibility to make written notification to PEHP within 60 days from the qualifying mid-year event. If not requested during this time period, Dependents may not be voluntarily removed until the next annual Enrollment period.

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, 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.

3.4.2 SUSPENSION OF COVERAGE

Coverage for a Member may be suspended if the Member misuses or abuses benefits as determined by PEHP and if either the Member does not provide PEHP with requested information, or the Member refuses to participate in Mandatory Care Coordination or other Personalized Health Program at PEHP's request. The suspension of Coverage shall last until the Member complies with the terms of the Personalized Health Program medical plan and this Master Policy. If a Member's Coverage is suspended and that suspension is subsequently lifted by PEHP, PEHP shall only retroactively pay claims if allowed under the current PEHP internal policy.

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 for termination of employment 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 the period of time and manner allowed by the Employer, but not longer than 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 LTD MEDICAL COVERAGE STIPEND

This benefit may be different for your plan. Please see your applicable Benefit Summary for details. If the Benefit Summary is silent regarding this benefit, then the following provisions apply. In accordance with Utah Code Annotated § 49-20-409 and only upon election by the Employer, if applicable [see applicable Benefit Summary Grid for details], if the covered Employer maintains Employer-based Coverage with PEHP, PEHP shall pay a monthly stipend to disabled former Employees receiving disability benefits in accordance with the following:

1. Disabled former Employees are eligible for this stipend if they qualified for long-term disability benefits through the PEHP LTD Program or from another Employer-sponsored long-term disability program that is both substantially similar to the PEHP LTD Program and pays the disabled former Employee a monthly disability benefit for a defined length of time. PEHP, in its sole discretion, shall determine whether another disability benefit is substantially similar to the PEHP LTD Program.
2. PEHP shall pay the disabled former Employee a stipend amount equal to a percentage of the medical premium for the Employer's single insurance Coverage for whom the disabled former Employee was working prior to the disability as follows (percentages change as of the last day worked):
 - a. 100% of the premium for the first year of disability
 - b. 90% of the premium for the second year of disability
 - c. 80% of the premium for any time after the second year of disability.
3. PEHP shall pay the disabled former Employee an additional amount for the difference in premiums for Employer double or family Coverage. The additional amount of a stipend above the single premium shall be paid only if the following conditions are met:
 - a. The disabled former Employee maintained double or family Coverage on the date the disabled former Employee became eligible for this stipend, and the disabled former Employee's Dependent(s) do not have other Employer Coverage available to them.
4. Notwithstanding any other provisions of this section, if a disabled former Employee would otherwise be eligible for a stipend and becomes eligible for Medicare benefits, the maximum stipend a disabled former Employee is eligible to receive is an amount reflecting a percentage amount, in accordance with subsection 2 above, of the premium for the PEHP Medicare Supplement Middle Plan option. A disabled former Employee may also receive an additional stipend under this section for their spouse if the spouse is also eligible for Medicare.
5. Notwithstanding any other provision of this section, any amount payable in a stipend shall be reduced so that it shall not exceed the premium amount for traditional family coverage.
6. This stipend benefit shall begin the day after the latest date of the following events:
 - a. The date of disability, or the day after the last day of actual work for the participating Employer as defined by Utah law;
 - b. The date family medical leave coverage ends; or
 - c. The date the disabled former Employee's insurance coverage as an active Employee ends.
7. This stipend benefit shall terminate upon the earliest of the following events:
 - a. The disabled former Employee or any spouse or Dependent elects COBRA coverage;
 - b. The disabled former Employee maintains an outstanding debt(s) with PEHP of more than 30 days;
 - c. The date long-term disability benefits terminate or would terminate pursuant to Utah Code Annotated § 49-21-403;
 - d. The date medical benefits would have otherwise ended pursuant to the PEHP Medical Master Policy; or
 - e. or the Employee obtains active employment and is eligible for medical coverage with the same employer group from which they are receiving the stipend.

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 eligibility for termination of employment, and is an alternative to COBRA. COBRA may be allowed during early retiree coverage for Eligible Dependents with a COBRA qualifying event where the Dependent would otherwise lose early retiree Coverage (eg, divorce, children reaching age 26, etc.) before early retiree Coverage would otherwise end.

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.

Once the Dependent turns 18, PEHP must be consulted to determine the order of benefit determination as it can be affected by may circumstances. A copy of the divorce decree may be requested for file documentation.

Please contact PEHP Customer Service with any questions regarding Coordination of Benefits.

3.6.3 COORDINATION OF BENEFITS RULES

When PEHP is the primary plan, its Covered Services 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 Covered Services 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 Covered Services it would normally apply 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 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 claims paid by the primary plan will be credited toward your Deductible and Out-of-Pocket maximums. On Traditional plans, pharmacy claims paid by the primary plan will not be credited toward your Deductible and Out-of-Pocket maximum.

Medical and pharmacy claims will be subject to all plan provisions as described in this Master Policy, including, but not limited to, Preauthorization 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) Covered Services 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 the In-Network Rate. 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 Covered Services are intended to work in conjunction with one another. If there is any conflict regarding Covered Services, 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 MANDATORY CARE COORDINATION

Mandatory Care Coordination is a type of Personalized Health Program outlined in Section 6.14.5 of this Master Policy. Mandatory Care Coordination is designed to enhance the value of medical care in cases of a Member's Misuse or Abuse of Benefits or non-compliance with medical advice. PEHP shall determine if it is appropriate for a Member to participate in Mandatory Care Coordination. PEHP will work with the Member and Providers to coordinate a medically appropriate treatment plan, which may include PEHP restricting payment to certain Providers. As a part of this plan, the Member enters into a supplemental agreement with PEHP. Failure to enter into this supplemental agreement or to abide by the treatment plan may result in a reduction, suspension or denial of benefits as determined by PEHP. This supplemental agreement may alter terms, such as Preauthorization requirements or plan Copayments for that Member if PEHP determines such action is warranted by the Member's behavior.

VI. Covered Benefits

PEHP provides Coverage to Utah public employers' employees and dependents. PEHP only provides Coverage for medical services not otherwise limited or excluded under this Master Policy or federal or state law. The Coverage provided herein applies only to proven and currently available services as of the start of the Member's plan year.

PEHP will only be liable for Covered Services for which the Member is liable. Payment will not be made, nor credit given toward Deductibles or out-of-pocket expenses for any expense for which the Member is not legally bound or if Provider otherwise waived any payment due.

6.1 IN-UTAH COVERAGE

PEHP provides access to medical services in the state of Utah and in specified border areas through In-Network Contracted Providers.

In-Network Contracted Providers may not charge the member above the contracted rate, regardless of the amount billed. PEHP members are also entitled to protection from balance billing under federal law for out-of-network Emergency care and other limited situations.

For out-of-network Emergency Services, PEHP shall pay the amount required by law. A Member's cost sharing responsibility shall be limited to the legally required amount that PEHP paid.

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

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.

Under most plans, PEHP pays for Covered Services from out-of-network Providers at a reduced benefit level. Please check your Benefits Summary for details.

Notwithstanding any other statements in this Master Policy or applicable Benefits Summary, PEHP will not cover any amounts billed by non-contracted Providers that PEHP has identified as Non-covered/Excluded Providers either by class under this Master Policy or individually by listing a provider as such on PEHP's Provider Look-up Tool found at www.PEHP.org or in writing upon request.

Other than for care in specified border areas, a member may not seek covered, nonemergency services outside of Utah without pre-authorization.

Nothing in this master policy restricts the ability of a member to receive non-Covered Services and to pay for them outside of this Master Policy

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

Except in specified areas bordering Utah and listed on the PEHP Provider Look-up Tool, PEHP does not contract with Providers or otherwise maintain a network of Providers outside of Utah. Instead, PEHP pays out-of-state Providers a fair rate and directs members to Providers from which a fair rate can most likely be obtained. To the extent possible, PEHP minimizes balance billing for Members.

6.2.1 OUT-OF-STATE EMERGENCY SERVICES

For any out-of-Utah Emergency Services, PEHP shall pay to the Provider in accordance with the law. A Member's cost sharing responsibility shall be limited to the legally required amount that PEHP paid.

6.2.2 OUT-OF-STATE NON-EMERGENCY SERVICES

Members may not seek covered, non-emergency services outside of the state in which they live without preauthorization, nor may they move to another state for the primary purpose of seeking care in that state.

For non-Emergency Covered Services outside of Utah, PEHP directs Members to Providers for fair payment as follows:

1. PEHP lists out-of-Utah physicians and other licensed professionals on the PEHP Provider Look-Up Tool for which a fair rate is most likely to be obtained.
2. PEHP requires Members to receive pre-authorization for out-of-Utah facility services so that PEHP can determine medical appropriateness, the likelihood of the Provider's acceptance of a fair rate, and whether another location may be preferable.
3. PEHP determines the best option for unique care when it is not available within Utah.

4. PEHP determines that the best option for care for a member living out-of-Utah is in Utah.

PEHP makes fair payment to out-of-state providers for non-Emergency services based on:

1. The willingness of a Provider to accept a rate that is also acceptable to PEHP;
2. A multi-factored analysis of what a provider should accept as a fair rate; or
3. The Utah prevailing rate or a variation thereof using a percent of Medicare as a benchmark.

A Member may not be held responsible for any amount above the applicable cost sharing when directed by PEHP to a provider for fair payment.

A Member is not required to use a Provider to which PEHP directs them. In such cases, fair payment will be limited to the Utah Prevailing Rate at the in-network benefit.

6.2.3 OUT-OF-COUNTRY SERVICES

Emergency Services received by a Member outside of the United States will be allowed by PEHP at the lesser of billed charges or the Utah Prevailing Rate, if the Member provides PEHP with a copy of the original foreign claim and provides PEHP with acceptable documentation of the claim. PEHP will reasonably translate the claim into English when possible and convert the charges to United States Currency.

Members may not seek covered, non-Emergency Services outside of the United States without Preauthorization. If a Member travels outside of the United States seeking coverage for any otherwise eligible medical service, medication other than those Preauthorized and approved through the PEHP Pharmacy Tourism Benefit, or Device, it will be deemed as not eligible as well as any complications arising thereof.

6.3 HOSPITAL BENEFITS

See your specific Benefits Summary for applicable Copayment amounts.

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.

6.3.1 INPATIENT HOSPITALIZATION

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

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. Preauthorization required for any procedure that PEHP determines could be safely performed in an office setting. 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. When an eligible Surgical Procedure is performed in conjunction with other ineligible Surgery, benefits will be prorated and only Covered Services will be payable per the In-Network Rate. All procedures must be disclosed for proper adjudication.
3. 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.
4. Inpatient benefits for Mental Health and/or substance abuse require Preauthorization. See Section 6.8 for more information about Mental Health and substance abuse benefits.
5. Human Pasteurized Milk is a covered benefit for Newborn ICU babies whose mother's milk supply is inadequate, and in cases of extreme immaturity.
6. Additional fees charged for a robotic surgical system used during surgery are considered incidental to the base procedure and will not be reimbursed separately.

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 or other therapies for activities of daily living, academic learning, vocational or life skills, developmental delay, unless authorized by PEHP for the treatment of Autism.
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, unless legally required and approved by PEHP.
12. Mastectomy for gynecomastia.
13. Ancillary services performed during an unauthorized or otherwise non-Covered stay or visit.

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. Preauthorization required for any procedure that PEHP determines could be safely performed in an office setting.

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 the In-Network Rate after deductible for the primary procedure and 50% of the In-Network Rate after Deductible if applicable, 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 the In-Network Rate and CPT guidelines for primary and secondary procedures. Only Covered Services will be payable. Provider's Preauthorization must disclose all proposed procedures and implantable Devices to allow for accurate adjudication.
5. Breast Reconstructive Surgery is an Eligible Benefit as allowed under WHCRA. Requires written Preauthorization through Medical Case Management.
6. 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 are not eligible.
7. Additional fees charged for a robotic surgical system used during surgery are considered incidental to the base procedure and will not be reimbursed separately.
8. Dental services, including ancillary procedures, not including bleaching, orthodontia, or the replacement/repair of dental appliances unless a member requires three or more adult teeth to be replaced as a result of the following conditions:
 - a. Accident, but only so long as the need for dental services or treatment was diagnosed, recommended, or received for the injury at the time of the Accident; or
 - b. Congenital absence of teeth (Oligodontia or Anodontia); or
 - c. Tumor, cyst, or similar medical diagnosis (but not dental hygiene, drug use, or dry mouth)Coverage under this section has a lifetime limit of one implant and one crown per missing or severely compromised, adult-size tooth (but no replacement for missing wisdom teeth or baby teeth) in a lifetime. Coverage includes maxillary, mandibular, and/or orthognathic procedures, as well as other ancillary services, such as anesthesia, related to or in preparation for dental implants and crowns as allowed.
9. Fixation implants for Hammertoe surgery (other than K-wires, screws, plates).
10. Panniculectomy must be Preauthorized and is only covered when it meets the criteria requirements listed in the applicable PEHP Clinical Policy.
11. Services, procedures, medications, or Devices received at or from an Out-of-Network birthing center.
12. Gender reassignment Surgery requires preauthorization and may be excluded by Employer Group.

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 and requires Preauthorization.
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. Rhytidectomy.
11. Dental services, except those listed in previous sections.
12. Complications as a result of non-covered or ineligible Surgery, regardless of when the Surgery was performed or whether the original Surgery was covered by a health plan.
13. Injection of collagen, except as approved for urological procedures.
14. Lipectomy, abdominoplasty, or repair of diastasis recti.
15. Sperm banking system, storage, treatment, or other such services.
16. Non-FDA Approved or Experimental or Investigational procedures, medications and Devices.
17. Hair transplants or other treatment for hair loss or restoration.
18. Chemical Peels and Dermabrasion.
19. Treatment for spider or reticular veins.
20. Liposuction.
21. Orthodontic treatment or expansion appliance in conjunction with jaw Surgery.
22. Chin implant, genioplasty or horizontal symphyseal osteotomy.
23. Unbundling or fragmentation of surgical codes.
24. Any Surgery solely for snoring.
25. Otoplasty.
26. Abortions, except if the pregnancy is the result of rape or incest, or if necessary to save the life of the mother.
27. Surgical treatment for sexual dysfunction.
28. Subtalar implants.
29. Mastectomy for gynecomastia.
30. Elective home delivery for childbirth, including any Provider charges if delivered at home.

31. Metatarsal phalangeal joint prosthetics, devices, modular implants, and biologic spacers (other than plates or screws).

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. When an eligible Surgical Procedure is performed in conjunction with other ineligible Surgery, anesthesia benefits will be prorated and only Covered Services will be payable per the In-Network Rate. All procedures must be disclosed for proper adjudication.
3. 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).
4. An epidural block during labor is not payable to the delivering Provider in addition to an anesthesiologist fee.

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, medications, equipment, etc.
5. Manipulation under anesthesia for any body part other than knees, elbows, or shoulders.
6. For Providers who bill for these services separately, General Anesthesia or Monitored Anesthesia Care for standard colonoscopy or standard EGD, if a Member does not have an ASA score of P3 or higher, or a Mallampati score of III or higher.

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. Outpatient and home physical therapy, occupational therapy, and pelvic floor therapy are limited to 20 combined visits per plan year. No Preauthorization required. A maximum of 10 additional physical therapy visits may be approved for a second orthopedic surgery in a plan year and requires Preauthorization. Benefits allow up to three units per visit depending on the Provider's contract terms or if performed by an Out-of-Network Provider, or are based on a per diem rate. See applicable Benefits Summary for plan limits.
2. 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.

3. Covered Services 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 Covered Services.
4. 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.
5. Gamma globulin injections are only eligible for documented immunosuppression with absence of Gamma globulin. Depending on the diagnosis, these medications may be required to be obtained through the Specialty Medication Program. No benefits are payable for prophylactic purposes or other diagnoses.
6. Speech therapy by a qualified speech therapist is payable up to 60 visits per lifetime unless otherwise limited in the benefit summary.

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. 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.
9. 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.
10. Cardiac Rehabilitation, Phase 2, is payable following heart attack, cardiac Surgery, severe angina (chest pain), etc. for up to 24 visits per plan year.
11. Pulmonary Rehabilitation, Phase 2, resulting from chronic pulmonary disease or Surgery is payable for up to 24 visits per plan year.
12. Hepatitis B immunoglobulin is covered if there is a documented exposure or if in conjunction with an eligible liver transplant.
13. Office visits in conjunction with eligible allergy, contraception, hormone, or repetitive therapeutic injections when the only service rendered is the injection are considered inclusive to the injection.
14. Dental services, not including bleaching, orthodontia, or the replacement/repair of dental appliances, are covered only in limited circumstances when pre-authorized by PEHP:
 - a. When the result of an Accident, so long as the need for dental services or treatment was diagnosed, recommended, or received for the injury at the time of the Accident; and
 - b. To treat congenital Oligodontia (absence of 6 or more teeth) or Anodontia (absence of all teeth) and limited as follows:
 - i. Maxillary, mandibular and/or orthognathic procedures, including anesthesia, only when medically necessary to prepare for dental implants; and
 - ii. One implant and one crown per congenitally missing or severely compromised, adult-size tooth (but no replacement for missing wisdom teeth or baby teeth) in a lifetime.
15. Vitamins are only covered in the following limited circumstances and only if medically necessary:
 - a. Vitamins listed as preventive services under the Affordable Care Act (Preventive Services under Section 6.14).
 - b. Vitamin K only when administered at birth or when used as an antidote to Warfarin.
 - c. Injectable vitamin B-6 when received for alcohol withdrawal and administered in a hospital.
 - d. Injectable vitamin B-12 for the treatment of pernicious anemia.
 - e. Injectable B-12 for rare conditions (e.g. post gastrectomy, reverse neurological effects of a deficiency, etc.) as solely determined by PEHP, and only after failure of oral regimens. Coverage of vitamin B12 injections is excluded for fatigue, low energy or similar indications.
 - f. Multivitamins when received in total parenteral nutrition and the member is unable to take food or other

supplements by mouth.

i. Prenatal vitamins when associated with pregnancy and listed in the Preferred Drug List.

16. Vision therapy is limited to 12 visits per lifetime.

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 otherwise indicated in this Policy or 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. Dental services except those listed in previous section.
5. Charges in conjunction with ineligible procedures, including pre- or post-operative evaluations.
6. Acupuncture treatment unless specifically covered as indicated in your Benefits Summary.
7. Chiropractic, physical, or occupational therapy primarily for maintenance care unless allowed as stated in your Benefits Summary.
8. Occupational therapy or other therapies for activities of daily living, academic learning, vocational or life skills, driver's evaluation or training, developmental delay and Recreational Therapy, unless authorized by PEHP for the treatment of Autism.
9. Speech therapy for educational purposes or delayed development, or speech therapy that does not qualify within the criteria as determined solely by PEHP.
10. Functional or work capacity evaluations, impairment ratings, work hardening programs or back school.
11. Hypnotherapy or biofeedback.
12. Hair transplants or other treatment for hair loss or restoration.
13. Study models, panorex, eruption buttons, orthodontics, occlusal adjustments or equilibration, crowns, photos, and mandibular kinesiograph are some, but not necessarily all, in Covered Services for the treatment of TMJ/TMD or myofascial pain.
14. Screening for developmental delay or child developmental programs.
15. Rolfing or massage therapy.
16. Training and testing in conjunction with Durable Medical Equipment or prosthetics.
17. 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).
18. Reports, evaluations, examinations not required for health reasons, such as employment or insurance examinations, or for legal purposes such as custodial rights, paternity suits, etc.
19. 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 Covered Services.
20. Cardiac Rehabilitation, Phases 3 and 4.
21. Pulmonary Rehabilitation, Phase 3.
22. Fitness programs.
23. 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.
24. Childbirth education classes.

25. Topical hyperbaric oxygen treatment.
26. Any services performed by or referred by a non-covered Provider.
27. Administration fees for non-eligible injections or infusions.
28. Speech therapy received by Members under age 2.

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. Qualifying adult members age 18 and up may receive one facility-based sleep study for obstructive sleep apnea in a hospital in a three-year period, Pre-authorization required. Additional attended sleep studies for adults must be performed at an office or an office-based clinic, but not a hospital or clinic whose allowed amount is based off a percentage of billed.
2. Lab and x-rays are only eligible for diagnosing or treating symptomatic illness and must be specific to the potential diagnosis.
3. 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.
4. Preauthorization is required for Genetic Testing or Molecular Diagnostics related to screening or evaluating a Member for a condition. In order to be covered, at a minimum, Molecular Diagnostic or Genetic Testing must be used to diagnose or evaluate a course of treatment for the Member, and not solely for family planning or screening. PEHP may require that these services be obtained from a designated lab, vendor, facility or location for Coverage.
5. Drug screening, up to 2 times in a 30-day period.
6. Drug confirmatory laboratory tests, up to 2 codes in a 30-day period.
7. Vitamin Assay Panels are covered at 50% except for the following vitamins which will be covered at regular benefits; a. Vitamin D, Vitamin B12, Folic Acid, Vitamin B-1, Vitamin B-6, Vitamin A.

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 and done for a medical purpose, as determined by PEHP, or unless otherwise allowed by the Master Policy.
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.

10. Drug screening in conjunction with PEHP authorized treatment are considered inclusive to the treatment and are not payable separately.
11. Whole exome and whole genome sequencing for the diagnosis of genetic disorders, unless pre-authorized by PEHP at a children's undiagnosed clinic.
12. Chromosomal Microarray Analysis (CMA) for Autism Spectrum Disorder.
13. Any genetic tests from direct-to-consumer labs or confirmatory tests resulting from such result.

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.)

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.

6.8.1 FACILITY AND HOSPITAL SERVICES

Medically Necessary services from In-Network 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 programs require Preauthorization. If approved, Benefit applied is the same as in-patient.

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 Preauthorization.

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 medications 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. 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.
3. Only one visit per Provider of the same specialty per day is payable.
4. Drug screening, up to 2 times in a 30-day period.
5. Drug confirmatory laboratory tests, up to 2 codes in a 30-day period.
6. If allowed by the Employer Group, residential treatment services are limited to 60 days per plan year and

require Preauthorization.

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 Preauthorization, 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. Tobacco abuse.
11. Routine drug screening, except when ordered by a treating physician and done for a medical purpose, as determined by PEHP, or unless otherwise allowed by the Master Policy.
12. Drug screening in conjunction with PEHP authorized treatment are considered inclusive to the treatment and are not payable separately.
13. Ancillary services performed during an unauthorized or otherwise non-Covered stay or visit.

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.
3. Non-Emergency Mental Health transportation is eligible at In-Network rates to the nearest facility where the appropriate level of care or type of treatment needed is available.
4. All facility-to-facility transfers are subject to review by PEHP.
5. A determination of what conditions constitute an emergency will be solely determined by PEHP.
6. Air or water ambulance charges will be payable to the nearest facility able to treat the Member if the emergency is considered Life-threatening by PEHP.
7. Ground transportation to a Member's home, only if the transfer is to facilitate the Member's end-of-life care or hospice services, must be Preauthorized by PEHP.

If emergency is considered to be non-Life-threatening by PEHP, otherwise eligible air or water 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. Home health services require Preauthorization.

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 Preauthorization and must be obtained through the pharmacy card.
2. A home visit by a Licensed Clinical Social Worker is payable from outpatient Mental Health benefits, if applicable. See Benefits Summary for details.
3. Skilled Nursing visits 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.
9. Skilled Nursing visits for administration of non-covered medications or related to other non-Covered Services under the plan.

6.11 ADOPTION BENEFITS

Adoption benefits 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 90 days old 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 domestic partners 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.
4. Legal or agency fees unless otherwise stated in applicable Benefits Summary.

6.12 PRESCRIPTION AND SPECIALTY MEDICATION 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 Medication benefit is categorized by the following tiers:

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

PEHP may change the tier placement to a higher tier (e.g. Tier 2 to Tier 3) of select drugs on January 1 and July 1 each year and may change tier placement to a lower tier (e.g. Tier 2 to Tier 1) at any time, and may change tier placement to a lower tier (e.g. Tier 2 to Tier 1) at any time.

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

6.12.1 COVERED FORMULARY MEDICATIONS

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 Medications.
5. Select prescription pre-natal vitamins.
6. Select birth control pills.
7. Select prescription creams and ointments.
8. Select asthma medications.
9. Select cholesterol and blood pressure medications.
10. Select antidepressants.
11. Select anticonvulsants.

6.12.2 PREAUTHORIZATION FOR PRESCRIPTION AND SPECIALTY MEDICATIONS

If this benefit is carved out by your employer, the benefits listed in this section will not apply.

PEHP has chosen specific prescription medications, Specialty medications and injectables to require Preauthorization. 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 Preauthorization.

To obtain Preauthorization, a Member's physician may obtain a Preauthorization form at www.PEHP.org or may contact PEHP's Customer Service to start the Preauthorization process. The Provider will be directed to PEHP's pharmacy Preauthorization 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. Preauthorization does not guarantee payment. Coverage is subject to eligibility, benefit Coverage and

Preauthorization requirements.

6.12.3 QUANTITY LEVELS AND STEP THERAPY

Medications may have specific limits on how much of the medication 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 medication manufacturer, duration of therapy, FDA, and the cost of the medication. Members must obtain Preauthorization for any quantity that exceeds a PEHP quantity level limit. PEHP may require an additional Copayment if Preauthorization is granted. Go to www.PEHP.org for a complete list of medications that require a quantity level.

For some disease states and some medication categories, one or more medications must be tried before a medication 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, 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, Preauthorization 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 medication 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 Preauthorization 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 MEDICATIONS

Specialty and injectable medications 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 Medications 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. Preauthorization 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.

6.12.7 LIMITATIONS RELATING TO PRESCRIPTION MEDICATION BENEFITS

The following are Limitations of the policy:

1. Medication quantities, dosage levels and length of therapy may be limited to the recommendations of the medication 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 medication may be restricted from Coverage.
5. PEHP may classify an FDA-approved 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 non-specialty 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. If the day supply for a specialty medication exceeds 30 days, the Member's out-of-pocket responsibility may require a Copayment for each 30-day supply of the anticipated duration of the medication.
11. Cash paid and Coordination of Benefits claims will be subject to PEHP's Preauthorization, step therapy, benefit Coverage and quantity levels. PEHP will reimburse up to the Contracted rate and PEHP's benefit rules.
12. 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 medication 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 medications in excess of what is Medically Necessary.
13. Fluoride tablets are limited to children up to the age of 12 years old.
14. Enteral formula requires Preauthorization 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. 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.
17. Compounding fees or materials require Preauthorization and are only covered if one or more of the

following conditions are met:

- a. There is not a commercially available dosage form to meet the member need.
- b. The requested product is covered by PEHP, FDA approved, and recommended for the condition.
- c. The member is unable to use alternate routes of administration.
- d. Commercially available dosage forms cannot be reasonably altered to meet the member need.
- e. The member has a condition that will result in significant morbidity if left untreated by the compounded product.

Whether these conditions are met is at the sole discretion of PEHP.

18. Vitamins are only covered in the following limited circumstances and only if medically necessary:
 - a. Vitamins listed as preventive services under the Affordable Care Act (Preventive Services under Section 6.14).
 - b. Vitamin K only when administered at birth or when used as an antidote to Warfarin.
 - c. Injectable vitamin B-6 when received for alcohol withdrawal and administered in a hospital.
 - d. Injectable vitamin B-12 for the treatment of pernicious anemia.
 - e. Injectable B-12 for rare conditions (e.g. post gastrectomy, reverse neurological effects of a deficiency, etc.) as solely determined by PEHP, and only after failure of oral regimens. Coverage of vitamin B12 injections is excluded for fatigue, low energy or similar indications.
 - f. Multivitamins when received in total parenteral nutrition and the member is unable to take food or other supplements by mouth.
 - i. Prenatal vitamins when associated with pregnancy and listed in the Preferred Drug List.

6.12.8 90-DAY SUPPLY

Members may obtain a 90 day supply of maintenance medication at a participating retail pharmacy or through the Express Scripts mail order facility. Maintenance medications as defined by PEHP are the only medications available through PEHP's 90 day program.

» Examples of maintenance medications available through the 90 day program include:

- › Diabetes medications
- › Anticonvulsants
- › Blood pressure medications
- › Asthma medications
- › Antidepressants

» Examples of medications not available through the 90 day program

- › Antibiotics
- › Anti-anxiety
- › Anti-migraine
- › Injectables
- › Pain medications
- › Muscle relaxants

Participating retail pharmacies and the Express Scripts mail order facility may contact Providers to see if a generic medication may be substituted for a brand name prescription.

Members should reserve the 90 day program for medications used for a chronic disease. To ensure that a medication will work for our Members, PEHP recommends that first time prescriptions be filled for a 30 day supply to ensure that there are no adverse effects or Complications.

To use the Express Scripts mail order facility, Members should ensure that their medication is eligible for a 90 day supply and that all Preauthorization 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. The Express Scripts mail order pharmacy 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.

To fill a 90 day supply at a participating retail pharmacy, Members should ensure that their medication is eligible for 90 days and that all Preauthorization requirements have been met. Members should obtain a 90 day prescription from their physician and present it to a pharmacy participating in 90 day dispensing.

If filled through the 90 day program at a participating retail pharmacy or through the Express Scripts mail-order facility, the prescription may be delayed to verify the strength, dosage, or directions with the prescribing physician. Members should also avoid ordering a refill before 75% of their prescription is gone. The mail-order facility or retail pharmacy will view the order as too early to fill.

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 medication plus a generic Copayment when the brand name medication is dispensed instead of a substitutable generic medication. If your benefit plan has a Deductible, the cost difference between a brand-name medication and a generic equivalent does not apply to meeting your Deductible.

6.12.10 EXCLUSIONS FROM COVERAGE RELATING TO PRESCRIPTION MEDICATION 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 Medication List or website.
2. Vitamin B-12 for fatigue, low energy, or similar indications.
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 medication research or medication study.
8. FDA-approved medication for Experimental or Investigational indications.
9. Non-approved indications determined by PEHP.
10. Medications for athletic and mental performance.
11. New medications released by the FDA until they are reviewed for efficacy, safety and cost-effectiveness by PEHP. Upon such review, PEHP may designate the new medication as non-covered.
12. Oral infant and medical formulas.
13. Therapeutic Devices or appliances unless listed in PEHP's Preferred Medication List.
14. Diagnostic agents.
15. Over-the-counter medications and products unless listed in PEHP's Preferred Medication List or covered under the Affordable Care Act (Preventive Services under Section 6.14) and processed by the pharmacy at the time of service with a valid prescription.
16. Take-home prescriptions from a Hospital or Skilled Nursing Facility, unless legally required and approved

by PEHP.

17. Biological serum, blood, or blood plasma.
18. Medications and injectables prescribed due to an Industrial Injury.
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. Medications used for Cosmetic indications.
21. Replacement of lost, stolen or damaged medications.
22. Nasal immunizations unless listed in the PEHP Preferred Medication List.
23. Medications for abortions except if the pregnancy is the result of rape or incest, or if necessary to save the life of the mother.
24. Medications to treat nail fungus.
25. Medications needed to treat Complications associated with Elective bariatric Surgery or other non-Covered Services.
26. Hypodermic needles.
27. Oral and nasal antihistamines for allergies, including but not limited to: Azelastine, Dymista, and Astepro.
28. Medications obtained outside the United States that are not for Urgent or emergency use, unless approved through the PEHP Pharmacy Tourism Benefit.
29. Medications used for sexual dysfunction or enhancement, including but not limited to: Cialis, Sildenafil, and Viagra.
30. Medications for assisted reproductive technology.
31. An additional medication that may be considered duplicate therapy defined by the FDA or PEHP.
32. Specific medications not listed on the PEHP website, including but not limited to: Adoxa, ammonium lactate, Amrix, Avidoxy DK, Avita, Belsomra, Cialis, DMSO (Dimethylsulfoxide), Doryx, Doxal, Dynacin, Doxycycline monohydrate, Emflaza, Eucrisa, Exondys 51, Fetzima, Fortamet, Glumetza, Invokana, Jublia, Keveyis, Northera, Oracea, Oraxyl, Procusbi, Relizorb, Riomet, Solodyn, Symbyax, Sarafem, Tresiba, Trokendi XR, Trintellix, Victoza, Viibryd, Vraylar, Xiaflex (if prescribed to treat Peyronie's Disease), Xiidra, Xultophy, Zegerid (and its generic). For a complete list of covered medications, refer to the PEHP website.
33. Medications purchased from non-participating Providers online.
34. Minerals, food supplements, homeopathic medicines, and nutritional supplements (Prenatal vitamins and folic acid will be covered for pregnancy).
35. Medications prescribed by non-covered Provider types or non-payable Providers.
36. PEHP non-covered supplies.

6.13 DURABLE MEDICAL EQUIPMENT/SUPPLY BENEFITS

See applicable Benefits Summary for specific Copayments.

For a complete list of Durable Medical Equipment that requires Preauthorizations, please visit pehp.org or call 801-366-7555.

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.

For items that require rental prior to 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 purchase for the treatment of sleep disorders is payable at plan benefits, one machine in a five-year period. All related supplies are limited to \$325 per plan year.
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 limbs, when made necessary by loss from an injury, illness, or congenitally missing limbs, must be Pre-authorized. If approved, the maximum prosthetic benefit available is one in a five-year period. Breast prosthetics require Preauthorization. If approved, the maximum breast prosthetic benefit available is one per affected breast in a two-year period.
7. Wheelchairs require Preauthorization through Medical Case Management and are limited to one power wheelchair in any five-year period.
8. Knee braces are limited to one custom and one off the shelf per knee in a 3-year period.
9. Oxygen Concentrators are allowed once in a 5-year period. PEHP will pay a monthly rental fee for a maximum of 36 months, regardless of the number of providers used. Contracted providers agree to 36 monthly rental payments as payment in full in a 5-year period.
10. Hearing aids for congenital hearing loss, or direct physical trauma, malignancy or infection affecting the middle or inner ear, including any associated visits, are payable up to a maximum \$1,500 per ear in a five-year period and require Preauthorization. See applicable Benefits Summary for additional plan limits or benefits.
11. Speech Generating Devices require Pre-Authorization.

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.

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. TENS Unit.
7. Neuromuscular Stimulator.
8. H-wave Electronic Device.
9. Sympathetic Therapy Stimulator (STS).
10. Only conventional, body powered, cable-operated prosthetics or non-electrical conventional braces 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.

11. Functional neuromuscular electrical stimulation Devices.
12. Replacement of lost, stolen, or damaged equipment or supplies.
13. Intermittent limb compression device after surgery, unless the patient is unable to tolerate taking medication for preventing blood clots.
14. Microprocessor or computer controlled braces and limbs.

6.14 PREVENTIVE SERVICES

Under the Affordable Care Act, PEHP offers the following preventive services covered at no cost to you when received from an In-Network Provider. This list of preventive services is designed to comply with the Affordable Care Act. Notwithstanding this list of preventive services, PEHP reserves the right to modify these benefits at any time without notice, in accordance with federal law.

If these services are received from an out-of-network Provider they will be allowed up to the In-Network Rate and paid by PEHP at the In-Network Rate specified for out-of-network Providers by the Member's applicable Benefit Summary, if the Member's plan allows the use of out-of-network Providers. If the Member's plan does not allow the use of out-of-network 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, in accordance with federal law; 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, which typically includes the following screenings:
 - › Blood Pressure screening;
 - › Alcohol Misuse screening and counseling;
 - › Depression screening for adults;
 - › 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;
 - › 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.
- » In addition to a preventive physical exam, the following preventive laboratory tests, procedures, and immunizations are also allowed once per plan year or as otherwise stated:
 - › Abdominal Aortic Aneurysm one-time screening for men aged 65-75 who have ever smoked.
 - › Basic/Comprehensive metabolic panel
 - › Cholesterol screening for adults of certain ages or at higher risk.

- › Colorectal Cancer screening for adults ages 45 to 75 (or prior to May 17, 2021, ages 50 to 75) using fecal occult blood testing, sigmoidoscopy, or colonoscopy. Cologuard, once every three years. (If Cologuard test is positive, follow-up colonoscopy will be covered at regular benefits.)

Note: For Providers who bill for these services separately, General Anesthesia, or MAC, must be Medically Necessary and requires Preauthorization through PEHP.

- › Complete blood count
- › Falls prevention: older adults – exercise interventions to prevent falls in a community-dwelling adults 65 years or older who are at increased risk of falls
- › Hepatitis C screening for all adults or persons at high risk.
- › HIV screening for all adolescents, adults, and all pregnant persons at higher risk.
- › Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
 - ›› Hepatitis A
 - ›› Hepatitis B
 - ›› 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)
 - ›› Shingles (Herpes Zoster)
 - › Shingrix age 50 and above
 - › Zostavax age 50 and above
 - ›› Tetanus, Diphtheria, Pertussis (Td or Tdap)
 - ›› Varicella (Chickenpox)

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

- › Lung cancer screening with Low-Dose Computed Tomography (LDCT) in adults age 50 to 80 who have a 30 pack per year smoking history and currently smoke or have quit within the past 15 years..
- ›› In addition, the following preventive medications are allowed when prescribed by a physician and obtained through the pharmacy:
 - › Aspirin use for men ages 45-79 and women ages 55-79.
 - › Aspirin, low-dose, for the primary prevention of cardiovascular disease (CVD) and colorectal cancer in adults age 50-59 years who have a 10% or greater 10-year CVD risk, and are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.
 - › PrEP-Preexposure Prophylaxis for all persons at high risk for HIV.
 - › Statin prevention medication for ages 40-75.
 - › Tobacco cessation interventions for tobacco users, up to the maximum approved dose and duration limits per plan year.

6.14.2 COVERED PREVENTIVE SERVICES SPECIFICALLY FOR WOMEN, INCLUDING PREGNANT WOMEN

- ›› In addition to the annual preventive physical exam for all adults listed in section 6.14.1 above, one well-woman exam is allowed per plan year to obtain recommended preventive services, which typically includes the following screenings:
 - › Domestic and interpersonal violence screening and counseling for all women;

- › Tobacco Use screening for all women and expanded counseling for pregnant tobacco users;
- › Sexually Transmitted Infections (STI) counseling for sexually active women.

Note: *Additional preventive well woman exams in the plan year will be reviewed and must be recommended by the Provider.*

- » In addition to a preventive physical exam and/or well-woman exam, the following preventive laboratory tests, procedures, and devices are also allowed one time per plan year, per pregnancy, or as otherwise stated:
 - › Anemia screening on a routine basis for pregnant women.
 - › Bacteriuria urinary tract or other infection screening for pregnant women, as needed.
 - › Bone density (DEXA) scanning for women age 60 and older.
 - › BRCA counseling about genetic testing for women at higher risk.
 - › BRCA testing for women at higher risk, requires Preauthorization from PEHP, one time per lifetime.
 - › Breast Cancer Mammography screenings one time per plan year for women age 40 and above.
 - › 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 during pregnancy or 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) every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).
 - › Chlamydia Infection screening for younger women and other women at higher risk.
 - › Contraception: FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient medications.
 - » Covered services/Devices include: One IUD every two years (including removal), generic oral contraceptives, NuvaRing, Ortho Evra, diaphragms, cervical caps, emergency contraceptives (Ella, and generics only), injections, hormonal implants (including removal), Essure, and tubal ligation.
 - › 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 (bone density) screening for women over age 60 depending on risk factors.
 - › Preeclampsia screening – for pregnant women with blood pressure measurements throughout pregnancy.
 - › Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
 - › Syphilis screening for all pregnant women or other women at increased risk.
- » In addition, the following preventive medications are allowed when prescribed by a physician and obtained through the pharmacy:
 - › Breast Cancer chemoprevention medications for women at higher risk. Tamoxifen or Raloxifene.
 - › Folic Acid supplements for women who may become pregnant..

6.14.3 COVERED PREVENTIVE SERVICES FOR CHILDREN

- » Preventive physical exam visits throughout childhood are allowed as recommended by the American Academy of Pediatrics which typically include the following screenings:
 - › 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;
 - › Alcohol and Drug Use assessments for adolescents;
 - › Autism screening for children at 18 and 24 months;
 - › Depression screening for adolescents;
 - › Height, Weight and Body Mass Index measurements for children;
 - › Obesity screening and counseling;
 - › Skin cancer behavioral counseling – young adults, adolescents, children, and parents of young children about minimizing exposure to UV radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer;
 - › Vision acuity screening for all children one time between age 3 and 5.
 - › Recommendations for children and adolescents:
 1. Newborn blood;
 2. Newborn Bilirubin;
 3. Critical congenital heart defect;
 4. Anemia
 5. Cervical dysplasia; and
 6. Developmental and behavioral screenings
- » In addition to a preventive physical exam, the following preventive laboratory tests, procedures, and immunizations are allowed once per plan year or as otherwise stated:
 - › Congenital Hypothyroidism screening for newborns.
 - › Dyslipidemia screening for children at higher risk of lipid disorders.
 - › Fluoride varnish application by a medical professional.
 - › Gonorrhea preventive medication for the eyes of all newborns.
 - › Hearing screening for all newborns, birth to 90 days old.
 - › 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/.

- › Phenylketonuria (PKU) screening for this genetic disorder in newborns.
- › Tuberculin testing for children at higher risk of tuberculosis.
- » In addition, the following preventive medications are allowed when prescribed by a physician and obtained through the pharmacy:
 - › Fluoride Chemoprevention supplements for children without fluoride in their water source, when obtained through the pharmacy.
 - › Iron supplements for children ages 6 to 12 months at risk for anemia.

6.14.4 ADDITIONAL COVERAGE WHEN ENROLLED ON THE STAR PLAN

The following services may be covered as preventive under the STAR HSA Plan. See applicable Benefits Summary for Coverage information.

- » Adults:
 - › Eye exam, routine. One per plan year;
 - › Glaucoma screening;
 - › Glucose test;
 - › Hearing exam;
 - › Hypothyroidism screening;
 - › Phenylketones test;
 - › Prostate cancer screening;
 - › PSA (prostate specific antigen) screening;
 - › Refraction exams;
 - › Blood typing for pregnant women;
 - › Rubella screening for all women of child bearing age at their first clinical encounter.
- » Children:
 - › Eye exam, routine. One per plan year;
 - › Glaucoma screening;
 - › Hearing exam;
 - › Hypothyroidism screening;
 - › Refraction exams.

6.14.5 PERSONALIZED HEALTH PROGRAMS

PEHP offers Personalized Health Programs to help address unique health needs based on specific PEHP Pre-authorization criteria and requires a supplemental Member agreement to the terms of participation. PEHP reserves the right to establish eligibility, benefit limits, Member Copayments, and other aspects of

any Personalized Health Program and the conditions for participation in these Programs. Information about these programs is available by calling PEHP Customer Service.

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 program 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. Additionally, PEHP Members living out-of-state may only take advantage of the National Access Program if they receive Covered Services in the State in which they reside, except for hidden Providers used by In-Network Providers for Covered Services and online In-Network eligible medical equipment unless otherwise authorized in writing by PEHP;
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 who require medical services that are not available in Utah and that have been Pre-authorized by PEHP.

VII. General Limitations and Exclusions

7.1 PREAUTHORIZATION LIMITATIONS

Certain medical services require Preauthorization by PEHP before being eligible for payment. While many Providers will Preauthorize on your behalf, it is your responsibility to ensure that PEHP has received notice and/or granted approval for any service requiring Preauthorization prior to the services being received. If you do not Preauthorize services that require such approval, benefits may be reduced or denied by PEHP. Unless otherwise stated, Preauthorizations are valid for the date span specified on the authorization form, even if treatment has not been completed.

The following services require Preauthorization by calling PEHP:

- » Inpatient Hospital Medical admissions at Primary Children's Medical Center, or at any Hospital when the stay is longer than six days
- » All inpatient Hospital Rehabilitation admissions, subject to 45 days maximum per plan year
- » Skilled Nursing Facilities
- » All inpatient Mental Health and Substance Abuse admissions
- » All inpatient Out-of-Network, Rehabilitation (subject to 45 days maximum per plan year), Skilled Nursing, Mental Health, and Substance Abuse admissions

To receive maximum benefits, a Member must call for Preauthorization 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.

Out-of-Area Hospital Admission

Requires Preauthorization 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.

The following service requires verbal Preauthorization by calling PEHP:

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

For a complete list of services that require Preauthorization, please visit pehp.org or call 801-366-7555.

7.2 MAXIMUM OUT-OF-POCKET BENEFITS

PEHP has set limits for maximum out-of-pocket expenses for Members. After the Member's share of eligible expenses exceeds specified amounts, PEHP will pay further Covered Services incurred during the remaining plan year at 100% of the In-Network Rate. 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. Any service or amount established as ineligible under this policy or considered inappropriate medical care;
2. Charges in excess of the In-Network Rate or contract Limitations.

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 In-Network Rate.
2. All charges as a result of an Industrial Claim (on-the-job) injury or illness, regardless of whether the claim is determined compensable or settled with a worker's compensation carrier. Whether charges are the result of an Industrial Claim is solely determined by PEHP.
3. PEHP will only be liable for Covered Services for which the Member is liable. Payment will not be made, nor credit given toward Deductibles or out-of-pocket expenses for any expense for which the Member is not legally bound.
4. Charges for educational material or literature.
5. 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).
6. Charges for scholastic education, vocational training, learning disabilities, or behavior modification.
7. Charges for medical care rendered by an Immediate Family Member.
8. Charges prior to Coverage or after termination of Coverage even if illness or injury occurred while a Member.
9. Provider's telephone calls or travel time, unless specifically covered by Employer group as indicated in the Benefits Summary.
10. Charges for services primarily for convenience, contentment, or other non-therapeutic purpose.
11. Overutilization of medical benefits as determined by PEHP.
12. 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.
13. Charges for Unproven medical practices or care, treatment, Devices or medications that are Experimental or Investigational in nature or generally considered Experimental or Investigational by the medical profession as

determined solely by PEHP.

14. Charges for services without adequate diagnosis or dates of service.
15. 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.
16. Charges for services as a result of an auto related injury and covered under No-fault insurance. If a Member fails to maintain No-fault insurance on his/ her own vehicle as required by law in the state they reside in, the minimum dollar amount they are required to maintain (\$3,000 in Utah) for claims related to the auto injury are also excluded from Coverage.
17. 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.
18. Services, drugs, or supplies received which were caused by a Member's active participation as a result of an insurrection, terrorism, war or an act of war, whether declared or undeclared, or due to injur or illness incurred in the armed services of any country.
19. Any service or supply not specifically identified as a benefit.
20. Unless preauthorized through the PEHP Pharmacy Tourism Benefit, charges for commercial or private aviation services, meals, accommodations and car rental.
21. Charges for mileage reimbursement except for eligible ambulance service.
22. Charges by a Provider for case management.
23. Charges for independent medical evaluations and/or testing for the purpose of legal defenses or disputes.
24. Charges for submission of Medical Records necessary for claims review.
25. Delivery, shipping, handling, sales tax, or finance charges.
26. PEHP is not responsible to pay any benefits given verbally or assumed except as written in a Preauthorization, documented by Customer Service or Medical Case Management, or as described in this policy.
27. Prescriptive services provided by the Internet or catalog.
28. Use of medication samples will not be considered by PEHP when determining eligibility for coverage under step-therapy requirements or prior pre-authorization.
29. Autopsy procedures.
30. Complications as a result of any non-covered service, procedure, Devices, or medication, regardless of when the Surgery was performed or whether the original Surgery was covered by a health plan.
31. Treatment of obesity by means of Surgery, medical services, or prescription medications, regardless of associated medical, emotional, or psychological condition.
32. Unless an injury or illness was the result of a previous medical condition, services incurred 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 received 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, medications, or Devices, including any complications thereof, unless specifically covered by Employer group as indicated in the Benefits Summary.

38. Medical services, procedures, supplies, Devices, or medications used to treat secondary conditions or Complications due to any non-covered medical services, procedures, supplies or medications 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 medications 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. MTHFR testing.
41. All vitamins, oral or injected, and/or the associated administration, not listed as eligible elsewhere in this Master Policy.
42. Minerals, food supplements, homeopathic medicines, and nutritional supplements (Prenatal vitamins and folic acid will be covered for pregnancy).
43. Powders, and non-covered medications used in compounded preparations.
44. Functional neuromuscular electrical stimulation Devices.
45. Whole exome and whole genome sequencing for the diagnosis of genetic disorders, unless pre-authorized by PEHP at a children's undiagnosed clinic.
46. Out-of-Network chiropractic services, unless specifically stated as covered in your Benefit Summary.
47. Trigger point injections done by an Out-of-Network Provider.
48. Court-ordered drug screening or confirmatory drug testing.
49. Genetic tests performed on tumors:
 - a. Solid Tumor Mutation Panels/ Comprehensive Tumor Sequence Analysis;
 - b. Myeloid Malignancies Mutation Panel (includes blood sample for hematologic tumors); or Genetic tests performed on blood sample ("Liquid" biopsy).
50. Surrogate pregnancy or Gestational Carrier expenses.
51. Microprocessor-controlled prosthetic limbs, except for those plans which offer coverage, requires Preauthorization. Please refer to your Employer to inquire if Coverage is offered.
52. Charges related to obtaining or caring for a service animal.
53. Radiofrequency for the Sacroiliac (SI) joint.
54. Charges in conjunction with or related to ineligible procedures, medications, or devices.
55. Surgical or medical treatment of Peyronie's Disease.
56. Micro-processor controlled braces.
57. Occipital nerve block for cervicogenic headache, occipital neuralgia, cluster headaches, chronic daily headache, and migraines.
58. Replacement of equipment, supplies, devices, Durable Medical Equipment, medications, or accessories that are lost, stolen or damaged.

59. Coverage is excluded for services outside the State of Utah when a member is traveling for the purpose of seeking medical care or treatment.
60. Excision of frenum, labial or buccal.
61. Medical CPT or HCPC codes billed by a General Dentist, except for custom molded oral sleep apnea devices.
62. Hypoglossal Nerve Neurostimulation.
63. Genicular Nerve Blocks.
64. Cryoneurolysis, including but not limited to the Iovera systems.
65. Except for routine patient care costs, services, drugs or devices received as part of a clinical trial, including any services used to evaluate the performance of a clinical trial.
66. Dry needling.
67. Chemical neurolysis for Morton's Neuroma and Plantar Fasciitis.
68. Ear popping devices.
69. Endoscopic balloon dilation of the Eustachian tube.
70. Prenatal genetic testing to determine fetal sex.
71. Intracept procedure.
72. Removal of excess skin on extremities, trunk, face or neck.
73. Rejuvenation of female genitalia.
74. PET for neurological disorders.
75. Pharmacogenetic tests for Major Depressive Order.
76. Charges that are a result of medical malpractice as reasonably determined by PEHP.
77. Services associated with newly released billing codes (e.g. CPT, HCPC, J, T, U, etc.) are not covered until they are reviewed for efficacy, safety, and cost-effectiveness by PEHP. Upon such review, PEHP may designate the new code or service as non-covered.
79. Radiofrequency neurolysis of the thoracic joints.

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 Covered Services 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 Covered Services 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 injury 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 Covered Services 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 Covered Services 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.

At the time of PEHP discovery of a possible Subrogation case, PEHP will send a Third Party Liability questionnaire to the Subscriber advising response is required within 30 days and that claims related to the incident will be held until the questionnaire is received. If not received within 12 months of the request, no payment will be made for the claims related to the incident. If received later than 90 days but less than 12 months from the request, payment will only be made for claims received in the 12 months prior to receipt of the information.

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, failure to keep PEHP up to date regarding any legal action or settlement with a responsible party, settling a claim with a responsible party without PEHP's involvement, or otherwise takes action that impairs PEHP's ability to recover amounts paid, PEHP reserves the right to withhold payment for any claims, and 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 Covered Services. 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 Covered Services.

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, 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 In-Network Rate 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 an In-Network Provider is used, the Provider will submit the claims directly to PEHP. Payment will be made directly to the In-Network Provider. It is the In-Network Provider's responsibility to ensure the claim is received by PEHP within 12 months from the date of service when PEHP is the primary payer, and 15 months from the date of service when PEHP is the secondary or further payer. Claims denied for untimely filing are not the Member's responsibility, with the following exception:

a. When the Member provides inaccurate or incomplete information regarding Medical Plan Coverage to the Provider.

In the event that Covered Services are received from a covered Out-of-Network Provider who holds no contract with PEHP, payment will be sent to the Member regardless of the assignment of benefits.

When an out-of-network 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.

PEHP will only be liable for Covered Services for which the Member is liable. Payment will not be made, nor credit given toward Deductibles or out-of-pocket expenses for any expense for which the Member is not legally bound

8.1.1 REQUIRED INFORMATION FOR CLAIMS SUBMISSION

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

Claims from In-Network Providers must be submitted electronically. Out-of-Network Providers may submit electronically, or mail 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 receipt of PEHP's adverse benefit 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 the following address:

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.

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 four months 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. 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).

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.

Notice of Privacy Practices for Protected Health Information

effective January 7, 2020

Public Employees Health Program (PEHP) our business associates and our affiliated companies respect your privacy and the confidentiality of your personal information. In order to safeguard your privacy, we have adopted the following privacy principles and information practices. PEHP is required by law to maintain the privacy of your protected health information, and to provide you with this notice which describes PEHP's legal duties and privacy practices. Our practices apply to current and former members.

It is the policy of PEHP to treat all member information with the utmost discretion and confidentiality, and to prohibit improper release in accordance with the confidentiality requirements of state and federal laws and regulations.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Types of Personal Information PEHP collects

PEHP collects a variety of personal information to administer a member's health, coverage. Some of the information members provide on enrollment forms, surveys, and correspondence includes: address, Social Security number, and dependent information. PEHP also receives personal information (such as eligibility and claims information) through transactions with our affiliates, members, employers, other insurers, and health care providers. This information is retained after a member's coverage ends. PEHP limits the collection of personal information to that which is necessary to administer our business, provide quality service, and meet regulatory requirements.

Disclosure of your protected health information within PEHP is on a need-to-know basis. All employees are required to sign a confidentiality agreement as a condition of employment, whereby they agree not to request, use, or disclose the protected health information of PEHP members unless necessary to perform their job.

Understanding Your Health Record / Information

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided.

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy,
- Better understand who, what, when, where, and why others may access your health information,
- Make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that

compiled it, the information belongs to you. You have the rights as outlined in Title 45 of the Code of Federal Regulations, Parts 160 & 164:

- Request a restriction on certain uses and disclosures of your information, though PEHP is not required to agree with your requested restriction.
- Obtain a paper copy of the notice of information practices upon request (although we have posted a copy on our web site, you have a right to a hard copy upon request.)
- Inspect and obtain a copy of your health record.
- Amend your health records.
- Obtain an accounting of disclosures of your health information.
- Request communications of your health information by alternative means or at alternative locations.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

PEHP does not need to provide an accounting for disclosures:

- To persons involved in the individual's care or for other notification purposes.
- For national security or intelligence purposes.
- Uses or disclosures of de-identified information or limited data set information.

PEHP must provide the accounting within 60 days of receipt of your written request.

The accounting must include:

- Date of each disclosure
- Name and address of the organization or person who received the protected health information
- Brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization, or a copy of the written request for disclosure.

The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

Examples of Uses and Disclosures of Protected Health Information

PEHP will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

Though PEHP does not provide direct treatment to individuals, we do use the health information described above for utilization and medical review purposes. These review procedures facilitate the payment and/or denial of payment of health care services you may have received. All payments or denial decisions are made in accordance with the individual plan provisions and limitations as described in the applicable PEHP Master Policies.

PEHP will use your health information for payment.

For example: A bill for health care services you received may be sent to you or PEHP. The information on or accompanying the bill may include information that identifies you as well as your diagnosis, procedures, and supplies used.

PEHP will use your health information for health operations.

For example: The Medical Director, his or her staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of PEHP's programs.

If your coverage is through an employer sponsored group health plan, PEHP may share summary health information with the plan sponsor, such as your enrollment or disenrollment in the plan. PEHP may disclose protected health information for plan administration activities. *Example: Your employer contracts with PEHP to provide a health plan, and PEHP provides your employer with certain statistics to explain the rates we charge.* For specific health information PEHP will only provide information after it receives a specific written request from the plan sponsor, which includes an agreement not to use your health information for employment related actions or decisions.

There are certain uses and disclosures of your health information which are required or permitted by Federal Regulations and do not require your consent or authorization.

Examples include:

Public Health.

As required by law, PEHP may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Business Associates.

There are some services provided in our organization through contacts with business associates. When such services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information.

Food and Drug Administration (FDA).

PEHP may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation.

We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Correctional Institution.

Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law Enforcement.

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority, or attorney provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Our Responsibilities Under the Federal Privacy Standard

PEHP is required to:

- Maintain the privacy of your health information, as required by law, and to provide individuals

with notice of our legal duties and privacy practices with respect to protected health information

- Provide you with this notice as to our legal duties and privacy practices with respect to protected health information we collect and maintain about you
- Abide by the terms of this notice
- Train our personnel concerning privacy and confidentiality
- Implement a policy to discipline those who violate PEHP's privacy, confidentiality policies.
- Mitigate (lessen the harm of) any breach of privacy, confidentiality.
- To notify affected individuals following a breach of unsecured protected health information.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should we change our Notice of Privacy Practices you will be notified.

We will not use or disclose your health information without your consent or authorization, except as permitted or required by law. PEHP is prohibited from using or disclosing the genetic information of an individual for underwriting purposes.

Most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information require your written authorization. Other uses and disclosures not described in this notice of privacy practices require your written authorization.

Inspecting Your Health Information

If you wish to inspect or obtain copies of your protected health information, please send your written request to PEHP, Customer Service, 560 East 200 South, Salt Lake City, UT 84102-2099. We will arrange a convenient time for you to visit our office for inspection. We will provide copies to you for a nominal fee. If your request for inspection or copying of your protected health information is denied, we will provide you with the specific reasons and an opportunity to appeal our decision.

For More Information or to Report a Problem

If you have questions or would like additional information, you may contact the PEHP Customer Service Department at (801) 366-7555 or (800) 955-7347

If you believe your privacy rights have been violated, you can file a written complaint with our Chief Privacy Officer at:

ATTN: PEHP Chief Privacy Officer
560 East 200 South
Salt Lake City, UT 84102-2099.

Alternately, you may file a complaint with the U.S. Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

