



**CHILDREN'S HEALTH
INSURANCE PROGRAM**

MASTER POLICY

Exclusive Medical Care

This Master Policy is subject to change each policy year.

It is important for you to familiarize yourself with the information provided in this Master Policy to best utilize your Exclusive Medical Care plan. It provides specific information on coverage levels and maximums, eligibility, enrollment, and other information particular to your Coverage.

This Master Policy contains a detailed overview of the benefits of the Children's Health Insurance Program (CHIP) Exclusive Medical Care plan only.

Public Employees Health Program

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IHC NETWORK CARE™

IHC® A Service of Intermountain Health Care

CHIP Exclusive Medical Care is offered through IHC Health Plans, a service of Intermountain Health Care.

Public Employees Health Program



Public Employees Health Program

CHILDREN'S HEALTH INSURANCE PROGRAM EXCLUSIVE MEDICAL CARE

Master Policy

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Table of Contents

Introduction

TRANSLATION SERVICES 5
ELIGIBILITY 5
PRE-NOTIFICATION/PRE-AUTHORIZATION 5
NON-CONTRACTED PROVIDERS 5
OUT-OF-AREA ALLOWABLE FEES 5
BALANCE BILLING 5
DEDUCTIBLES, OUT-OF-POCKET MAXIMUMS, LIFETIME MAXIMUM, PRE-EXISTING CONDITION 5
COVERAGE LEVELS 5-11

PEHP and Enrollee Responsibilities

1.1 AVAILABILITY OF CONTRACT FOR REVIEW 12
1.2 NO VESTED RIGHTS 12
1.3 ACCEPTANCE OF CONTRACT 12
1.4 PEHP DETERMINES ELIGIBLE SERVICES 12
1.5 PROVIDER AGENCY 12
1.6 MANAGED CARE 12
1.7 BENEFITS ARE LIMITED 12
1.8 ADMINISTRATIVE PROVISIONS 13
1.9 COMPLIANCE RESPONSIBILITIES 13
1.10 CHANGES IN ENROLLEE CONTACT INFORMATION 13
1.11 REQUESTS FOR INFORMATION 13
1.12 NOTICES 13
1.13 PEHP EMPLOYEE RESPONSES 13
1.14 NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT 13
1.15 NOTICE OF NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT 13

Definitions

2.1 ACCIDENT, ACCIDENTAL 14
2.2 AMBULATORY SURGICAL FACILITY 14

2.3 BENEFITS REVIEW COMMITTEE 14
2.4 CERTIFICATION AND DISCLOSURE OF COVERAGE 14
2.5 COMMUNITY STANDARD 14
2.6 COMPLICATIONS 14
2.7 CONTRACTED HOSPITAL 14
2.8 CONTRACTED PROVIDER 14
2.9 COPAYMENT 14
2.10 COSMETIC PROCEDURE 14
2.11 COVERAGE 15
2.12 CUSTODIAL CARE 15
2.13 DEDUCTIBLE 15
2.14 DEVICE 15
2.15 DURABLE MEDICAL EQUIPMENT 15
2.16 ELECTIVE TREATMENT 15
2.17 ELIGIBLE BENEFIT 15
2.18 EMERGENCY CARE 15
2.19 ENROLLEE 15
2.20 EXCEPTED BENEFITS 15
2.21 EXCLUSIONS 16
2.22 EXPERIMENTAL, INVESTIGATIONAL, OR UNPROVEN 16
2.23 FDA APPROVED 16
2.24 FORMULARY 16
2.25 GLOBAL FEE 16
2.26 HOSPICE CARE 16
2.27 HOSPITAL 16
2.28 IMMEDIATE FAMILY MEMBER 16
2.29 INDUSTRIAL CLAIM 16
2.30 LIFE THREATENING 16
2.27 HOSPITAL 16
2.28 IMMEDIATE FAMILY MEMBER 16
2.29 INDUSTRIAL CLAIM 16
2.30 LIFE THREATENING 16
2.31 LIFETIME MAXIMUM BENEFITS OR LIFETIME LIMITS 17
2.32 LIMITATIONS 17

Table of Contents

- 2.33 MAXIMUM ALLOWABLE FEE 17
- 2.34 MEDICAL CASE MANAGEMENT 17
- 2.35 MEDICAL RECORDS 17
- 2.36 MEDICALLY NECESSARY/
MEDICAL NECESSITY 17
- 2.37 MENTAL HEALTH 17
- 2.38 PACKAGE FEE 17
- 2.39 PBM 17
- 2.40 PRE-AUTHORIZATION 17
- 2.41 PRE-NOTIFICATION 17
- 2.42 PROVIDER 18
- 2.43 RECONSTRUCTIVE SURGERY 18
- 2.44 REHABILITATION THERAPY 18
- 2.45 SKILLED NURSING FACILITY 18
- 2.46 SPECIALTY DRUGS 18
- 2.47 SUBROGATION 18
- 2.48 SURGICAL PROCEDURE OR SURGERY 18
- 2.49 UNBUNDLING 18
- 2.50 URGENT CONDITION 19
- 2.51 VERBAL PRE-AUTHORIZATION 19

Enrollment, Eligibility & Termination

- 3.1 TRANSFER OF COVERAGE 19
- 3.2 CERTIFICATION AND DISCLOSURE
OF COVERAGE 19
- 3.3 TERMINATION OF COVERAGE 19
- 3.4 LIABILITY FOR SERVICES
AFTER TERMINATION 25

General Provisions

- 4.1 MASTER POLICY 19
- 4.2 AUTHORIZATION TO
OBTAIN/RETAIN/SHARE INFORMATION 19

Conditions of Service

- 5.1 EXCESS PAYMENT OR
MISTAKEN PAYMENTS 20
- 5.2 MEDICAL CASE MANAGEMENT 20

Covered Benefits

- 6.1 CONTRACTED PROVIDERS 20
- 6.2 NATIONAL ACCESS PROGRAM 21
- 6.3 HOSPITAL BENEFITS 21
- 6.4 SURGICAL BENEFITS 23
- 6.5 ANESTHESIA BENEFITS 25
- 6.6 MEDICAL VISIT BENEFITS 25
- 6.7 DIAGNOSTIC TESTING,
LAB AND X-RAY BENEFITS 28
- 6.8 MENTAL HEALTH
AND SUBSTANCE ABUSE BENEFITS 28
- 6.9 AMBULANCE BENEFITS 29
- 6.10 HOME HEALTH AND
HOSPICE CARE BENEFITS 29
- 6.11 PRESCRIPTION AND
SPECIALTY DRUG BENEFITS 30
- 6.12 DURABLE MEDICAL
EQUIPMENT/SUPPLY BENEFITS 33
- 6.13 ADDITIONAL BENEFIT PROGRAMS 34

General Limitations and Exclusions

- 7.1 PRE-AUTHORIZATION LIMITATIONS 35
- 7.2 CATASTROPHIC BENEFITS 36
- 7.3 SPECIFIC EXCLUSIONS 37
- 7.4 GENERAL EXCLUSIONS FROM COVERAGE 37
- 7.5 SUBROGATION AND CONTRACTUAL
REIMBURSEMENT 38

Claims, Submission & Appeals

- 8.1 CLAIMS SUBMISSION 39
- 8.2 CLAIMS APPEAL PROCESS 40

Appendix

- APPENDIX A | DURABLE MEDICAL EQUIPMENT 41
- CHIP AND OUT-OF-POCKET COSTS 48
- NOTICE OF PRIVACY PRACTICES 49

Introduction

The Benefit Summary is a description of Eligible Benefits and/or Copayments when all eligibility requirements are met. For a complete description, see the plan guidelines, Limitations and Exclusions sections of this Master Policy.

All benefits are subject to the maximum allowable fee (MAF) as determined by the Public Employees Health Program (PEHP) and the maximum yearly or Lifetime limits.

TRANSLATION SERVICES

CHIP Exclusive Care Medical Plan provides benefits for translation services. All translation services must be performed by interpreters with a valid Tax Identification number.

ELIGIBILITY

All Enrollment and eligibility requirements for the Children’s Health Insurance Program (CHIP) are determined by Title 26, Chapter 40 of the Utah Code, Section 26-40-105, and administered by the Utah Department of Health.

PRE-NOTIFICATION/PRE-AUTHORIZATION

To be eligible, all inpatient hospitalization requires Pre-notification and some other services require Pre-authorization by PEHP and will be subject to a denial of benefits if not complete. Pre-notified or Pre-authorized benefits are subject to all plan provisions and eligibility at time of service, and plan changes with new plan year provisions. Some prescription drugs may require Pre-authorization. (See the Limitations in the Pharmacy section of the Master Policy on page 31 of this booklet.)

NON-CONTRACTED PROVIDERS

Enrollees must use Contracted Providers or no benefits will be paid. Exceptions may be made only when PEHP does not have Contracted Providers in a particular specialty or within a 30-mile radius of the Enrollee’s residence. In a medical emergency, an Enrollee may obtain services from a non-contracted provider without a penalty.

OUT-OF-AREA ALLOWABLE FEES

Coverage for eligible medical services outside the state of Utah, while on vacation, or when medical services are not available in Utah will be allowed up to MAF minus applicable Copayments.

BALANCE BILLING

For eligible services, Provider cannot balance bill the Enrollee and must consider reimbursement from PEHP plus Enrollee Copayments as payment in full.

DEDUCTIBLES, OUT-OF-PACKET LIMITS, LIFETIME MAXIMUM, PRE-EXISTING CONDITIONS

Yearly Deductible, Plan A	None
Yearly Deductible, Plan B	\$40 per family
Yearly Deductible, Plan C	\$500 per individual/ \$1500 per family
Yearly Out-of-pocket Maximum, Plans A, B and C	5% of the family’s annual gross income (medical, dental, pharmacy)
Maximum Lifetime Benefit, Plans A, B and C	None
Pre-existing Condition Waiting Period, Plans A, B and C	None

Coverage Levels for CHIP Exclusive Care

Refer to the Master Policy section of this booklet for specific criteria for the benefits listed below, as well as information on Limitations and Exclusions.

BASIC BENEFITS	PLAN A	PLAN B	PLAN C	NATIVE AMERICAN PLAN
Allergy Injections	100% of MAF	100% of MAF	100% of MAF	100% of MAF
Allergy Serum	100% of MAF	95% of MAF	80% of MAF	100% of MAF
Allergy (Skin) Testing				
Under \$350	100% of MAF	100% of MAF	100% of MAF	100% of MAF
Over \$350	100% of MAF after \$3 Copayment	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
Ambulance, ground or air	95% of MAF	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
Ambulatory Surgical Facility	100% of MAF after \$3 Copayment	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
Anesthesia	100% of MAF	95% of MAF	80% of MAF	100% of MAF

BASIC BENEFITS	PLAN A	PLAN B	PLAN C	NATIVE AMERICAN PLAN
Assistant Surgeon	100% of MAF (MAF is 20% of allowable surgical fee or 10% for a PA or RN assistant)	95% of MAF (MAF is 20% of allowable surgical fee or 10% for a PA or RN assistant)	80% of MAF (MAF is 20% of allowable surgical fee or 20% for a PA or RN assistant)	100% of MAF (MAF is 20% of allowable surgical fee or 10% for a PA or RN assistant)
Cardiac Rehabilitation, Phase 2 <i>Up to 24 visits allowed per plan year</i>	100% of MAF after \$3 Copayment per visit	100% of MAF after \$5 Copayment per visit	100% of MAF after applicable office Copayment per visit	100% of MAF
Chemotherapy, outpatient, office, home <i>Pharmacy benefits may apply</i>	100% of MAF after \$3 Copayment per visit	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
Diagnostic Radiology				
<i>Under \$350</i>	100% of MAF	100% of MAF	100% of MAF	100% of MAF
<i>Over \$350</i>	100% of MAF after \$3 Copayment	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
Diagnostic Testing/Laboratory				
<i>Under \$350</i>	100% of MAF	100% of MAF	100% of MAF	100% of MAF
<i>Over \$350</i>	100% of MAF after \$3 Copayment	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
Transplant Donor Typing	Same as above, up to \$5,000 Maximum	Same as above, up to \$5,000 Maximum	Same as above, up to \$5,000 Maximum	Same as above, up to \$5,000 Maximum
Dialysis, Outpatient	100% of MAF after \$3 Copayment per visit	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
Emergency Room				
<i>Facility</i>	100% of MAF after \$3 Copayment per visit	100% of MAF after \$5 Copayment per visit for emergency visit. 100% of MAF after \$10 Copayment per visit for non-emergency visit	100% of MAF after \$100 Copayment per visit for participating provider. 100% of MAF after \$200 Copayment for non-participating provider	100% of MAF
<i>Physician</i>	100% of MAF	100% of MAF	100% of MAF	100% of MAF
Eye/Vision Exams <i>Limited to one per plan year</i>	100% of MAF after \$3 Copayment	100% of MAF after \$5 Copayment	100% of MAF after \$20 Copayment	100% of MAF
Functional Reconstructive Surgery <i>Requires Pre-authorization</i>	100% of MAF	95% of MAF	80% of MAF	100% of MAF
Hearing Aids				
<i>Single</i>	100% of MAF, up to \$500 after \$3 Copayment	95% of MAF after Deductible, up to \$500	80% of MAF after Deductible, up to \$500	100% of MAF, up to \$500
<i>Bilateral</i>	100% of MAF, up to \$800 after \$3 Copayment	95% of MAF after Deductible, up to \$800	80% of MAF after Deductible, up to \$800	100% of MAF, up to \$800
Hearing Exam <i>Limited to one per plan year</i>	100% of MAF after \$3 Copayment	100% of MAF after \$5 Copayment	100% of MAF after \$20 Copayment	100% of MAF
Hemophilia Factor Products	Pharmacy benefits apply			

CHIP Master Policy » Exclusive Medical Care

BASIC BENEFITS	PLAN A	PLAN B	PLAN C	NATIVE AMERICAN PLAN
Home Health Care	Up to 60 visits per plan year. All services require Pre-authorization and Medical Case Management			
<i>Skilled Nursing</i>	100% of MAF after \$3 Copayment per visit	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
<i>IV Therapy (antibiotics)</i>	100% of MAF	100% of MAF	100% of MAF	100% of MAF
<i>Chemotherapy, Dialysis</i>	100% of MAF after \$3 Copayment per visit	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
<i>Physical, Occupational, Speech Therapy</i> <i>Maximum limits apply</i>	100% of MAF after \$3 Copayment per visit	100% of MAF after \$5 Copayment per visit	100% of MAF after applicable office Copayment per visit	100% of MAF
<i>LCSW</i>	100% of MAF after \$3 Copayment per visit (except Hospice)	100% of MAF after \$5 Copayment per visit (except Hospice)	100% of MAF after \$30 Copayment per visit (except Hospice)	100% of MAF (except Hospice)
<i>Total Parenteral Nutrition (TPN)</i>	100% of MAF	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
<i>Enteral (Tube) Feeding Supplies</i>	100% of MAF	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
<i>Enteral Formula</i>	If approved, must be obtained through the Pharmacy Card			
Hospice Services <i>Up to 6 months in a 3-year period. Requires Pre-authorization and Medical Case Management</i>	100% of MAF after \$3 Copayment per visit	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
Hospital				
<i>Inpatient</i> <i>Requires Pre-notification</i>	100% of MAF after \$50 Copayment per admit	100% of MAF after Deductible and \$150 Copayment per admit	80% of MAF after Deductible	100% of MAF
<i>Outpatient</i>	100% of MAF after \$3 Copayment	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
<i>Physician Visits</i>	100% of MAF after \$3 Copayment per visit	100% of MAF after \$5 Copayment per visit	100% of MAF after applicable office Copayment per visit	100% of MAF
Hyperbaric Oxygen Treatment <i>Requires Pre-authorization</i>	100% of MAF	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
Immunizations <i>Birth to Age 19</i>	100% of MAF	100% of MAF	100% of MAF	100% of MAF
Injections (Medical)	Requires Pre-authorization if over \$750			
<i>Under \$50</i>	100% of MAF	100% of MAF	100% of MAF	100% of MAF
<i>Over \$50</i>	100% of MAF	95% of MAF	80% of MAF	100% of MAF
Jaw Surgery (Osteotomy/TMJ Surgery) <i>Requires Pre-authorization</i>	100% of MAF	95% of MAF	80% of MAF	100% of MAF

BASIC BENEFITS	PLAN A	PLAN B	PLAN C	NATIVE AMERICAN PLAN
Medical Equipment (DME)	All DME over \$750 or as indicated in Appendix A to the Master Policy requires Pre-authorization			
<i>General</i>	100% of MAF after \$3 Copayment	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
<i>Sleep Disorder</i> <i>Up to \$2,500 in a 5-year period</i>	100% of MAF after \$3 Copayment	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
<i>TENS Unit</i> <i>Up to \$500 Lifetime Maximum</i>	100% of MAF after \$3 Copayment	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
<i>Neuromuscular Stimulator</i> <i>Up to \$1,000 Lifetime Maximum</i>	100% of MAF after \$3 Copayment	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
<i>H-Wave Electronic Device</i> <i>Up to \$2,000 Lifetime Maximum</i>	100% of MAF after \$3 Copayment	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
<i>Sympathetic Therapy Stimulator (STS)</i> <i>Up to \$2,000 Lifetime Maximum</i>	100% of MAF after \$3 Copayment	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
<i>Wheelchairs (including parts and replacements)</i> <i>Up to \$20,000 in a 5-year period. See Limitations</i>	100% of MAF after \$3 Copayment	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
<i>Knee Braces</i> <i>Up to \$1,500 in a 3-year period. See Limitations</i>	100% of MAF after \$3 Copayment	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
Mental Healthcare				
<i>Inpatient Hospital</i> <i>Requires Pre-notification by calling 801-233-4100</i>	100% of MAF after \$50 Copayment per admit	100% of MAF after \$150 Copayment per admit	80% of MAF after Deductible	100% of MAF
<i>Outpatient Therapy</i>	100% of MAF after \$3 Copayment per visit	100% of MAF after \$5 Copayment per visit	100% of MAF after \$30 Copayment per visit	100% of MAF
Neuro-psychiatric Testing				
<i>Under \$350</i>	100% of MAF	100% of MAF	100% of MAF	100% of MAF
<i>Over \$350</i>	100% of MAF after \$3 Copayment	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
Occupational Therapy <i>Outpatient/Home</i> <i>Up to 8 visits per plan year</i>	100% of MAF after \$3 Copayment per visit	100% of MAF after \$5 Copayment per visit	100% of MAF after \$30 Copayment per visit	100% of MAF
Office Visits	100% of MAF after \$3 Copayment per visit	100% of MAF after \$5 Copayment per visit	100% of MAF after \$20 Copayment per visit	100% of MAF
<i>Specialist</i>	100% of MAF after \$3 Copayment per visit	100% of MAF after \$5 Copayment per visit	100% of MAF after \$30 Copayment per visit	100% of MAF

BASIC BENEFITS	PLAN A	PLAN B	PLAN C	NATIVE AMERICAN PLAN
Pain Clinics/Treatment				
<i>Inpatient</i> <i>Requires Pre-notification</i>	100% of MAF after \$50 Copayment per admit	100% of MAF after Deductible and \$150 Copayment per admit	80% of MAF after Deductible	100% of MAF
<i>Outpatient Facility/Surgical Suite</i>	100 % of MAF after \$3 Copayment per visit	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
<i>All services related to Trigger Point, Sacroiliac Joint, Nerve Block, Epidural Steroid and/or Facet Injections</i> <i>Up to \$5,000 per plan year</i>	100% of MAF	95% of MAF	80% of MAF	100% of MAF
<i>Office</i>	First 5 visits payable at 100% of MAF after \$3 Copayment per visit	First 5 visits payable at 100% of MAF after \$5 Copayment per visit	First 5 visits payable at 100% of MAF after applicable office Copayment per visit	First 5 visits payable at 100% of MAF
<i>Repetitive Visits/Injections</i> <i>Up to \$1,500 per plan year</i>	100% of MAF after \$3 Copayment per visit after 5 visits	95% of MAF after 5 visits	50% of MAF after 5 visits	100% of MAF after 5 visits
Physical Examinations	100% of MAF	100% of MAF	100% of MAF	100% of MAF
Physical Therapy <i>Up to 20 visits per plan year</i>	100% of MAF after \$3 Copayment per visit	100% of MAF after \$5 Copayment per visit	100% of MAF after \$20 Copayment per visit	100% of MAF

BASIC BENEFITS	PLAN A	PLAN B	PLAN C	NATIVE AMERICAN PLAN
Prescription Drugs (RX Selections Formulary) <i>Up to a 30-day supply</i>	Preferred Generic: 100% of discounted cost after \$1 Copayment if cost is less than or equal to \$50 100% of discounted cost after \$3 Copayment if cost is greater or equal to \$50.01 Preferred Brand Name: 100% of discounted cost after \$1 Copayment if cost is less than or equal to \$50 100% of discounted cost after \$3 Copayment if cost is greater or equal to \$50.01 Non-Preferred Brand Name: 95% of discounted cost	Preferred Generic: 100% of discounted cost after \$5 Copayment Preferred Brand Name: 95% of discounted cost Non-Preferred Brand Name: 95% of discounted cost	Preferred Generic: 100% of discounted cost after \$15 Copayment Preferred Brand Name: 75% of discounted cost Non-Preferred Brand Name: 50% of discounted cost	Preferred Generic: 100% of discounted cost Preferred Brand Name: 100% of discounted cost Non-Preferred Brand Name: 100% of discounted cost
<i>Diabetic Supplies</i>	Pharmacy benefits apply			
<i>Enterals</i> <i>Requires Pre-authorization and Medical Case Management</i>	95% of of discounted cost	95% of of discounted cost	50% of discounted cost	100% of discounted cost
<i>Food Supplements</i>	Non-covered, except as required for phenylketonuria (PKU). Requires Pre-authorization and Medical Case Management. If approved, pharmacy benefits apply			
<i>Foreign Country Claims</i>	Pharmacy benefits apply			
<i>Specialty</i> <i>Must use PEHP's specialty vendor, Accredo</i>	Pharmacy benefits apply			
Prosthetics <i>Up to \$20,000 in a 5-year period (per limb). Requires Pre-authorization and Medical Case Management</i>	100% of MAF after \$3 Copayment	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
Psychiatric Testing				
<i>Under \$350</i>	100% of MAF	100% of MAF	100% of MAF	100% of MAF
<i>Over \$350</i>	100% of MAF after \$3 Copayment	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
Pulmonary Rehabilitation, Phase 2 <i>Up to 24 visits allowed per plan year</i>	100% of MAF after \$3 Copayment per visit	100% of MAF after \$5 Copayment per visit	100% of MAF after applicable office Copayment per visit	100% of MAF
Radiation Therapy	100% of MAF after \$3 Copayment per visit	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
Rehabilitation, Inpatient <i>Up to \$75,000 Lifetime Maximum. Requires Pre-authorization and Medical Case Management</i>	100% of MAF after \$50 Copayment per admit	100% of MAF after Deductible and \$150 Copayment per admit	80% of MAF after Deductible	100% of MAF

BASIC BENEFITS	PLAN A	PLAN B	PLAN C	NATIVE AMERICAN PLAN
Residential Treatment <i>Requires Pre-notification by calling 801-233-4100</i>	100% of MAF after \$50 Copayment per admit	100% of MAF after Deductible and \$150 Copayment per admit	80% of MAF after Deductible	100% of MAF
Second Surgical Opinion	100% of MAF	100% of MAF	100% of MAF	100% of MAF
Skilled Nursing/ Rehabilitation Facility (SNF), non-custodial <i>Up to 60 days per plan year. Requires Pre-authorization and Medical Case Management</i>	100% of MAF after \$50 Copayment per admit	100% of MAF after Deductible and \$150 Copayment per admit	80% of MAF after Deductible	100% of MAF
Sleep Studies <i>Up to \$2,000 maximum in a 3-year period</i>	100% of MAF after \$3 Copayment	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
Sleep Disorder Surgery	100% of MAF	95% of MAF	80% of MAF	100% of MAF
Sleep Disorder Equipment <i>Up to \$2,500 in a 5-year period</i>	100% of MAF after \$3 Copayment	95% of MAF after Deductible	80% of MAF after Deductible	100% of MAF
Speech Therapy <i>Requires Pre-authorization. Lifetime Maximum of 60 visits (must meet criteria to be Eligible)</i>	100% of MAF after \$3 Copayment per visit	100% of MAF after \$5 Copayment per visit	100% of MAF after \$30 Copayment per visit	100% of MAF. Lifetime Maximum of 60 visits
Substance Abuse Treatment				
Inpatient Hospital <i>Requires Pre-notification by calling 801-233-4100</i>	100% of MAF after \$50 Copayment per admit	100% of MAF after Deductible and \$150 Copayment per admit	80% of MAF after Deductible	100% of MAF
Outpatient	100% of MAF after \$3 Copayment per visit	100% of MAF after \$5 Copayment	100% of MAF after \$30 Copayment per visit	100% of MAF
Surgery, Physician <i>Inpatient or Outpatient Facility</i>	100% of MAF	95% of MAF	80% of MAF	100% of MAF
<i>Physician's Office</i>	100% of MAF after \$3 Copayment per visit	100% of MAF after \$5 Copayment per visit	100% of MAF after applicable office Copayment per visit	100% of MAF
Temporomandibular Joint Dysfunction (TMJ, TMD) <i>Requires Pre-authorization. Up to a \$1,000 Lifetime Maximum</i>	100% of MAF after \$3 Copayment per visit	95% of MAF after Deductible	50% of MAF after Deductible	100% of MAF
Transplants	Payable with applicable Copayments per service rendered. Requires Pre-authorization and Medical Case Management (must meet criteria to be Eligible)			
Well Child Exams	100% of MAF	100% of MAF	100% of MAF	100% of MAF
Urgent Care Facility	100% of MAF after \$3 Copayment per visit	100% of MAF after \$5 Copayment per visit	100% of MAF after \$30 Copayment per visit	100% of MAF

This Master Policy is the contract between Public Employees Health Program (PEHP) and its Enrollees.

Recitals

This Master Policy between PEHP and its Enrollees 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 Enrollees 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 supersedes all prior communications, representations, or agreements, either verbal or written, between the parties.

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 Enrollee Responsibilities

1.1 AVAILABILITY OF CONTRACT FOR REVIEW

Enrollees are entitled to review a copy of this contract at www.pehp.org. Enrollees may also request a hard copy of this contract from PEHP.

1.2 NO VESTED RIGHTS

Enrollees are only entitled to receive benefits from PEHP while this contract is in effect. Enrollees 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. Enrollees only have rights to benefits under this contract when they are properly enrolled and recognized by PEHP as Enrollees. Unless otherwise expressly stated in this contract, all benefits end when this contract ends. Enrollees have no right to receive any care, services, treatments, drugs, medications, supplies, or equipment from or through PEHP except in strict compliance with this entire contract.

1.3 ACCEPTANCE OF THIS CONTRACT

As a condition to receiving Coverage from PEHP, Enrollees are presumed and required to accept, comply with, and agree to, the terms of this contract.

1.4 PEHP DETERMINES ELIGIBLE SERVICES

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

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

1.5 PROVIDER AGENCY

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

PEHP does not promise, represent, warrant, or otherwise guarantee that care or services provided to Enrollees 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 an Enrollee and resulting from care or services rendered, withheld, covered, limited, excluded, or otherwise provided or not under this Master Policy. Enrollees agree that Providers are solely responsible to Enrollees for care or services rendered, limited, or withheld by such Providers.

1.6 MANAGED CARE

Enrollees agree to the managed care features that are a part of the health benefit program in which they are enrolled. For example, see Section Six of this Master Policy.

1.7 BENEFITS ARE LIMITED

Coverage under this contract is limited in defined ways. It is the responsibility of each Enrollee 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.

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

1.8 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 Enrollees. Enrollees are subject to such rules, regulations, policies, procedures, and protocols in connection with obtaining covered services and other matters under this Master Policy. Such things will not be used to change what are the covered services, Exclusions and Limitations set forth in the Master Policy.

1.9 COMPLIANCE RESPONSIBILITIES

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

1.10 CHANGES IN ENROLLEE CONTACT INFORMATION

It is the Enrollee's responsibility to keep CHIP informed of any change of address and phone number. Enrollees should keep copies of any notices sent to CHIP.

1.11 REQUESTS FOR INFORMATION

As a condition of receiving benefits under this Master Policy, Enrollees shall provide PEHP with all information at PEHP's request, including, but not limited to, providing releases for prior Medical Records. Failure by an Enrollee to provide information to PEHP at PEHP's request under this section 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 until the requested information is received by PEHP.

1.12 NOTICES

Any notice required of PEHP under this Master Policy will be sufficient if mailed by first class mail to the Enrollee at the address appearing on the records of PEHP. Any notice to PEHP will be sufficient if mailed to the principal office of PEHP in Salt Lake City, Utah.

1.13 PEHP EMPLOYEE RESPONSES

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

1. Modify the terms and conditions of this Master Policy;
2. Extend or modify the benefits available under this Master Policy, either intentionally or unintentionally;
3. Waive or modify any Exclusion or Limitation; or
4. Waive compliance with PEHP requirements, such as the use of Contracted Providers or the necessity of obtaining Pre-authorizations

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

1.14 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 Co-payment Limitations consistent with those established for other benefits.

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

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

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

1.15 NOTICE OF NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

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

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

II. Definitions

2.1 ACCIDENT, ACCIDENTAL

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

2.2 AMBULATORY SURGICAL FACILITY

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

2.3 BENEFITS REVIEW COMMITTEE

A Committee which may consist of the Medical Director, Claims Managers, Claims Supervisors or other appropriate PEHP personnel which has the authority to review and approve or deny, based on established criteria, claims for Eligible Benefits.

2.4 CERTIFICATION AND DISCLOSURE OF COVERAGE

A certificate describing an individual's Creditable Coverage as prior Coverage, beginning and termination dates of prior Coverage, and applicable Pre-existing Condition waiting periods. Certification shall specify any Pre-existing Condition waiting periods imposed on an individual for any Coverage.

2.5 COMMUNITY STANDARD

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

2.6 COMPLICATION(S)

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

2.7 CONTRACTED HOSPITAL

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

2.8 CONTRACTED PROVIDER

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

2.9 COPAYMENT

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

2.10 COSMETIC PROCEDURE

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

2.11 COVERAGE

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

Benefits must be provided:

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

2.12 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 an Enrollee 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 Enrollee to a condition in which care would not be required.

2.13 DEDUCTIBLE

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

2.14 DEVICE

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

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

2.15 DURABLE MEDICAL EQUIPMENT

Medical equipment that is all of the following:

1. Used only to benefit in the care and treatment of an illness or injury;
2. Durable and useful over an extended period of time;

3. Used only for a medical purpose rather than convenience or contentment;
4. Is prescribed by a Provider; and
5. Not used by other family members for non-therapeutic purposes.

2.16 ELECTIVE TREATMENT

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

2.17 ELIGIBLE BENEFIT

Medical expenses which are covered under this Master Policy. Preventive care services are covered in accordance with the applicable Benefits Summary.

2.18 EMERGENCY CARE

Care provided for an acute health condition with a sudden unexpected onset, which requires immediate medical attention in order to preserve life. A determination of emergency will be made by PEHP on the basis of the final diagnosis.

2.19 ENROLLEE

A child who is enrolled in the Children's Health Insurance Program (CHIP).

2.20 EXCEPTED BENEFITS

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

2.21 EXCLUSIONS

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

2.22 EXPERIMENTAL, INVESTIGATIONAL, OR UNPROVEN

Those services, supplies, or pharmaceutical (drug) products which are not recognized or proven to be effective for treatment of illness or injury in accordance with generally accepted standards of medical practice as determined by PEHP or which have not received Food and Drug Administration (FDA) approval for the diagnosis being treated, duration of treatment, or dosage.

2.23 FDA APPROVED

Pharmaceuticals, Devices, or Durable Medical Equipment which have been approved by the FDA for a particular diagnosis. Off-label use of pharmaceuticals or Durable Medical Equipment for diagnoses other than approved by the FDA, do not qualify as FDA Approved.

2.24 FORMULARY

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

2.25 GLOBAL FEE

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

2.26 HOSPICE CARE

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

2.27 HOSPITAL

1. An institution which is licensed by the state in which it resides and maintains Medicare and Medicaid approval for services.

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

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

2.28 IMMEDIATE FAMILY MEMBER

Immediate Family Members are considered to be (for purposes of this policy): spouse, children, son-in-law, daughter-in-law, brother, sister, brother-in-law, sister-in-law, mother, father, mother-in-law, father-in-law, step-parents, stepchildren, grandparents, grandchildren, uncles, aunts, nieces, nephews.

2.29 INDUSTRIAL CLAIM

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

2.30 LIFE-THREATENING

The sudden and acute onset of an illness or injury where delay in treatment would jeopardize the Enrollee's life or cause permanent damage to the Enrollee's health such as, but not limited to, loss of heartbeat, loss of consciousness, cessation or severely obstructed breathing, massive and uncontrolled bleeding. A determination of Life-threatening will be made by PEHP on the basis of the final diagnosis and medical review of the records. PEHP reserves the right to solely determine whether or not a situation is Life-threatening.

2.31 LIFETIME MAXIMUM BENEFITS OR LIFETIME LIMITS

Policy provisions that have a Lifetime Maximum Benefit apply to the Lifetime of the Enrollee, and apply when an Enrollee terminates and reinstates Coverage with PEHP.

2.32 LIMITATIONS

Provisions in the plan indicating services or supplies that are not fully covered or covered only when specific criteria is met.

2.33 MAXIMUM ALLOWABLE FEE

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

2.34 MEDICAL CASE MANAGEMENT

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

2.35 MEDICAL RECORDS

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

2.36 MEDICALLY NECESSARY / MEDICAL NECESSITY

Any healthcare services, supplies or treatment provided for an illness or injury which is consistent with the Enrollee's symptoms or diagnosis provided in the most appropriate setting that can be used safely, without regard for the convenience of an enrollee 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 Enrollee's condition or the quality of medical care the Enrollee received as determined by established medical review mechanisms, within the scope of the Provider's licensure, and/or consistent with and included in policies established and recognized by PEHP. Any medical condition, treatment, service, equipment, etc. specifically excluded in the Master Policy is not an "Eligible Benefit" regardless of Medical Necessity.

2.37 MENTAL HEALTH

Mental Health Coverage shall include diagnosis code numbers 290-319 (Mental Disorders) as described in the ICD-9 (International Classification of Disease), except where otherwise described or excluded in the policy.

2.38 PACKAGE FEE

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

2.39 PBM

Pharmacy Benefit Manager.

2.40 PRE-AUTHORIZATION

The administrative process whereby an Enrollee and Provider can learn, in advance of treatment, the level of benefits provided by the Master Policy for the proposed treatment plan. The process, prior to service, that the Enrollee and the treating Provider must complete in order to obtain authorization for specified benefits of this Master Policy which may be subject to Limitations and to receive the maximum benefits of this Master Policy for Hospitalization, Surgical Procedures, Durable Medical Equipment, pharmaceutical drug products, or other services as required. Pre-authorization does not guarantee payment should Coverage terminate, should there be a change in benefits, should benefit limits be used by submission of claims in the interim, or should actual circumstances of the case be different than originally submitted.

2.41 PRE-NOTIFICATION

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

2.42 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 and Licensed Professional Counselor (LPC).

2.43 RECONSTRUCTIVE SURGERY

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

2.44 REHABILITATION THERAPY

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

2.45 SKILLED NURSING FACILITY

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

1. Has organized facilities for medical treatment and provides 24-hour nursing service under the full time supervision of a physician or a graduate registered nurse;
2. Maintains daily clinical records on each patient and has available the services of a physician under an established agreement;
3. Provides appropriate methods for dispensing and administering drugs and medicines; and

4. Has transfer arrangements with one or more Hospitals, a utilization review plan in effect, and operation policies developed in conjunction with the advice of a professional group including at least one Provider. Any institution that is, other than incidentally, a rest home, a home for the aged, or a place for the treatment of mental disease, drug addiction, or alcoholism, is not considered a Skilled Nursing Facility.

2.46 SPECIALTY DRUG

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

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

2.47 SUBROGATION

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

2.48 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, administering pneumothorax, or endoscopy.

2.49 UNBUNDLING

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

2.50 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 Enrollee if not attended by a physician within 24 hours; e.g., serious lacerations, fractures, dislocations, marked increase in temperature, etc.

2.51 VERBAL PRE-AUTHORIZATION

Prior approval obtained by calling PEHP Customer Service in advance of treatment as required for some specific services and as documented by PEHP.

III. Enrollment, Eligibility & Termination

Enrollment, eligibility, and termination will be determined by the Children's Health Insurance Program (CHIP).

3.1 TRANSFER OF COVERAGE

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

3.2. CERTIFICATIONS AND DISCLOSURE OF COVERAGE

PEHP shall provide a Certificate of Creditable Coverage when an Enrollee requests a Certificate of Creditable Coverage from PEHP within 24 months of the date of termination of Coverage.

3.3 TERMINATION OF COVERAGE

PEHP shall have the right to deny claims, terminate any or all Coverages of a Enrollee and seek reimbursement of claims paid upon the determination by PEHP that the Enrollee 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. LIABILITY FOR SERVICES AFTER TERMINATION

All care, services, treatments, drugs, medications, supplies, or equipment obtained after the date of termination are the responsibility of the Enrollee 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.

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 Enrollees. PEHP does not authorize any other use of this Master Policy.

This Master Policy and applicable Benefits Summary are intended to work in conjunction with one another. In any conflict regarding Eligible Benefits, the Master Policy supersedes the Benefits Summary.

4.2 AUTHORIZATION TO OBTAIN/RETAIN/SHARE INFORMATION

By enrolling with PEHP and accepting or receiving services and/or benefits through PEHP, all Enrollees 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 Enrollees, 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 for the covered Enrollee.

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, whether such payment was made in error or otherwise. Such right will apply to payments made to Enrollees, Providers or Facilities. If an excess payment is made by PEHP, the Enrollee 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 an Enrollee or for an Enrollee to a Provider or Facility. The making of a payment in error or under a mistaken understanding of the relevant facts is not recognition by PEHP that the service in question is covered under this Master Policy. If a claim incurred due to false pretenses, whether intentional or not, false representation, or actual fraud is discovered, PEHP may deny or seek reimbursement for payment, including associated costs and legal fees made in association with such claim.

5.2 MEDICAL CASE MANAGEMENT

Medical Case Management is designed to enhance the value of medical care in cases of complex medical conditions or injudicious use of medical benefits. Under Medical Case Management, a nurse case manager will work with the Enrollee, the Enrollee's family, Providers, outside consultants and PEHP to coordinate a comprehensive, medically appropriate treatment plan. PEHP must receive a signed consent from the Enrollee in order for the Enrollee to receive the maximum benefit from Medical Case Management services. See Section 6.17.2 for information about the WeeCare case management program for high-risk pregnancies. Medical Case Management may use alternative treatment plans and benefits in accordance with this section.

PEHP may use Medical Case Management in situations involving complex medical conditions or overutilization of benefits. Overutilization occurs when the treatment sought by an Enrollee exceeds medically appropriate levels as determined through any of the following methods:

1. Claims management database review indicating overutilization of benefits for the Enrollee's diagnosis;
2. Expert review system based on peer review criteria showing variations or irregularities in the Enrollee's pattern of care; or
3. Outside peer review.

Under Medical Case Management, PEHP may review an Enrollee's claims history and assist in the development of an alternative eligible treatment plan along with the Enrollee's treating physician. This review may include obtaining the following:

1. Documentation of the medical level of care for the Enrollee's diagnosis;
2. An independent medical examination;
3. The Enrollee's Medical Records; or
4. Second opinions from other physicians.

A formal Medical Case Management plan may be created by PEHP or PEHP's consultants. Once a Medical Case Management plan has been agreed to by the Enrollee, failure to comply with the Medical Case Management plan may result in PEHP's termination or Limitation of the Enrollee's benefits.

PEHP may use Medical Records in its possession to facilitate the Case Management process, including providing Enrollee's Medical Records to other entities in the Medical Case Management process.

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

PEHP may require that all services be authorized through a primary care physician and/or case manager to be eligible for benefits.

VI. Covered Benefits

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

6.1 CONTRACTED PROVIDERS

PEHP Exclusive Care offers quality medical care in the state of Utah through Contracted Providers, primarily based around the Intermountain Healthcare Network facilities and affiliated Providers. For emergencies and some limited benefits outside the state of Utah, PEHP has Contracted with National Health Benefits Corporation (NHBC) to secure discounts with Provider networks.

It is the Enrollee's responsibility to use Contracted Providers. Failure to use Contracted Providers may result in a denial of benefits. PEHP will make available a current list of Contracted Providers at www.pehp.org or by contacting PEHP. PEHP reserves the right to make

changes to the Provider list at any time during a plan year without notice.

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

The Enrollee's PEHP Identification/Prescription and Out-of-State Network card (if applicable) 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 Enrollee.

6.2 NATIONAL ACCESS PROGRAM

The National Access Program is a value added adjunct to PEHP's Exclusive Provider Network. This program allows Enrollees access to the best provider networks outside of Utah. Each PEHP Enrollee will be issued an Out-of-State Network (OSN) card. This card is for Enrollees who are traveling outside the State of Utah, and should be used for services that cannot be performed in Utah that have been Pre-authorized by PEHP.

How the OSN card works

Locate a Contracted Provider by clicking on the Out-of-State Network Provider List link at www.pehp.org or call the toll-free number listed on the card. When medical services are received from participating providers you must show your PEHP OSN Card and your PEHP Exclusive Care ID Card. If you do not present your OSN card at the time of service, PEHP cannot guarantee discounts or in-network provider coverage.

6.3 HOSPITAL BENEFITS

See the Benefits Summary for applicable Copayment amounts.

6.3.1 INPATIENT HOSPITALIZATION

Charges for Medically Necessary inpatient hospitalization (semi-private room, ICU, and eligible ancillaries) at Contracted Hospitals are payable after applicable Copayment.

Hospital and inpatient pain clinic admissions require Pre-notification (see Section 7).

When a Hospital stay spans an old and new plan year, benefits will be based on the old plan year provisions. When Coverage terminates during a Hospital stay, the Health Plan is responsible for the entire hospital stay including physician charges until discharge or thirty days following termination, whichever occurs first.

For Out-of-area Coverage for inpatient Hospital admissions, refer to Section 6.2 of this Master Policy.

6.3.2 OUTPATIENT FACILITY BENEFITS

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

6.3.3 EMERGENCY ROOM SERVICES

Medically Necessary emergency room facility services are payable after applicable Copayment. Each follow-up visit in the emergency room will require an additional emergency room Copayment. When emergency room treatment results in an inpatient admission (within 24 hours), benefits are payable as an inpatient stay.

6.3.4 URGENT CARE FACILITY

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. Room and board charges are limited to the semi-private room rate.
2. Charges for ambulance services, physician's Hospital or emergency room visits, and Durable Medical Equipment billed on the Hospital bill are payable separately, subject to applicable plan provisions and specified Copayments.
3. Newborn nursery room charges are separate from the mother's claim and the child must be enrolled to be eligible.
4. When an eligible Surgical Procedure is performed in conjunction with other ineligible Surgery, benefits will be prorated and only Eligible Benefits will be payable per Maximum Allowable Fee. All procedures must be disclosed for proper adjudication.
5. Inpatient confinement or Hospitalization in a Rehabilitation unit is limited to a Lifetime Maximum of \$75,000.
6. 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.

7. For Enrollees on Plan C, Hospital treatment for the following conditions or procedures, including Complications, are payable at 50% of Maximum Allowable Fee:
 - a. Breast reduction;
 - b. Mastectomy for gynecomastia; and
 - c. Blepharoplasty (or other eyelid Surgery).
8. Inpatient benefits for Mental Health and/or substance abuse require Pre-notification. See Section 6.8 for more information about Mental Health and Substance Abuse benefits.
9. Only acute Emergency Care for Life-threatening injury or illness is covered in conjunction with attempted suicide or anorexia/bulimia. Other services require Pre-notification through the inpatient Mental Health benefits.
10. If the Enrollee is six years of age or older, and is at high risk due to medical diagnoses which make it necessary to have a dental procedure performed in an outpatient surgical facility, benefits may be payable with Pre-authorization.
11. For Enrollees on Plan C, eligible expenses related to Spinal Cord Stimulators are payable at 50% of Maximum Allowable Fee. All plans are limited to a \$25,000 Lifetime Maximum. Requires written Pre-authorization through Medical Case Management.
12. Human Pasteurized Milk is a covered benefit for Newborn ICU babies whose mother's milk supply is inadequate, and in cases of extreme immaturity. Requires Pre-authorization.

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

The following are Exclusions of the policy:

1. Room charges in excess of the semi-private room rate.
2. Ineligible Surgical Procedures or related Complications.
3. Treatment programs for enuresis or encopresis.
4. 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.
5. Occupational therapy for activities of daily living, academic learning, vocational or life skills, developmental delay.
6. 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.
7. Recreational therapy.
8. Autologous (self) blood storage for future use.
9. Hospital charge while on "leave of absence" from the Hospital.
10. Organ or tissue donor charges, except when the recipient is an eligible Enrollee covered under a PEHP plan, and the transplant is eligible.
11. Nutritional analysis or counseling, except in conjunction with treatment for anorexia/bulimia under Mental Health benefits, or diabetes education.
12. Custodial Care and/or maintenance therapy.
13. Non-emergency follow-up care including obtaining non-emergent prescription medications from an emergency room.
14. Take Home Medications.

6.4 SURGICAL BENEFITS

See the Benefits Summary for specific Copayment amounts.

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

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

PEHP pays a Global Fee for maternity charges for normal delivery, C-section, Complications, and miscarriage. With exception of the pre-natal lab charge and RhoGam injection, Global Fee benefits are payable at time of delivery. If the Enrollee 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.

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 Maximum Allowable Fee for the primary procedure and 50% of Maximum Allowable Fee 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 and RBRVS guidelines.
3. Laser Surgery is payable for eligible proven procedures up to Maximum Allowable Fee. Additional surgical fees are not payable because a laser was used.
4. When an eligible Surgical Procedure is performed in conjunction with other ineligible Surgery, benefits will be prorated per Maximum Allowable Fee and CPT guidelines for primary and secondary procedures. Only Eligible Benefits will be payable. Provider's Pre-authorization must disclose all proposed procedures and implantable Devices to allow for accurate adjudication.
5. For Enrollees on Plan C, the following surgeries, when Medically Necessary, are payable at 50% of Maximum Allowable Fee:
 - a. Breast Reduction;
 - b. Blepharoplasty (or other eyelid Surgery);
 - c. Mastectomy for gynecomastia
6. Breast Reconstructive Surgery is an Eligible Benefit if performed within five years of a mastectomy, and within three years of the initial breast reconstruction.
7. Maxillary/Mandibular bone or Calcitite augmentation Surgery is covered when an enrollee is edentulous (absence of all teeth) and the general health of the Enrollee is at risk because of malnutrition or possible bone fracture. If the Enrollee elects a more elaborate or precision procedure, PEHP may allow payment for the standard Calcitite placement towards the cost and the Enrollee will be responsible for the difference. Quadrant or individual tooth areas or osseous implants are not eligible.

8. For Enrollees on Plan C, eligible Surgical expenses related to Spinal Cord Stimulators are payable at 50% of Maximum Allowable Fee. All plans are limited to \$25,000 Lifetime Maximum. Requires written Pre-authorization through Medical Case Management.
9. All services related to Trigger Point, Sacroiliac Joint, Nerve Block, Neurolytic procedures, Epidural Steroid and/or Facet Injections are payable per Maximum Allowable Fee up to \$5,000 per plan year.
10. Surgical Procedures utilizing robotic assistance require written Pre-authorization. PEHP will determine whether the indication for robotic assistance is Medically Necessary or Experimental/Investigational.

6.4.3 EXCLUSIONS FROM COVERAGE RELATING TO SURGERY

The following are Exclusions of the policy:

1. Breast Reconstructive Surgery, augmentation or implants solely for Cosmetic purposes.
2. Capsulotomy, replacement, removal or repair of breast implant originally placed for Cosmetic purposes or any other Complication(s) of Cosmetic or non-covered breast Surgery.
3. Obesity Surgery such as Lap Band, gastric bypass, stomach stapling, gastric balloons, etc., including any present or future Complications.
4. Any service or Surgery that is solely for Cosmetic purposes to improve or change appearance or to correct a deformity without restoring a physical bodily function, with the following exceptions:
 - a. Breast Reconstructive Surgery as allowed under WHCRA for Cosmetic purposes: and
 - b. Reconstructive Surgery made necessary by an Accidental injury in the preceding five years.
5. Rhinoplasty for Cosmetic reasons is excluded except when related to an Accidental injury occurring in the preceding five years.
6. All infertility services.
7. Surgical treatment for correction of refraction errors, such as radial keratotomy, astigmatic keratotomy, LASIK or excimer laser Surgery.
8. Organ or tissue transplant not specified as a benefit.
9. Expenses incurred for Surgery, pre-operative testing, treatment, or Complications by an organ or tissue donor, where the recipient is not an eligible Enrollee, covered by PEHP, or when the transplant for the PEHP Enrollee is not eligible.
10. Artificial organs.
11. Reversal of sterilization.
12. Trans-sexual operations.
13. Rhytidectomy.
14. Surgery that is dental in origin, including care and treatment of the teeth, gums, or alveolar process, extraction of teeth; dental implants and crowns or pontics over implants, re-implantation or splinting, endodontia, periodontia, and orthodontia, including anesthesia or supplies used in such care.
15. Complications as a result of non-covered or ineligible Surgery.
16. Injection of collagen, except as approved for urological procedures.
17. Lipectomy, abdominoplasty, panniculectomy.
18. Repair of diastasis recti.
19. Non-FDA Approved or Experimental or Investigational procedures, drugs and Devices.
20. Hair transplants or other treatment for hair loss or restoration.
21. Chemical peels.
22. Treatment for spider veins.
23. Liposuction.
24. Nurse (except to assist Surgery), medical assistant, medics, pediatric assistant, medical student, intern, resident in training and all other post-graduate medical education fellows.
25. Orthodontic treatment or expansion appliance in conjunction with jaw Surgery.
26. Chin implant, genioplasty or horizontal symphyseal osteotomy.
27. Unbundling or fragmentation of surgical codes.
28. Laser assisted uvulopalatoplasty (LAUP) or any other Surgery for snoring.
29. Otoplasty.
30. Abortions, except as in accordance with State Law, Utah Code Annotated §76-7-326, et.seq.
31. Surgical treatment for sexual dysfunction.
32. Subtalar Implants to correct flat feet.
33. Artificial ankle prosthetic.

6.5 ANESTHESIA BENEFITS

See the Benefits Summary for specific Copayment amounts.

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

6.5.1 LIMITATIONS RELATING TO ANESTHESIA

The following are Limitations of the policy:

1. Anesthesia must be administered by a qualified licensed practitioner other than the primary surgeon. Exceptions:
 - a. A Provider in a rural area, when an anesthesiologist is not available, may administer anesthesia and will be paid up to 20% of the eligible Surgery fee.
 - b. Anesthesia performed by an oral surgeon in conjunction with an eligible medical Surgical Procedure.
2. Anesthesia in conjunction with a Surgery that is payable at 50%, will also be payable at 50% of Maximum Allowable Fee.
3. When an eligible Surgical Procedure is performed in conjunction with other ineligible Surgery, anesthesia benefits will be prorated and only Eligible Benefits will be payable per Maximum Allowable Fee. All procedures must be disclosed for proper adjudication.
4. Anesthesia for labor and delivery is payable on a sliding scale with one base rate (first hour— full time, second hour—half time, quarter time for every hour thereafter).
5. An epidural block during labor is not payable to the delivering Provider in addition to an anesthesiologist fee.
6. If the Enrollee is six years of age or older, and is at high risk due to medical diagnoses which make it necessary to have a dental procedure performed under general anesthesia, benefits may be payable with Pre-authorization.
7. For Plan C Enrollees, eligible expenses related to Spinal Cord Stimulators are payable at 50% of Maximum Allowable Fee. All plans are limited to a \$25,000 Lifetime Maximum. Requires written Pre-authorization through Medical Case Management.
8. All services related to Trigger Point, Sacroiliac Joint, Nerve Block, Neurolytic procedures, Epidural Steroid and/or Facet Injections are payable per Maximum Allowable Fee up to \$5,000 per plan year.

6.5.2 EXCLUSIONS FROM COVERAGE RELATING TO ANESTHESIA

The following are Exclusions of the policy:

1. Anesthesia in conjunction with ineligible Surgery.
2. Anesthesia administered by the primary surgeon.
3. Monitored anesthesia care or on-call time for consultant.
4. Additional charges for supplies, drugs, equipment, etc.

6.6 MEDICAL VISIT BENEFITS

See the 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 Enrollee'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. Up to 20 physical therapy visits may be payable when Medically Necessary. Benefits allow up to three units per visit.
2. Outpatient occupational therapy for fine motor function may be covered up to 8 visits per plan year when Medically Necessary. Benefits allow up to three units per visit.
3. Only one medical, psychiatric, or physical therapy visit per day for the same diagnosis for any one Enrollee is allowable. Same-day visits by a multidisciplinary team are eligible with applicable Copayment(s) per Provider.
4. Eligible Benefits for TMJ/TMD/Myofacial Pain are limited to the following services: initial diagnostic exam, TMJ/TMD radiographs, range of motion measurements, TMJ/TMD appliance and appliance adjustments, physical therapy, and use of TENS unit. See Benefits Summary for Eligible Benefits.
5. Therapeutic injections in the Provider's office will not be eligible if oral medication is an effective alternative or if covered through the Specialty Drug Program.

6. Gamma globulin injections are only eligible for documented immunosuppression with absence of Gamma globulin. Depending on the diagnosis, these drugs may be required to be obtained through the Specialty Drug Program. No benefits are payable for prophylactic purposes or other diagnoses.
7. Parenteral hormone injections or pellet implants may be approved when oral medication cannot be tolerated, up to \$300 per plan year.
8. Speech therapy by a qualified speech therapist to restore speech loss or correct an impairment due to:
 - a. A congenital defect for which corrective Surgery has been performed; or
 - b. A physical injury or illness (i.e., head injury, stroke).

Therapy or evaluation provided by speech therapists for dysphagia (difficulty in swallowing) is payable separate from the speech therapy limit as a medical visit. Visits are limited to a lifetime maximum of 60 visits.
9. Long term rehabilitative physical therapy treatment, if Medically Necessary for a chronic long term illness or injury, and there is ability to functionally improve and progress, a Pre-authorization and treatment plan may be submitted by the treating Provider for an extension of benefits from the Lifetime Rehabilitation Maximum. This extension may not exceed 45 visits per plan year. Copayments will apply to each visit.
10. Medical services to treat or diagnose enuresis and/or encopresis as a physical organic illness are eligible on an outpatient basis.
11. After hours and/or holidays are payable only when special consultation is Medically Necessary beyond normal business hours or on calls or shift work requirements.
12. For Enrollees on Plan C, after the first five visits, Eligible Benefits for chronic pain disorders or syndromes requiring repetitive analgesic injections or procedures, and/or ongoing management (above five visits per year) are payable under a limited benefit of 50% of Maximum Allowable Fee. All plans are limited to a maximum of \$1,500 per plan year. Drug screenings will be included in this benefit.

13. Cardiac Rehabilitation, Phase 2, is payable following heart attack, cardiac Surgery, severe angina (chest pain), etc. for up to 24 visits per plan year.
14. Injectable vitamins and their administration require Pre-authorization.
15. Pulmonary Rehabilitation, Phase 2, resulting from chronic pulmonary disease or Surgery is payable for up to 24 visits per plan year.
16. For Enrollees on Plan C, eligible expenses related to Spinal Cord Stimulators are payable at 50% of Maximum Allowable Fee. All plans are limited to a \$25,000 Lifetime Maximum. Requires written Pre-authorization through Medical Case Management.
17. All services related to Trigger Point, Sacroiliac Joint, Nerve Block, Neurolytic procedures, Epidural Steroid and/or Facet Injections are payable per Maximum Allowable Fee, up to a maximum of \$5,000 per plan year.
18. Hepatitis B immunoglobulin is covered if there is a documented exposure or if in conjunction with an eligible liver transplant.
19. Sublingual antigens require Pre-authorization.
20. Medical visits for diabetic education are covered.

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. Services for weight loss or in conjunction with weight loss programs regardless of the medical indications.
3. Office visits in conjunction with hormone injections.
4. Services that are dental in origin, including care and treatment of the teeth, gums, alveolar process, extraction of teeth, re-implantation or splinting, endodontia, periodontia, orthodontia, prosthetics, dental implants, crowns or pontics over implants, anesthesia or supplies used in such care.
5. Charges in conjunction with ineligible procedures, including pre- or post-operative evaluations.
6. Epidemiological and predictive genetic screening and/or counseling except intrauterine genetic evaluations (amniocentesis or chorionic villi sampling) for high-risk pregnancy.

7. Acupuncture treatment.
8. Physical or occupational therapy for maintenance care.
9. Occupational therapy for activities of daily living, academic learning, vocational or life skills, drivers evaluation or training, developmental delay and recreational therapy.
10. Speech therapy for educational purposes or slow development, or speech therapy that does not qualify within the criteria previously stated in Limitations. Speech therapy following chronic otitis media is not eligible for Coverage.
11. Functional or work capacity evaluations, impairment ratings, work hardening programs or back school.
12. Hypnotherapy or biofeedback.
13. Hair transplants or other treatment for hair loss or restoration.
14. Study models, panorex, eruption buttons, orthodontics, occlusal adjustments or equilibration, crowns, photos, and mandibular kinesiograph are some, but not necessarily all, ineligible services for the treatment of TMJ/TMD or myofascial pain.
15. Vision therapy.
16. Treatment for tobacco abuse.
17. Take home medications charged by the Provider's office.
18. Treatment therapies for developmental delay or child developmental programs.
19. Rolfing or massage therapy.
20. Training and testing in conjunction with Durable Medical Equipment or prosthetics.
21. Nutritional analysis or counseling, except in conjunction with treatment for anorexia/bulimia under Mental Health benefits, or diabetes education.
22. Care, treatment or services for diagnosis of illness limited to multiple environmental chemicals, food, holistic or homeopathic treatment, including drugs.
23. Injections (including the office visit) when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.
24. 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.
25. Visits in conjunction with orthotics or subtalar implants to correct flat feet; 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.
26. Additional charges for after hours and holidays that are within the Provider's usual hours or "on call" duties such as emergency room Providers or radiologists.
27. Cardiac and/or pulmonary Rehabilitation, Phases 3 and 4.
28. Chelation therapy.
29. Office visits in conjunction with allergy or repetitive therapeutic injections.
30. Exercise programs.
31. 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.
32. Pre-natal classes.
33. Topical hyperbaric oxygen treatment.
34. Physical therapy modalities in conjunction with subtalar implant Surgery are not payable.
35. Chiropractic therapy.

6.7 DIAGNOSTIC TESTING, LAB AND X-RAY BENEFITS

See the Benefits Summary for specific Copayments.

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

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

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

The following are Limitations of the policy:

1. Sleep Studies for sleep disorders are payable. See the Benefits Summary for plan limits.
2. RAST Testing for allergies will be approved only under the following conditions:
 - a. Enrollee is under age four;
 - b. Severe generalized atopic dermatitis or eczema; or
 - c. Marked dermographism, urticaria, or severe asthma.
3. Lab and x-rays are only eligible for diagnosing or treating symptomatic illness and must be specific to the potential diagnosis. Additional testing beyond the appropriate codification or which does not correlate with Medical Records will be adjudicated as routine screening procedures.
4. Amniocentesis or chorionic villi sampling are payable when Medically Necessary for high-risk pregnancy, subject to applicable Copayment for the service rendered.
5. Laboratory typing/testing for organ transplant donors is eligible only when recipient is an eligible Enrollee, covered under a PEHP plan, and the transplant is eligible. The maximum payable per transplant is \$5,000.
6. Diagnostic genetic testing in the course of evaluating an Enrollee for genetic or congenital disease must be Pre-authorized.
7. For Enrollees on Plan C, eligible expenses related to Spinal Cord Stimulators are payable at 50% of Maximum Allowable Fee. All plans are limited to a \$25,000 Lifetime Maximum. Requires written Pre-authorization through Medical Case Management
8. All services related to Trigger Point, Sacroiliac Joint, Nerve Block, Neurolytic procedures, Epidural Steroid and/or Facet Injections are payable per Maximum Allowable Fee, up to \$5,000 per plan year.

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.
3. Sublingual or colorimetric allergy testing.
4. Charges in conjunction with weight loss programs regardless of Medical Necessity.
5. Epidemiological and predictive genetic screening and counseling.
6. Probability and predictive analysis and testing.
7. Unbundling of lab charges or panels.
8. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations.
9. Hair analysis, trace elements, or dental filling toxicity.
10. Infertility services.

6.8 MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

See the Benefits Summary for details.

6.8.1 FACILITY AND HOSPITAL SERVICES

Medically Necessary services from Contracted Hospitals, inpatient treatment centers, residential treatment programs, day treatment facilities or intensive outpatient programs are payable after applicable Copayments and must be Pre-notified through Behavioral Health at 801-233-4100. Failure to Pre-notify will result in denial of benefits. Charges for the full Hospital stay will be prorated into a per diem rate, or as Contracted with specific Providers, for adjudication of daily benefits.

Day treatment or intensive outpatient program may be considered in lieu of inpatient care with two or more days applicable to one inpatient day based on Provider agreements or Pre-notification.

Electro Convulsive Therapy is eligible under Medical benefits.

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

6.8.2 INPATIENT PROVIDER VISITS

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.

Eligible neuropsychological evaluations and testing are payable as medical benefits.

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

6.8.4 LIMITATIONS RELATING TO MENTAL HEALTH AND SUBSTANCE ABUSE

The following are Limitations of the policy:

1. Benefits for group family counseling will be payable for the primary patient. Benefits will not be considered separate for each individual family member.
2. When an inpatient stay spans an old and new plan year, benefits will be based on the old plan year provisions.
3. Only one visit per Provider per day is payable.

6.8.5 EXCLUSIONS FROM COVERAGE RELATING TO MENTAL HEALTH AND SUBSTANCE ABUSE

The following are Exclusions of the policy:

1. Inpatient treatment for Mental Health and/or substance abuse without Pre-notification.
2. Milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy.
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.

6.9 AMBULANCE BENEFITS

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.
2. Only services to transport to the nearest Hospital where proper medical care is available are eligible.
3. Benefits will be payable for air ambulance only in Life-threatening emergencies when an Enrollee could not be safely transported by ground ambulance, and only to the nearest facility where proper medical care is available.

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

6.9.2 EXCLUSIONS FROM COVERAGE RELATING TO AMBULANCE BENEFITS

The following are Exclusions of the policy:

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

6.10 HOME HEALTH AND HOSPICE CARE BENEFITS

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

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

6.10.1 LIMITATIONS RELATING TO HOME HEALTH AND HOSPICE CARE BENEFITS

The following are Limitations of the policy:

1. Total Enteral Nutrition (TEN) formula requires Pre-authorization and must be obtained through the pharmacy card.
2. Physical and/or occupational therapy performed in the home is subject to the outpatient plan limits. See the Benefits Summary for details.
3. Skilled Nursing visits are subject to plan Limitations. See the Benefits Summary for details.
4. Hospice services are subject to plan Limitations.

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

6.11 PRESCRIPTION AND SPECIALTY DRUG BENEFITS

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

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

- **Tier 1:** Preferred generic drugs that are available at the lowest Copayment.
- **Tier 2:** Preferred brand name drugs that are available at the intermediate Copayment.
- **Tier 3:** Non-Preferred medications that are available at the highest Copayment.

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

PEHP Enrollees will receive a pharmacy Identification card upon Enrollment in the PEHP's Pharmacy program. Enrollees need to present their pharmacy card or provide their PEHP Identification number to a participating pharmacy along with an eligible prescription and any applicable Copayment to receive their prescription medication.

6.11.1. COVERED FORMULARY DRUGS

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

6.11.2 PRE-AUTHORIZATION FOR PRESCRIPTION AND SPECIALTY MEDICATIONS

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

To obtain Pre-authorization, an Enrollee's physician may obtain a Pre-authorization form at www.pehp.org or may contact PEHP's Customer Service to start the Pre-authorization process. The Provider will be directed to Medco's or PEHP's pharmacy Pre-authorization phone line. Approval or denial will be communicated to the Provider's office. Enrollees may also phone the PEHP Customer Service Department for a status of the physician's request. Pre-authorization does not guarantee payment. Coverage is subject to eligibility, benefit Coverage and Pre-authorization requirements.

6.11.3 QUANTITY LEVELS AND STEP THERAPY

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

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

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

6.11.4 OUT-OF-AREA PRESCRIPTIONS OR OTHER CASH PURCHASES

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

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

6.11.5 SPECIALTY DRUGS

Specialty injectables and Specialty Drugs are typically bio-engineered medications that have specific shipping and handling requirements or are required by the manufacturer to be dispensed by a specific facility. PEHP's list of Specialty medications may include drugs and injectables that Enrollees may have had previously dispensed at their physicians office, home health or at a local pharmacy. PEHP requires that most Specialty medications be obtained from a designated pharmacy or facility for Coverage. The Specialty vendor will coordinate with an enrollee or physician to provide delivery to either an enrollee's home or a Provider's office. Go to www.pehp.org or contact PEHP's Customer Service for a complete list of these medications required to be dispensed through our designated Specialty pharmacy. Pre-authorization requirements may also apply.

6.11.6 LIMITATIONS RELATING TO PRESCRIPTION DRUG BENEFITS

The following are Limitations of the policy:

1. Drug quantities, dosage levels and length of therapy may be limited to the recommendations of the drug manufacturer, FDA, clinical guidelines, or PEHP's Pharmacy and Therapeutics Committee.
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. Diabetic supplies and medications must be purchased with an enrollee's pharmacy card at a PEHP Contracted pharmacy.
5. A medication in a different dosage form or delivery system that contains the same active ingredient as an already covered drug may be restricted from Coverage.
6. PEHP may classify an FDA-approved generic medication as non-Preferred or not covered when directed by the Pharmacy and Therapeutics Committee.
7. When a medication is dispensed in two different strengths or dosage forms, a separate Copayment will be required for each dispensed prescription.
8. Prescription prenatal vitamins are covered at 100% when a female Enrollee enrolls in WeeCare and uses their pharmacy card to obtain their prescription within the first or second trimester. Enrollees who enroll after the first or second trimester are responsible for applicable Copayments.

9. If an enrollee is required by the FDA to be enrolled in a manufacturer Access or Disease Management Program, Coverage may be limited to Enrollee's participation.
10. 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.
11. If a medication is packaged in a day supply that is greater than a 30-day supply, the Enrollee's out-of-pocket responsibility may require a Copayment for each 30-day supply of the anticipated duration of the medication.
12. Cash paid claims will be subject to PEHP's Pre-authorization, step therapy, benefit Coverage and quantity levels. PEHP will reimburse up to Medco's Contracted rate and PEHP's benefit rules.
13. PEHP will have the ability to limit the availability and filling of any medication, Device or supply when the drug is susceptible to misuse. 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 for any underlying medical condition.
 - e. Require completion of a drug treatment program.
 - f. Adhere to a PEHP Limitation or program to help reduce or eliminate drug abuse or dependence.
 - g. Deny medications or quantities needed to support any dependence, addiction or abuse if an enrollee misuses the health care system to obtain drugs in excess of what is Medically Necessary.
14. Fluoride tablets are limited to children up to the age of 12 years old.
15. Enteral formula requires Pre-authorization and is limited to the pharmacy network for Coverage.
16. Retail prescriptions are not refillable until 75% of the total prescription supply is used. Twenty-three days must pass at a local pharmacy before a prescription can be refilled.
17. A separate Copayment may be required if Federal or state law, clinical guidelines, PEHP quantity levels

or manufacturer's package size requires a prescription to be dispensed in a quantity less than a 30-day supply.

6.11.7 EXCLUSIONS FROM COVERAGE RELATING TO PRESCRIPTION DRUG BENEFITS

The following are Exclusions of the policy:

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

their pharmacy card at a PEHP Contracted pharmacy are not payable as a pharmacy claim.

20. Compounding fees, powders, and non-covered medications used in compounded preparations.
21. Medications used for Cosmetic indications.
22. Replacement of lost, stolen or damaged medications.
23. Medications used for foreign travel.
24. Nasal immunizations unless listed in the PEHP Preferred Drug List.
25. Medications for Elective abortions.
26. Contraceptive jellies, creams, foams, implants, or IUDs.
27. Skin patches for motion sickness.
28. Drugs for the treatment of nail fungus.
29. Medications for sex change operations.
30. Medications needed to treat Complications associated with Elective obesity Surgery and non-covered services.
31. Medications for the treatment of bedwetting.
32. Hypodermic needles.
33. Oral and nasal antihistamines for allergies.
34. Medications obtained outside the United States that are not for Urgent or emergency use.
35. Drugs used for sexual dysfunction or enhancement.
36. An additional medication that may be considered duplicate therapy defined by the FDA or PEHP.
37. The following specific medications and any additions listed on the PEHP website: Adoxa, ammonium lactate, Avita, Doryx, Dynacin, Solodyn, Subutex, Doxycycline monohydrate, Fortamet, Glumetza, Symbyax and Sarafem.
38. Leukotrienes (e.g. Singulair) when prescribed for allergies.
39. Smoking cessation products.

6.12 DURABLE MEDICAL EQUIPMENT/SUPPLY BENEFITS

See the Benefits Summary for specific Copayments.

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

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

Coverage is provided when the equipment is:

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

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

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

6.12.1 LIMITATIONS RELATING TO DURABLE MEDICAL EQUIPMENT/SUPPLY BENEFITS

The following are Limitations of the policy:

1. Machine rental or purchase for the treatment of sleep disorders is payable at plan benefits, up to \$2,500 in a five-year period, including all related equipment and supplies.
2. One lens for the affected eye following eligible corneal transplant Surgery. Contact lenses for documented Keratoconus may be approved as Medically Necessary.
3. Two pair support hose per plan year for phlebitis or other eligible diagnosis.
4. One pair of ear plugs within 60 days following eligible ear Surgery.

5. The equipment listed below is limited to the following Lifetime Maximums:
 - a. TENS Unit — \$500
 - b. Neuromuscular Stimulator — \$1,000
 - c. H-wave Electronic Device — \$2,000
 - d. Sympathetic Therapy Stimulator (STS) — \$ 2,000
 - e. Similar or new technology will be subject to review and limited benefits.
6. Continuous Passive Motion (CPM) machine rentals may be approved for up to 21 days rental only for total knee or shoulder arthroplasty.
7. Artificial prosthetics, such as eyes, breasts or limbs, when made necessary by loss from an injury or illness, must be Pre-authorized. If approved, the maximum prosthetic benefit available in any five-year period is \$20,000 (per site), including all services, repairs and replacements.
8. Only conventional, body powered, cable-operated prosthetics will be eligible for loss of a limb or congenitally missing limb(s). Additional charges for more elaborate or precision equipment will be the Enrollee's responsibility.
9. Wheelchairs require Pre-authorization through Medical Case Management and are limited to one in any five-year period. The maximum wheelchair benefit available in any five-year period is \$20,000 including all services, repairs and replacement. The wheelchair base is included in the above limit and may not exceed \$6,000.
10. Knee braces are limited to \$1,500 in a three-year period.

6.12.2 EXCLUSIONS FROM COVERAGE RELATING TO DURABLE MEDICAL EQUIPMENT/SUPPLY BENEFIT

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

1. Training and testing in conjunction with Durable Medical Equipment or prosthetics.
2. More than one lens for each affected eye following Surgery for corneal transplant.
3. More than two pair of support hose for a medical diagnosis per plan year.
4. Durable Medical Equipment that is inappropriate for the patient's medical condition.
5. Diabetic supplies, i.e. insulin, syringes, needles, etc., are a pharmacy benefit.
6. New or used equipment purchased from non-licensed Providers.

6.13 ADDITIONAL BENEFIT PROGRAMS

6.13.1 NATIONAL ACCESS PROGRAM

The National Access Program is a value added adjunct to PEHP's Advantage Provider Network. This program allows Enrollees access to the best Provider networks outside of Utah. Each PEHP Subscriber will be issued an Out-of-State Network card. **This card is for Enrollees who are traveling or living outside the State of Utah, and should be used for services that cannot be performed in Utah that have been Pre-authorized by PEHP.**

6.13.2 WEECARE PROGRAM

WeeCare is PEHP's pregnancy case management service. It is a prenatal risk reduction program which offers educational, consultative and pregnancy case management to expectant mothers.

When an Enrollee calls WeeCare within the first or second trimester of pregnancy, pre-natal vitamins may be authorized at 100% through the pharmacy program. The Enrollee will receive an additional incentive of \$100 cash if contact with WeeCare is made during the first 20 weeks of pregnancy or an incentive of \$50 cash if contact with WeeCare is made during weeks 21-30 of pregnancy. Cash incentives are payable at the end of the pregnancy.

While WeeCare is not intended to take the place of the Enrollee's physician or regular prenatal care, it will provide the Enrollee with another resource for answers to questions during pregnancy. After initial contact with WeeCare the Enrollee will receive educational materials concerning pregnancy.

VII. General Limitations and Exclusions

7.1 PRE-AUTHORIZATION LIMITATIONS

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

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

- All inpatient Hospital admissions
- All inpatient Hospital Rehabilitation admissions
- Skilled nursing facilities

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

Elective Treatment

Treatment for a medical condition that can be scheduled in advance without causing harm or suffering to the Enrollee's health. At least five working days before the admission date or Surgery, call PEHP at 801-366-7755 or 1-800-753-7754.

Urgent Treatment

Treatment for a medical condition that, if left untreated, may cause unnecessary suffering or prolonged treatment to restore Enrollee's health. At least three working days before the admission date or Surgery, call PEHP at 801-366-7755 or 1-800-753-7754.

Emergency Treatment

Treatment for a medical condition of an unforeseen nature that, if left untreated, may cause death or permanent damage to the Enrollee's health. Enrollees do not have to call prior to admission. Enrollee or a responsible person must contact PEHP within 48 hours following admission or Surgery (or, if during a weekend, the first working day following treatment) at 801-366-7755 or 1-800-753-7754.

Failure to call will result in denial of benefits. See the Benefits Summary for specific penalties.

Maternity Care

Call PEHP's WeeCare Program at 801-538-9943 or 1-800-662-9660. See Section 6.13.2 for more information on WeeCare.

Inpatient Treatment for Mental Health and/or Substance Abuse

Call Behavioral Health at 801-233-4100. See the Benefits Summary for further details. Failure to call will result in denial of benefits.

Out-of-Area Hospital Admission

Requires Pre-notification by the Enrollee, the physician, the Hospital, or, in an emergency, a responsible person. Call PEHP at 801-366-7755 or 1-800-753-7754 within the time specified above for the type of treatment. Failure to call will result in a denial of benefits.

The following services require verbal Pre-authorization by calling PEHP Customer Service:

- Dialysis when using non-Contracted Providers
- Breast pumps
- Human pasteurized milk
- Speech therapy
- Any inpatient maternity stay that exceeds 48 hours following a vaginal delivery or 96 hours following delivery by Cesarean section.
- Jaw surgery

The following services require written Pre-authorization:

- Dental procedures performed in an outpatient facility for patients six years of age or older.
- Organ or tissue transplants
- Surgery that may be partially or wholly Cosmetic
- Coronary CT angiography
- Surgery performed in conjunction with obesity Surgery
- Implantation of artificial Devices
- New or Unproven technologies
- Cochlear implants
- Diagnostic genetic testing in the course of evaluating an Enrollee for genetic and congenial diseases.
- Durable Medical Equipment with a purchase price over \$750 or any rental of more than 60 days
- Home intrauterine fetal monitoring
- Botox injections
- Maxillary/Mandibular bone or Calcitite augmentation Surgery
- Any out-of-state service that is not Urgent or Life-threatening
- Wound care
- Home health and Hospice Care
- Hyperbaric oxygen treatments
- Intrathecal pumps
- Spinal cord stimulators
- Subtalar implants
- Surgical Procedures utilizing robotic assistance
- Lymphedema therapy after 10 visits
- Implantable medications
- Certain prescription and Specialty Drugs
- Continuous glucose monitoring Devices and supplies

7.2 CATASTROPHIC BENEFITS

CHIP has set limits for maximum out-of-pocket expense for Enrollees. After the Enrollee's share of eligible expenses exceeds specified amounts, PEHP will pay further Eligible Benefits incurred during the remaining plan year at 100% of Maximum Allowable Fee. See the Benefits Summary for specific out-of-pocket limits.

7.2.1 EXCLUSIONS FROM COVERAGE RELATING TO CATASTROPHIC SICKNESS OR INJURY BENEFITS

Amounts paid by the Enrollee for the following services will not apply to the Enrollee'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 Maximum Allowable Fee 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 Maximum Allowable Fee.
2. All charges for services received as a result of an Industrial Claim (on-the-job) injury or illness, any portion of which is payable under Worker's Compensation or Employer's liability laws.
3. PEHP will only be liable for Eligible Benefits for which the Enrollee is liable. Payment will not be made for any expense for which the Enrollee is not legally bound.
4. Charges for educational material, literature, or charges made by a Provider to the extent that they are related to scholastic education, vocational training, learning disabilities, or behavior modification, or for dealing with normal living such as diet, or medication management for illness (except for the benefit provided for diabetes education and anorexia or bulimia education).
5. Charges for medical care rendered by an Immediate Family member.
6. Charges prior to Coverage or after termination of Coverage even if illness or injury occurred while an Enrollee. If Enrollee is inpatient at the time of termination, eligible charges for the length of the hospital stay will be covered.
7. Provider's telephone calls or travel time.
8. Charges for services primarily for convenience, contentment, or other non-therapeutic purpose.
9. Overutilization, charges which are not Medically Necessary to treat or diagnose the condition, as determined by PEHP; charges for any service, supply or medication not reasonable or necessary for the medical care of the patient's illness or injury.
10. Charges for Unproven medical practices or care, treatment, Devices or drugs that are Experimental or Investigational in nature or generally considered Experimental or Investigational by the medical profession or non-FDA Approved for the diagnosis given. PEHP shall determine whether medical care, treatment, Devices, or drugs are Unproven medical practices, or Experimental or Investigational.
11. Charges for services without adequate diagnosis or dates of service.
12. Charges for services, supplies or medications to the extent they are provided by any governmental plan or law under which the Enrollee is, or could be covered.
13. Charges for services as a result of an auto related injury and covered under No-fault insurance or would have been covered if Coverage were in effect as required by law.
14. Services, treatments, or supplies furnished by a Hospital or facility owned or operated by the United States Government or any agency thereof.
15. Services or supplies received as a result of an act of war.
16. Any service or supply not specifically identified as a benefit.
17. Charges for commercial or private aviation services, meals, accommodations and car rental.
18. Charges for mileage reimbursement except for eligible ambulance service.
19. Charges by a Provider for case management.
20. Charges for independent medical evaluations and/or testing for the purpose of legal defenses or disputes.
21. Charges for submission of Medical Records necessary for claims review.
22. Delivery, shipping, handling, sales tax, or finance charges.
23. PEHP is not responsible to pay any benefits given verbally or assumed except as written in a Pre-authorization, documented by Customer Service or Medical Case Management, or as described in this policy.
24. Charges for remote medical evaluation and management, including prescriptive services provided by the Internet, telephone or catalog.
25. Autopsy procedures.
26. Complications as a result of any non-covered service, procedure, device, or drug.
27. Treatment of obesity by means of Surgery, medical services, or prescription drugs, regardless of associated medical, emotional, or psychological condition.

28. Services incurred in connection with injury or illness arising from the commission of
 - a. a felony;
 - b. an assault, riot or breach of peace;
 - c. a Class A misdemeanor;
 - d. any criminal conduct involving the illegal use of firearm or other deadly weapon;
 - e. other illegal acts of violence.
29. Claims submitted more than 12 months after service has been rendered.
30. Charges for expenses in connection with appointments scheduled and not kept.
31. Charges for the treatment of sexual dysfunction.
32. Charges for services received as a result of medical tourism, or for traveling out of the United States to seek medical services or drugs.
33. Medical services, procedures, supplies or drugs used to treat secondary conditions or Complications due to any non-covered medical services, procedures, supplies or drugs are not covered. Such Complications include, but are not limited to:
 - a. Complications relating to services and supplies for or in connection with gastric bypass or intestinal bypass, gastric stapling, or other similar Surgical Procedure to facilitate weight loss, or for or in connection with reversal or revision of such procedures, or any direct Complications or consequences thereof;
 - b. Complications as a result of a Cosmetic Surgery or procedure, except in cases of Reconstructive Surgery:
 1. When the service is incidental to or follows a Surgery resulting from trauma, infection or other diseases of the involved party; or
 2. Related to a congenital disease or anomaly of a covered Enrollee that has resulted in functional defect;
 - c. Complications relating to services, supplies or drugs which have not yet been approved by the FDA or which are used for purposes other than its FDA-Approved purpose.
34. Infertility treatment.

7.5 SUBROGATION AND CONTRACTUAL REIMBURSEMENT

7.5.1 CONTRACTUAL REIMBURSEMENT

The Enrollee agrees to seek recovery from any person(s) who may be obligated to pay damages arising from occurrences or conditions caused by the person(s) for which Eligible Benefits are provided or paid for by PEHP and promises to keep PEHP informed of his/her efforts to recover from those person(s). If the Enrollee 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 Enrollee's behalf.

In the event that Eligible Benefits are furnished to an Enrollee for bodily injury or illness, the Enrollee shall reimburse PEHP with respect to an Enrollee's right (to the extent of the value of the Benefits paid) to any claim for bodily illness or injury, regardless of whether the Enrollee 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 Enrollee'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 Enrollee chooses to incur in securing the amount of the claim.

7.5.2 SUBROGATION

The Enrollee agrees to seek recovery from any person(s) who may be obligated to pay damages arising from occurrences or conditions caused by the person(s) for which Eligible Benefits are provided or paid for by PEHP and promises to keep PEHP informed of his/her efforts to recover from those person(s). If the Enrollee 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 Enrollee's behalf. The Enrollee will cooperate fully with PEHP and will sign and deliver instruments and papers and do whatever else is necessary on PEHP's behalf to secure such rights and to authorize PEHP to pursue these rights.

In the event that Eligible Benefits are furnished to an Enrollee for bodily injury or illness, PEHP shall be and is hereby subrogated (substituted) with respect to an Enrollee's right (to the extent of the value of the Benefits paid) to any claim for bodily illness or injury, regardless of whether the Enrollee 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 Enrollee'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 Enrollee chooses to incur in securing the amount of the claim.

7.5.3 ACCEPTANCE OF BENEFITS AND NOTIFICATION

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

7.5.4 RECOUPMENT OF BENEFIT PAYMENT

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

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

VIII. Claims Submission & Appeals

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

PEHP may request Medical Records, operative reports, pathology reports, x-rays, photos, etc. of an Enrollee. The PEHP Benefits Review Committee 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 Maximum Allowable Fee and code review systems implemented by PEHP. Claims may be returned for incomplete or improper coding. If, after a second request, necessary records are not received, the claim(s) will be denied for insufficient documentation.

8.1 CLAIMS SUBMISSION

When a Contracted Provider is used, the Provider will submit the claims directly to PEHP. Payment will be made directly to the Contracted Provider. It is the Contracted Provider's responsibility to file the claim within 12 months from the date of service. Claims denied for untimely filing are not the Enrollee's responsibility, unless the Enrollee provides inaccurate or incomplete information regarding Medical Plan Coverage to the Provider.

When a non-Contracted Provider is used, it is the responsibility of the Enrollee to ensure that the claim is filed promptly and properly. PEHP accepts paper and electronic claims. Claims that are not received within 12 months from the date of service will be denied. The Enrollee will be responsible for the entire claim.

**8.1.1 REQUIRED INFORMATION
FOR CLAIMS SUBMISSION**

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

PEHP shall pay claims directly to the non-Contracted Provider, except where the Enrollee provides acceptable written documentation to PEHP, in a timely manner, that the Enrollee has paid the claim. Claims are always paid directly to Contracted Providers.

Claims may be submitted electronically, or mailed to:

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

8.2 CLAIMS APPEALS PROCESS

If the Enrollee disagrees with PEHP's action, an Enrollee may request a full and fair review, by writing to the Benefits Review Committee within 180 days after receiving notice of denial. Requests for review of claims should be mailed to:

PEHP
Benefits Review Committee
560 East 200 South
Salt Lake City, Utah 84102-2004

If the Enrollee disagrees with the decision or action taken by the Benefits Review Committee, he/she has the right to request an Administrative Review within 60 days of notification of the Committee's action. Upon written request, including receipt of any pertinent additional information or comments, the Administrative Review Committee will commence an investigation. Written notification of its outcome will be mailed to the Enrollee.

If an Enrollee is not satisfied with a decision of the Administrative Review Committee, an appeal in writing may be sent within 60 days of notification of the Administrative Review Committee's decision to:

Director's Office/Formal Hearings
Division of Healthcare Financing
288 North 1460 West
Salt Lake City, Utah 84114-3101

Appendix A

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

Durable Medical Equipment

COVERED EQUIPMENT

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

Durable Medical Equipment (CONTINUED)

Item	COVERED	NON-COVERED	PRE-AUTHORIZATION	PHARMACY CARD SYSTEM ONLY
Abdominal Binder/Support	●			
Adaptive Devices or Aids to Daily Living		●		
Aerochamber				●
Air Cleaner, Purifier		●		
Air Conditioners		●		
Alarm Systems		●		
Allergy Free Blanket, Pillow Case, or Mattress Cover		●		
Ankle Foot Orthotic (AFO)	●			
Apnea Monitor (infant)			●	
Arch Supports, Insoles, Heel Cushions, etc.		●		
Automatic Blood Pressure Monitor		●		
Auto-Tilt Chair		●		
Bandages		●		
Bar Bell Set, Dumb Bells		●		
Barrel Crawl		●		
Bathtub Lifts		●		
Bathtub Seat/Bench/Chair		●		
Bathtub/Toilet Rails		●		

Durable Medical Equipment (CONTINUED)

Item	COVERED	NON-COVERED	PRE-AUTHORIZATION	PHARMACY CARD SYSTEM ONLY
Batteries, Replacement, any type		●		
Battery Charger		●		
Bed, Air Fluidized			●	
Bed Baths (home type)		●		
Bed Board		●		
Bed Cradle		●		
Bed Pans		●		
Bed Side Rails			●	
Bed Wedges, Foam Slants		●		
Bed, Hospital, standard, semi-electric			●	
Bed, Hospital, total electric		●		
Bed, non-Hospital, Adjustable		●		
Bed, Oscillating		●		
Bed, Pressure Therapy			●	
Beeper		●		
Bilirubin Lights (phototherapy) <i>Up to seven days</i>	●			
Biofeedback Device		●		
BiPAP (including eligible attachments and supplies) <i>Limited to \$2,500 in a five-year period</i>	●			
Blood Pressure Cuff and/or Kit		●		
Bone Growth Stimulator (Osteogenesis)—purchase			●	
Bone Growth Stimulator—rental		●		
Booster Chair, pediatric		●		
Brace, back (see Corset)	●			

Durable Medical Equipment (CONTINUED)

Item	COVERED	NON-COVERED	PRE-AUTHORIZATION	PHARMACY CARD SYSTEM ONLY
Brace, knee				
Limited to \$1,500 in a three year period	●			
Brace, leg (child)	●			
Brace, scoliosis	●			
Braille Teaching Texts		●		
Brassiere/Bra (mastectomy)		●		
Breast Pump			●	
Cane		●		
Car Seat, adult or pediatric		●		
Car/Van Lift, Car modifications		●		
Carafe		●		
Cast Boot (ambulatory surgical boot)	●			
Cervical Collar	●			
Cervical Pillow		●		
Chair, adjustable (for dialysis only)			●	
Chest Compression Vest, System Generator and Hoses			●	
Circle Balance Discs		●		
Cleaning Solutions		●		
Coagulation Protime Self-Testing Device (CoaguChek)			●	
Commode and accessories		●		
Communicative Device, Equipment or Repair		●		
Computer Systems or Components		●		
Computerized Assistive Devices		●		
Contact Lens		●		
Contact Lens, following corneal transplant	●			
Limited to one lens per eye				

Durable Medical Equipment (CONTINUED)

Item	COVERED	NON-COVERED	PRE-AUTHORIZATION	PHARMACY CARD SYSTEM ONLY
Contact Lens, for keratoconus	●			
Continuous Hypothermia Machine		●		
Continuous Passive Motion (CPM) Machine	●			
Up to 21 days for Total Knee or Shoulder Replacement				
Continuous Passive Motion (CPM) Machine for toe/foot surgeries		●		
Continuous Passive Motion (CPM) Machine – other procedures			●	
Continuous Positive Airway Pressure (CPAP Machine—including eligible attachments and supplies)	●			
Limited to \$2,500 in a five year period				
Contour Chair		●		
Corset (lumbar), custom, orthopedic	●			
Cranial Electro Stimulation (CES)		●		
Crawler, height adjustable		●		
Crawler, prone		●		
Crawling Coordination Training Unit		●		
Crutches – purchase	●			
Crutches – rental		●		
Crutches, Underarm Pad Replacement		●		
Cuff Weights		●		
Dehumidifiers (room or central heating system)		●		
Deionizer, Water Purification System		●		
Dialysis Equipment, home			●	

Durable Medical Equipment (CONTINUED)

Item	COVERED	NON-COVERED	PRE-AUTHORIZATION	PHARMACY CARD SYSTEM ONLY
Diabetic Supplies (syringes, needles)				●
Diapers		●		
Drionic Machine			●	
Dynamic Hip Splint, Infant			●	
Dynasplint			●	
Ear Plugs, molds <i>Limited to one pair, following ear Surgery</i>	●			
Elastic Stockings, surgical <i>Limited to four per plan year for eligible diagnosis</i>	●			
Electrodes and Accessories for stimulators <i>Included in maximum dollar limits</i>	●			
Electronic Controlled Thermal Therapy Devices		●		
Electrostatic Machine		●		
Elevators		●		
Emesis Basins		●		
EMG Machine (Biofeedback)		●		
Enuresis Alarm Unit		●		
Environmental Control Systems		●		
Erectile Aid System (vacuum system)		●		
Exercise Equipment		●		
Eyeglasses		●		
Face Masks		●		
Fracture Frame	●			
Gel Flotation Pads and Mattresses			●	
Glucometer (blood glucose monitor)		●		
Glucose Monitor, Continuous			●	
Gluowatch		●		

Durable Medical Equipment (CONTINUED)

Item	COVERED	NON-COVERED	PRE-AUTHORIZATION	PHARMACY CARD SYSTEM ONLY
Grab Bars		●		
Gym Mat		●		
Hand Controls for Motor Vehicle		●		
Handgrip Replacement (cane, crutch, walker, wheelchair, etc.)		●		
Head Float		●		
Health Spa		●		
Hearing Aids, hearing Devices	●			
Heat Lamps		●		
Heating Pads, Hot Water Bottle		●		
Helmet			●	
Home Modifications		●		
Home Physical Therapy Kits		●		
Hot Tub		●		
Humidifier		●		
Humidifier, room or central heating		●		
Humidifier, with IPPB or other respiratory equipment			●	
H-Wave Electronic Device, including supplies <i>Limited to \$2,000 Lifetime maximum</i>			●	
Hydraulic Patient Lifts			●	
Hydrocollater Unit		●		
Hydrotherapy Tanks		●		
Ice Packs		●		
Immobilizer, shoulder	●			
Incontinence Treatment System			●	
Infusion Pumps (ambulatory), Parenteral, Enteral			●	
Insulin Pump, external, ambulatory			●	
Interferential Nerve Stimulator		●		

Durable Medical Equipment (CONTINUED)

Item	COVERED	NON-COVERED	PRE-AUTHORIZATION	PHARMACY CARD SYSTEM ONLY
IPPB Machine			●	
IV Pole	●			
Kangaroo Pump/Kit			●	
Lambswool Pads		●		
Lift Platform, wheelchair, van or home		●		
Lift, Chair (seat)		●		
Light Box (seasonal)	●			
Lumbosacral Support	●			
Lymphedema Pump (pneumatic compressor)			●	
Lymphedema Sleeves/Supplies			●	
Maclaren Buggy, Stroller		●		
Maintenance, Warranty or Service Contracts		●		
Maintenance/Repair, Routine		●		
Massage Devices		●		
Mattress, Hospital bed			●	
Mattress, inner spring or foam rubber		●		
Mattress, pressure-reducing, including overlay			●	
Motor Vehicle		●		
Motor Vehicle Alterations, Conversions		●		
Motor Vehicle Devices, Hand Controls, Lifts, etc.		●		
Mouth Guard		●		
Muscle Stimulator, including supplies <i>Limited to Lifetime dollar maximum</i>			●	
Myoelectric Prosthetics		●		
Nebulizer, with compressor, ultrasonic, heater, etc. <i>Limited to one in five years</i>	●			

Durable Medical Equipment (CONTINUED)

Item	COVERED	NON-COVERED	PRE-AUTHORIZATION	PHARMACY CARD SYSTEM ONLY
Neo-control Chair		●		
Neuromuscular Stimulator (NMES) <i>Limited to \$1,000 Lifetime maximum</i>			●	
Orthopedic Brace for sports activities		●		
Orthotics, Shoe Inserts (any type) <i>Except when covered by specific Employer group up to \$200 annually</i>		●		
Overbed Tables		●		
Oximeter (pulse oximeter)			●	
Oxygen (contents), Cylinders, Carrier	●			
Oxygen, Portable Systems	●			
Oxygen Humidifier	●			
Oxygen Regulators	●			
Oxygen Systems, Concentrators and Accessories—purchase		●		
Oxygen Systems, Concentrators and Accessories—rental	●			
Oxygen Tent	●			
Pager		●		
Paraffin Bath Units (therabath)		●		
Parallel Bars		●		
Patient Lifts, Slings			●	
Peak Flow Meter, handheld <i>Limited to one per plan year</i>	●			
Pelvic Floor Stimulator			●	
Percussor, Chest (with generator)			●	
Polarcare (cold compression Device)		●		
Portable Room Heaters		●		

Durable Medical Equipment (CONTINUED)

Item	COVERED	NON-COVERED	PRE-AUTHORIZATION	PHARMACY CARD SYSTEM ONLY
Postural Drainage Board		●		
Posture Chair		●		
Pressure Pads, Cushions and Mattresses (with or without pumps)			●	
Prosthesis, Breast (non-implant), Eye, Limb <i>See Limitations</i>			●	
Prosthetic Socks (stump socks), and supplies <i>See Limitations</i>	●			
Protonics Knee Orthosis			●	
Pulsed Galvanic Stimulator, including supplies <i>Limited to Lifetime dollar maximum</i>			●	
Quad-Cane	●			
Raised Toilet Seats		●		
Reflux Board, infant	●			
Repairs, Non-Routine Performed by a skilled technician			●	
Rib Belt	●			
Rocking Bed		●		
Roho Air Floatation System			●	
Rollabout Chair		●		
Rowing Machine		●		
Safety Grab Bar, Rail, Bathroom, Toilet, Bed		●		
Safety Rollers, with walkers			●	
Sauna Baths		●		
Scales		●		
Scoliosis Orthotic Devices	●			
Scooter Board		●		
Seat Lift Mechanism		●		

Durable Medical Equipment (CONTINUED)

Item	COVERED	NON-COVERED	PRE-AUTHORIZATION	PHARMACY CARD SYSTEM ONLY
Shoes, Orthopedic or Corrective, Modifications, Lifts, Heels, Wedges, Inserts, etc.		●		
Shower Bench		●		
Sitz Bath		●		
Sling, Arm	●			
Spa Membership		●		
Speech Augmentation Communication Device		●		
Speech Generating Device		●		
Speech Teaching Machines, Language Master		●		
Sphygmomanometer with Cuff (blood pressure cuff)		●		
Spinal Pelvic Stabilizers		●		
Stairglide (Stairway Elevator Lift)		●		
Stander			●	
Standing Table		●		
Stethoscope		●		
Suction Pump, Aspirator	●			
Sun Glasses		●		
Supine Board			●	
Support Hose (elastic stockings) <i>Limited to four per plan year for eligible diagnosis</i>	●			
Support Pillow		●		
Swimming Pool		●		
Sympathetic Therapy Stimulator (STS), including supplies <i>Limited to \$2,000 Lifetime maximum</i>			●	
Telephone		●		
Telephone Alert Systems		●		

Durable Medical Equipment (CONTINUED)

Item	COVERED	NON-COVERED	PRE-AUTHORIZATION	PHARMACY CARD SYSTEM ONLY
Telephone Arms		●		
Theraband		●		
Therapy Ball, Roll, Putty		●		
Thermometer		●		
Three-Wheeler <i>Wheelchair benefits apply</i>			●	
Tips, Replacement (wheelchair, walker, crutches, etc.)		●		
Toddler Walkabout		●		
Toileting Aids		●		
Tool Kits		●		
Tracheostomy Filter			●	
Tracheostomy Speaking Valve		●		
Traction, Cervical, Extremity, Pelvic		●		
Traction, Overdoor		●		
Transcutaneous Electrical Nerve Stimulator (TENS) Unit, including supplies <i>Limited to \$500 Lifetime maximum</i>	●			
Transfer Board			●	
Trapeze Bars			●	
Tray, Desk, Drafting Table, Easel, Caddy Tray, Cup Holder, etc. (wheelchair)		●		
Tricycle, Hip Extensor		●		
Truss	●			
Ultraviolet Cabinet			●	
Ultraviolet Lamp, handheld			●	
Upholstery, Reinforcement or Replacement		●		
Urinals		●		

Durable Medical Equipment (CONTINUED)

Item	COVERED	NON-COVERED	PRE-AUTHORIZATION	PHARMACY CARD SYSTEM ONLY
Used Equipment, purchased from other than a licensed DME vendor		●		
Uterine Activity Monitor, with pregnancy			●	
Vacuum Assisted Closure (VAC) Wound Healing			●	
Van, Van Conversion		●		
Vaporizer, room type		●		
Ventilator—rental			●	
Ventilator—purchase		●		
Vibrating Chair		●		
Vibrators		●		
Vision Aid or Device		●		
Walkers and attachments, Basic—purchase	●			
Walkers and attachments, Basic—rental		●		
Walkers and attachments, Specialty—purchase			●	
Walkers and attachments, Specialty—rental		●		
Waterbed		●		
Wheelchair <i>Limited to \$20,000 in a five-year period</i>			●	
Wheelchair, armrest replacements		●		
Wheelchair, auto carrier		●		
Wheelchair, backpacks, caddy, carrier, baskets, etc.		●		
Wheelchair, caster replacement	●			
Wheelchair, cushions			●	
Wheelchair, footrest replacement		●		
Wheelchair, heel, toe loops replacement		●		

Durable Medical Equipment (CONTINUED)

Item	COVERED	NON-COVERED	PRE-AUTHORIZATION	PHARMACY CARD SYSTEM ONLY
Wheelchair, Safety Equipment (belt, harness, vest)			●	
Wheelchair, Seatbelts, Crossbar Replacement		●		
Wheelchair, Seating System			●	
Wheelchair, Spoke Protectors		●		
Wheelchair, Stand-Up		●		
Wheelchair, Strap/Belt Harness Replacement		●		
Wheelchair, Tires/Tubes, Replacement		●		
Wheelchair, Tune-up		●		
Wheelchair, Utility Tray		●		
Wheelchair Ramp		●		
Wheelmobile		●		
Whirlpool Bath Equipment		●		
Whirlpool Pumps		●		
White Cane		●		
Wig, Hair Piece		●		
Work Table		●		
Wrist Alarm		●		

The Device and equipment trade names presented herein are for informational purposes only. All trademarks, registered trademarks, and licenses product names - and their accompanying rights - are the property of their respective owners. PEHP warrants no rights to, or ownership of, these trade names.



CHILDREN'S HEALTH INSURANCE PROGRAM

A program of the Utah Department of Health.

CHIP and Out-of-Pocket Costs

THIS GUIDE WILL HELP YOU TRACK COSTS TO AVOID PAYING TOO MUCH.

WHAT IS THE MOST I NEED TO PAY?

Five percent of your family's income is the most you need to pay in co-pays and premiums per year. This dollar amount is printed on your CHIP approval notice and on the renewal notice you get every year from your eligibility worker. CHIP calculates the maximum you need to pay out-of-pocket by using your family's income before taxes and subtracting your CHIP quarterly premium.

WHAT HAPPENS WHEN I HAVE PAID THE MAXIMUM OUT-OF-POCKET?

Once you have reached the 5% maximum, your family will no longer have co-pays for that year. You will still owe a quarterly premium.

WHEN DOES TRACKING BEGIN?

CHIP tracks your out-of-pocket costs beginning July 1st and ending on June 30th of the following year.

HOW DO I SHOW THAT I HAVE PAID THE MAXIMUM OUT-OF-POCKET?

- 1) Each time you pay a co-pay, write it on the 5% maximum out-of-pocket claim form. List the child's name, date of claim, provider's name, provider's address, and the amount paid.
- 2) Once the co-pays add up to your 5% maximum or more, send the completed claim form to: CHIP, PO Box 144102, Salt Lake City UT 84114-4102

WHAT HAPPENS NEXT?

CHIP will:

- 1) Check and see that you have met your 5% maximum out-of-pocket costs.
- 2) Send you a letter verifying the 5% is met and you don't owe co-pays through June 30 (the end of the plan year).
- 3) You can show this letter to your health care provider to prove that you don't owe co-pays.

FOR MORE INFORMATION

Call CHIP at 1-866-772-1261 (toll-free) or 801-538-9004 to get help filling out your form or if you have questions.

Revised 11/2006

Notice of Privacy Practices for Protected Health Information

effective April 14, 2003

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. This notice describes how we protect the confidentiality of the personal information we receive. 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, life, and long term disability 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
- 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
- That occurred before April 14, 2003.

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.

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.

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 privacy practices, we will mail a revised notice to the address you have supplied us.

We will not use or disclose your health information without your consent or authorization, except as permitted or required by law.

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.