UTAH ACCIDENT & HEALTH SURVEY INSTRUCTIONS
For Reporting Year 2025

PLEASE NOTE: THE STOP-LOSS AND ASO SUPPLEMENTS ARE LOCATED ON A DIFFERENT TAB IN THE SAME WORKBOOK AS THE AH SURVEY.

All Fraternal, Health, Life and Property & Casualty insurers in Utah that report accident and health business on the Utah State page of the NAIC Annual Statement are required to complete and file this annual survey. Insurers that do not meet this criteria are exempt.
Submit the completed survey to the Utah Insurance Department (UID) by April 1st of each year. All surveys should be submitted through the UID secure file upload website: https://forms.uid.utah.gov/fileUploads/, then select the **HEALTH RESEARCH*Notify All**. Any other forms of data submission are not acceptable. To submit your form, you will need to have a UtahID account. If you do not have one already, you can find instructions on setting up your UtahID here (https://insurance.utah.gov/wp-content/uploads/CreatingYourUtahID.pdf).

Failure to file by the deadline may subject your company to the enforcement penalties under Utah Code § 31A-2-308. Any questions on completing this survey form should be directed to the Research Analyst via email to healthresearch@utah.gov.

This survey is designed to collect accident and health data at a more detailed level than what is reported on the Utah State page of the NAIC Annual Statement. To the extent possible the survey uses the same definitions and categories as the NAIC Annual Statement. All amounts reported on the survey must reflect the year-end totals of the report year and be consistent with the Utah specific data reported on the NAIC Annual Statement.

For the purposes of this survey, direct insured business refers to business for which the insurance company bears the underwriting risk prior to cession or assumption. This includes all Utah residents, even if the policy was originally issued in another state and the insured later moved into Utah. If your company reported no direct accident and health insurance business in Utah (i.e., zero direct accident and health business on the Utah State page of the NAIC Annual Statement), your company is exempt from filing this survey.

SIGNATURE FORM

This survey includes a business confidentiality signature form. The UID collects this survey data with the intent and understanding that these records are classified as protected records under § 63G-2-305(2). The signature form is available from the website along with the instructions and survey.

The signature form should be filed along with the survey. This form ensures that the data is properly classified as a protected record under § 63G-2-305(2). A version of this signature form will be a standard part of the annual Accident and Health Survey and any Stop-Loss or ASO

Supplement filed with the survey. Any representative of your company can sign the form. Please sign and date the signature form and submit an electronic copy (e.g., Adobe PDF format) along with the survey to the UID. A copy will be kept on file with your survey.

Part 1
UTAH INSURED ACCIDENT & HEALTH BUSINESS

COLUMN DEFINITIONS

Number of Insured Members

For individual policies, insured member counts must include dependents. For group policies, the number of insured members must equal the number of subscribers (certificate holders) and their dependents.

Number of Insured Policies

For individual policies, enter the number of insured policyholders. For group policies, enter the number of subscribers (certificate holders).

Direct Premiums Written

Enter the total premiums collected during the report year for policies written in each A&H insurance category.

Direct Premiums Earned

Enter the portion of the premiums paid by the insured that was allocated to the insurer's loss experience, expenses, and profit during the report year for each A&H insurance category.

Direct Losses Paid

Enter the actual amount of losses paid by the insurer during the reporting year for each A&H insurance category.

Direct Losses Incurred

Enter the total amount of losses incurred by the insurer during the reporting year for each A&H insurance category.

ROW DEFINITIONS

Comprehensive Hospital and Medical

Business that includes major medical, comprehensive medical and other hospital-surgical-medical benefit plans designed to serve as the insured member's primary health benefit coverage. This category includes H16 major medical health benefit plans filed through SERFF as H16I, H16G, HOrg02I, or HOrg02G.

Exclude all H15 hospital, medical, surgical expense plans that are designed to function as a supplement to a primary health benefit plan . Also, exclude all short-term limited-duration plans .

Hosp-Med-Surgical (Supplement Only)
Business that includes any hospital only expense, medical only expense, surgical only expense, hospital and medical expense, hospital and surgical expense, medical and surgical expense, and hospital, medical and surgical expense (supplement). This category includes H15I or H15G hospital, medical, surgical expense plans that are designed to function as a supplement to a primary health benefit plan (e.g., H16 major medical). Exclude all comprehensive hospital and medical plans. Also, exclude all short-term limited duration plans.

Short Term Limited Duration
Business that meets the definition of short-term limited duration plans under § 31A-1-301(175). "Short-term limited duration health insurance" refers to a health benefit product that:

- After accounting for any renewals and extensions, has a total duration of no more than 36 months; and
- Has an expiration date specified in the contract that is less than 12 months after the original effective date of coverage.

Short-term limited duration plans provide limited medical benefits and are not considered a "health benefit plan" under Chapter 30 under Utah Code.

This category includes short-term limited duration plans filed via SERFF as H16I, H16G, H15I, or H15G product with a State Sub-TOI – Short Term. Exclusions: All comprehensive hospital and medical plans or hospital-medical-surgical (supplement only) plans are excluded.

Medicare Supplement
Business reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement. Includes all standardized and pre-standardized plans that are sold as a supplement to Medicare Part A and Part B. These plans serve only as a supplement to Medicare and do not cover the full cost of Medicare subscribers. Exclude all Medicare Advantage policies. If a Medicare supplement is reported, parts 3-A and 3-B must also be completed.

Medicare Advantage (Part C)
Policies that qualify as Medicare Part C plans including all full replacement policies that cover the full medical cost of Medicare subscribers. These plans are not sold as supplements to Medicare, but rather as full replacements of Medicare coverage. They may provide additional benefits such as pharmacy, hospital, and medical coverage beyond what Medicare typically covers. Exclusions: Do not include Medicare supplement policies. In some cases, these plans may have been previously reported under Title XVIII Medicare or under Medicare supplement).

For the purposes of this survey, all Medicare Advantage policies must be reported as a separate, distinct product. If Medicare Advantage is reported, Parts 3-C and 3-D must also be completed.

Medicare Drug Plan (Part D)
Policies that qualify as Medicare Part D plans include all stand-alone prescription drug plans and any plans offering prescription drug coverage that meets or exceeds Medicare Part D requirements. Excludes all Medicare supplement and Medicare Advantage policies. If Medicare Part D is reported, Part 3-E must be completed.

Dental Only
Policies that provide dental coverage only, whether issued as a stand-alone dental or as a rider to a medical policy. For dental coverage issued as a rider, include only those policies where the dental benefits are not linked to the medical policy through shared deductibles or out-of-pocket limits.

Vision Only
Policies that provide vision coverage only, whether issued as stand-alone vision or as a rider to a medical policy. For vision coverage issues as a rider, include only those policies where the vision benefits are not related to the medical policy through deductibles or out-of-pocket limits.

Federal Employees (FEHBP)
Business allocable to the Federal Employees Health Benefit Plan premium.

Title XVIII Medicare
Business where a premium is collected and the insurer covers the full medical costs of Medicare subscribers. This includes all specialized coverage that provides full medical coverage of Medicare subscribers, except for Medicare Advantage plans. Although Medicare Advantage plans technically fall under this category, for the purposes of this survey they should be excluded from this section.

Title XIX Medicaid and/or CHIP
Business where a premium is collected and the insurer covers the full medical costs of Medicaid subscribers and/or CHIP (Children's Health Insurance Program) subscribers. If your company has both Medicaid and CHIP coverage, combine the total Medicaid and CHIP business and report it on line 10 of the survey.

Stop-Loss
Policies that provide stop-loss coverage for a self-insured group plan, or non-proportional reinsurance of a medical insurance product. These policies are designed to protect the insurer or plan sponsor against the risk that a single claim or the total losses of a plan exceed a specified dollar amount.

Disability Income
Policies providing coverage for loss of income resulting from a disability.

Long-Term Care
Business that is allocated to long-term care coverage. If reporting long-term care business, parts 4-A and 4-B must also be completed.

Credit A&H
Policies that provide credit disability insurance. Exclusions: Do not include credit unemployment, credit life, and credit property insurance.

All Other A&H
Other coverage not specifically addressed in any of the other categories.

Total Accident and Health
The sum of all of the A&H categories reported previously in Part 1. Part 1, line 17 must match the total accident and health premium and losses reported on the Utah State page of the Annual Statement.

Part 2
MARKETING OF ACCIDENT & HEALTH BUSINESS

In addition to reporting the accident & health business your company conducted during the reporting year, you must provide information on the specific lines of A&H business your company had on the market in Utah during the reporting year.

Comprehensive Hospital and Medical
Actively selling policies that include major medical, comprehensive medical and other hospital and medical plans designed to be the insured member's primary health benefit plan.

Hosp-Med/Surgical (Supplement Only)
Actively selling hospital, medical or medical expense plans (such as hospital only, medical only, surgical only), which are designed to supplement a primary health benefit plan.

Short-Term Limited Duration
Actively selling short-term limited duration plans that comply with the definition under §31A-1-301(175).

Medicare Supplement
Actively selling Medicare supplement policies for individuals 64 years or younger, as reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement.

Medicare Supplement
Actively selling Medicare supplement policies for individuals 65 years or older as reported in the Medicare Supplement Insurance Experience Exhibit of the annual statement.

Medicare Advantage (Part C)
Actively selling Medicare advantage policies (Part C) that act as full replacement policies for Medicare coverage for individuals 64 years or younger. These policies cover the full cost of Medicare in exchange for a premium.

Medicare Advantage (Part C)
Actively selling Medicare Advantage policies (Part C) that act as full replacement policies for Medicare coverage for individuals 65 and older.

Medicare Drug Plan (Part D)
Actively selling stand-alone pharmacy-only policies that qualify as a Medicare Part D plan.

Dental Only
Actively selling policies that provide dental-only coverage, issued either as a stand-alone dental plan or as a rider to a medical policy not linked to deductibles or out-of-pocket limits.

Vision Only
Actively selling policies that provide vision-only coverage, issued either as stand-alone vision plans or as a rider to a medical policy not linked to deductibles or out-of-pocket limits.

Stop Loss
Actively selling stop-loss insurance policies that cover a self-insured group plan, provider/provider group or non-proportional reinsurance of a medical insurance product. These policies protect against the risk that a single claim or an entire plan's losses will exceed a specified dollar amount.

Disability Income
Actively selling policies providing coverage for loss of income due to disability.

Long-Term Care
Actively selling policies that provide long-term care coverage.

Credit A&H
Actively selling policies that provide credit disability insurance. Excludes credit unemployment, credit life, and credit property insurance.

All Other A&H
Actively selling accident & health coverage not specifically addressed in any of the other categories.

Company Selling A&H
If your company was actively selling any form of accident & health insurance in Utah in the reporting year, enter "YES" in this category. Otherwise, enter "NO".

Part 3
MEDICARE PRODUCT BUSINESS

This section provides additional detail on Medicare product business in Utah. If your company reports Medicare supplement business in Part 1, line 4; Medicare advantage business in Part 1, line 5; or Medicare Part D business in Part 1, line 6, then your company must complete this section.

3-A: Age Statistics for Medicare Supplement Business in Utah

To complete this section, determine the total number of Utah members with Medicare supplement coverage and classify them by age.

Begin with all members enrolled in a Medicare supplement plan in Utah as of December 31st of the reporting year. The total number of members must match the number reported in Part 1, line 4, column 1.

Calculate each member's age in years as of December 31st of the reporting year. Classify members into age categories listed below.

Age 0-64: Members age 64 and younger.
Age 65 and older: Members age 65 and older.
Total Members: Total members regardless of age. Lines 1 and 2 must total this line.

3-B: Medicare Supplement Membership in Utah by Plan Type

To complete this section, determine the total number of Utah members with Medicare supplement coverage as of December 31st of the reporting year, and classify them by the Medicare supplement plan types listed on the survey. The total number of members must match the number of insured members reported in Part 1, line 4, column 1.

3-C: Age Statistics for Medicare Advantage (Part C) Business in Utah

To complete this section, determine the total number of Utah members with Medicare Advantage (Part C) coverage and classify them by age.

Begin with all members that were enrolled in a Medicare advantage (Part C) plan in Utah as of December 31st of the reporting year. The total number of members should match the number reported in Part 1, line 5, column 1.

Calculate each member's age in years as of December 31st of the reporting year using the members date of birth. Classify each member into the age categories listed below.

Age 0-64: Members age 64 and younger.
Age 65 and older: Members age 65 and older.
Total Members: Total members regardless of age. Lines 1 and 2 must total this line.

3-D: Medicare Advantage (Part C) Membership in Utah by Plan Type
To complete this section, determine the total number of Utah members with Medicare Advantage (Part C) as of December 31st of the reporting year, and classify them by the Medicare Advantage (Part C) plans listed on the survey. The total number of members must match with the number of insured members reported in Part 1, line 5, column 1.

3-E: Age Statistics for Medicare Drug Plan (Part D) Business in Utah
To complete this section, determine the total number of Utah members with Medicare drug plan (Part D) coverage and classify them by age.

Begin with all members that were enrolled in a Medicare Drug Plan (Part D) in Utah as of December 31st of the reporting year. The total number of members should match the number reported in Part 1, line 6, column 1.

Calculate each member's age in years as of December 31st of the reporting year. Classify each member into the age categories listed below.

Age 0-64: Members age 64 and younger.
Age 65 and older: Members age 65 and older.
Total Members: Total members regardless of age. Lines 1 and 2 must total this line.

Part 4
LONG-TERM CARE BUSINESS

This section provides additional detail on long-term care business in Utah. If your company reports long-term care business in Part 1, line 14, then your company must complete this section.

4-A: Utah Insured Long-Term Care Business Only
Number of Insured Members
For individual policies, the number of insured members includes dependents. For group policies, the number of insured members must equal the number of subscribers (certificate holders) plus dependents.

Number of Insured Policies
For individual policies, enter the number of insured policyholders. For group policies, enter the number of subscribers (certificate holders).

Direct Premiums Written
Enter the total premiums collected for policies written during the reporting year.

Direct Premiums Earned
Enter the portion of the premium paid by the insured that was allocated to the insurer's loss experience, expenses, and profit during the report year.

Direct Losses Paid
Enter the actual amount of losses paid by the insurer during the reporting year.

Direct Losses Incurred
Enter the total amount of losses incurred by the insurer during the reporting year.

ROW DEFINITIONS

- **Individual**
  Long-term care policies issued to an individual person.
- **Group (2 or more)**
  Long-term care policies issued to a group organization.
- **Total**
  The sum total of individual and group long-term care policies.

4-B: Age Statistics for Long-Term Care Business In Utah
To complete this section, determine the total number of Utah members with long-term care coverage and classify them by age.

Begin with all members enrolled in a long-term care plan in Utah as of December 31st of the reporting year. The total number of members must match the number reported in Part 1, line 14, column 1.

Calculate each member's age in years as of December 31st of the reporting year. Use the calculated age to classify members into the age categories listed below.

Age 0-59: Members age 59 and younger.
Age 60-64: Members age 60 to 64.
Age 65-69: Members 65 to 69.
Age 70-74: Members 70 to 74.
Age 75-79: Members 75 to 79.
Age 80-84: Members 80 to 84.
Age 85 and older: Members age 85 and older.
Total Members: Total members regardless of age must equal the sum of the seven age categories and balance with Part 1, line 14, Column 1.

ADMINISTRATIVE SERVICES

Please see separate instructions for Administrative Services. Administrative Services supplement is now located in the same workbook (on a different tab) as the A&H Survey.

You should only complete this section if your company provides administrative services only (ASO), administrative services contracts (ASC) and other non-underwritten administrative business related to the Federal Employee Health Benefit Plan (FEHBP), Utah Medicaid, Federal

Medicare programs, self-funded dental benefit plans, self-funded vision benefit plans, or other type of administrative services that the Utah Insurance Department needs additional information on. Exclude all business reported under self-funded health benefit plans. All data should be current as of December 31 of the reporting year. If you have questions on whether you should use this category, contact the Research Analyst at healthresearch@utah.gov.

Part 5
VALUE ADDED-BENEFITS
(see § 31A-8a-207)

All health insurers and health maintenance organizations (HMOs) licensed under the Utah Insurance Code are required to file annually with the Utah Insurance Department a list of all value-added benefits offered at no cost to its enrollees. This should be listed on the tab at the bottom of the accident and health survey titled "VAB."

Parts 6-15
COMPREHENSIVE HOSPITAL AND MEDICAL SUPPLEMENT

This section provides additional detail on comprehensive hospital & medical business in Utah. If your company reports comprehensive hospital & medical business in Part 1, line 1, then your company must complete Parts 6 and 7. Depending on the nature of your business, you may also be required to complete Parts 8 through 15.

Part 6 breaks out the comprehensive hospital & medical market into three market segments:

- Non-ACA off-exchange plans
- ACA compliant off-exchange plans (includes any plans sold through private exchanges)
- ACA-complaint Federally Facilitated Marketplace (FFM) plans (includes all plans sold through Utah's federally facilitated exchange).

Part 7 provides a breakout of the comprehensive hospital & medical business by ACA type.

Companies with no Non-ACA Off-Exchange plans may disregard Parts 8 and 9

Parts 8 and 9 provide additional detail on non-ACA off-exchange plans. The information reported must balance with the information reported in Part 6 (for Part 8) and Part 8 (for Part 9), and be internally consistent.

Companies with no ACA Compliant Off-Exchange plans may disregard Parts 10 and 11

Parts 10 and 11 are additional details about ACA Compliant Off-Exchange Plans. The information reported here should balance with the information reported in Part 6 (for Part 10) and Part 10 (for Part 11), and be internally consistent.

Companies with no Federally Facilitated Marketplace plans may disregard Parts 12 -15

Parts 12 through 15 provide additional details on ACA-compliant Federally Facilitated Marketplace (FFM) plans. The information reported must balance with Part 6, and be internally consistent.

Use the column and definitions listed below to complete each section. If you have questions please contact the Utah Insurance Department.

COLUMN DEFINITIONS

Number of Insured Members

For individual policies, the number of insured members must include dependents. For group policies, the number of insured members must equal the number of subscribers (certificate holders) plus dependents.

Cumulative Member Months

Enter the total cumulative member months for each comprehensive hospital & medical plan category for the reporting year. If premiums are reported, member months must also be reported, even if insured members are zero at year-end. To calculate cumulative member months, count the number of insured members for each month of the year (12 monthly counts). Add all 12 monthly counts together. Example: 10 members x 12 months = 120 cumulative member months.

Direct Premiums Written

Enter the total premiums collected for policies written during the reporting year.

Direct Premiums Earned

Enter the portion of premiums paid by the insured that was allocated to loss experience, expenses, and profit during the reporting year.

Direct Losses Paid

Enter the actual amount of losses paid by the insurer during the reporting year.

Direct Losses Incurred

Enter the total amount of losses incurred by the insurer during the reporting year.

Non-ACA Off-Exchange Plans

Plans that are not fully ACA-compliant and operate under regulatory criteria available during 2010-2013. If your company reports Non-ACA Off-Exchange Plans in Part 6, you must also complete parts 8 and 9.

Grandfathered Plans (Non-ACA Off-Exchange)

Comprehensive hospital & medical plans filed for use in Utah under pre-ACA regulatory rules. These plans must have been established prior to the ACA regulations. Grandfathered plans are those that have been in effect prior to March 23, 2010, and may have various effective dates

through the calendar year (January-December). While these plans are exempt from most ACA requirements; they must provide coverage for adult children up to age 26, cannot exclude coverage for pre-existing conditions and may not impose lifetime benefit limits.

Transition Plans (Non-ACA Off-Exchange Plans)
Transitional plans are comprehensive hospital & medical plans filed for use in Utah for individuals or groups that may have lost coverage due to plan cancellation or that otherwise would have been terminated or cancelled. Transitional plans have a range of renewal dates and may carry over in some cases. These plans may have varying renewal dates and, in some cases, may be carried over.

Transitional plans are exempt from most ACA regulations; however, they must still include coverage related to pre-existing condition protections, mental health parity, applicable waiting periods, and may not impose annual benefit limits. Under the Utah Insurance Code, transitional plans are not an option for large groups and should generally be reported only for individual or small group coverage. The only exception occurs when a small group initially enrolled in a Comprehensive Hospital and Medical Supplement transitional plan and later grew into a large group.

Early Renewal Plans (Non-ACA Off-Exchange)
Early renewal plans are comprehensive hospital & medical plans filed for use in the State of Utah that comply with ACA regulatory requirements implemented between 2010 to 2013, but do not include the ACA regulations that took effect on or after January 1, 2014. There should be very few, if any, of these plans in existence.

Under the Utah Insurance Code, early renewal plans in Utah are not an option for large groups. The only exception occurs when a small group initially enrolled in an early renewal plan and later grew into a large group. All early renewal plans should be reported under the Transitional Plans category.

Transitional / Early Renewal Plans (Special Case) (Non-ACA Off-Exchange)
As indicated in the Transitional Plans and Early Renewal Plans above, transitional and early renewal plans are not an option for large groups under the Utah Insurance Code. An exception may occur when a small group originally filed a plan in Utah as a transitional or early renewal policy and later grew into a large group with 51 or more employees.

Large groups should be reviewed to determine whether any began as small group, transitional, or early renewal plans and were retained as the group grew into a large group.

If you have a large group policy that appears to meet the definition of a Transitional Plan or an Early Renewal Plan and was not issued in Utah, please contact the Research Analyst at healthresearch@utah.gov for guidance on the appropriate reporting category.

ACA Compliant Plans
Plans that are fully compliant with the ACA regulations, including all of the new requirements effective as of January 1, 2014.

Off-Exchange Plans (ACA Compliant)
Off-Exchange Plans are comprehensive hospital & medical plans filed for use under Utah's standard state and federal regulatory requirements, and are not sold through the Avenue H (SHOP) Marketplace or the Federal Health Exchange. Most plans currently in existence fall under this definition.

Off-Exchange Plans may also include Qualified Health Plans (QHP) that are offered outside of the exchanges by carriers that also provide QHPs through Avenue H (SHOP) or the Federal Health Exchange. Any business sold through private company health exchanges should be reported in this category.

If your company reports ACA Complaint Off-Exchange plans, you must also complete parts 10 and 11.

Federally Facilitated Marketplace (FFM) Plans (ACA Compliant)
Federally Facilitated Marketplace (FFM) Plans are comprehensive hospital and medical plans filed for use under the specialized regulatory requirements of the individual federal exchange also known as the Federally Facilitated Marketplace. To sell these plans, a company must be registered with the FFM, and the plans must meet the ACA definition of QHP.

Companies that offer QHP plans through the FFM may also offer QHPs as Off-Exchange Plans. In Utah, FFM plans are available to individuals only.

Group Categories
Individual
Insured policies that are issued to an individual person.
Small Group (1 to 50)
Insured policies issued to a group organization of 1 to 50 employees.
Large Group (51 or more)
Insured policies issued to a group organization of 51 employees or more.
Total
Total of Individual, Small Group, and Large Group Comprehensive Hospital & Medical.

Plan Categories
Indemnity / Fee For Service Plan (FFS)
Under a traditional indemnity or fee for service plan (FFS), the insured member may obtain covered services from any provider of their choice, provided the services are covered under the terms of the insurance plan. These plans do not use preferred provider networks, and all covered services are reimbursed at the same cost-sharing level - typically a fixed percentage of billed

charges - regardless of the provider selected. The insured member generally pays a fixed coinsurance rate after meeting the deductible.

In Utah, only licensed accident & health insurers may offer FFS plans.

If an FFS plan includes a PPO rider that allows insured members to pay lower co-payments or coinsurance rates when services are obtained from a network of preferred providers, the plan should be classified as a Preferred Provider Organization for purposes of the survey.

Preferred Provider Organization Plan
Under a Preferred Provider Organization plan (PPO), insured members pay lower deductibles and coinsurance when they receive care from physicians or hospitals within the preferred provider network. Under Utah law, PPOs may not restrict members to in-network providers only, as this would constitute an EPO arrangement, which PPOs are prohibited from offering. Instead, PPOs provide a financial incentive for members to use preferred providers by offering lower cost sharing for in-network services.

Members may obtain care from providers outside the network; however, services are reimbursed at a lower rate and members typically incur higher out-of-pocket costs to do so. Only licensed Accident & Health insurers may offer PPO plans in Utah.

Historically, PPO plans that required permission from a primary physician, gatekeeper, or other forms of pre-authorization before receiving services from a non-preferred provider were classified as PPOs with Point of Service (POS) features for survey purposes. All PPOs with POS features should be classified as PPO plans. Do not report PPO with POS feature plans under "Other"; they must be reported as "PPO".

Exclusive Provider Organization Plan
Under an exclusive provider organization (EPO) plan, the insured member must obtain covered services exclusively from providers within the EPO network, except in the case of an emergency. Services outside of the EPO network are not covered.

EPO plans are similar to Health Maintenance Organization (HMO) plans in that coverage is limited to a defined network of providers. However, EPO plans differ from HMOs in that they are offered by standard Accident and Health insurance carriers that may also offer PPO plans, rather than by carriers licensed as HMOs.

Health Maintenance Organization Plan
Under an HMO, the members must obtain covered services exclusively from providers within the network, except in the case of an emergency. Services received outside of the HMO network are not covered. In Utah, only carriers licensed as HMOs may offer HMO plans.

If an HMO plan includes a point-of-service option, indemnity carve out, out-of-network rider, or another provision that allows members to receive routine (non-emergency) care from providers

outside the HMO network at a lower reimbursement rate resulting in higher out-of-pocket costs for the member - the plan should be classified as HMO with POS feature for survey purposes.

Health Maintenance Organization Plan with Point of Service Feature (POS)
This is a special category for certain types of HMO plans. Use this category when an HMO plan includes a point-of-service option, indemnity carve out, out-of-network rider, or other provision that allows members to obtain routine (non-emergency) medical services from providers outside the HMO network at a lower reimbursement rate (e.g., costs the member more to use non-network providers).

Other Plans
Use the "Other" category only for plans that do not fit into any of the preceding categories. If this category is selected, include a brief description of the plan's features and explain why the other categories are not applicable.

PPO plans with POS features must not be reported in this category; they should be reported under the PPO category. In most cases this category should not be used as comprehensive hospital and medical plans filed for use in Utah should qualify under one of the other categories.

Product Categories
Standard
These are standard health benefit plans that have traditionally been sold in Utah. The plans do not omit mandated benefits or modify coverage to create specialized insurance products defined under specific statutes of the Utah Insurance Code. Exclude HSA-qualified High Deductible Health Plans (HDHPs).

HSA-Qualified High Deductible Health Plan
Any High Deductive Health Plan that is eligible for use with a Health Savings Account (HSA). Exclude any plan that is not an HSA-Qualified HDHP such as traditional health benefit plans.

Actuarial Value Categories
Actuarial Value
Actuarial Value means the relative cost of benefits covered under a health benefit plan. It represents the estimated percentage of eligible health care expenses that are paid by the plan, as opposed to the portion paid out of pocket by the consumer. Actuarial value is calculated based on the plan's cost-sharing features, including deductibles, coinsurance, copayments, and out of pocket limits.

Metal Tiers
Under the ACA, actuarial values are used to classify ACA-compliant health benefit plans in the individual and small group markets into benefit tiers. The Federal HHS Actuarial Value Calculator is used to determine a plan's metal tier classification . There are five metal tiers. Platinum, Gold, Silver, Bronze, and Catastrophic as described below.

Platinum Tier
ACA-complaint plans in the individual or small group market with an actuarial value of 90 percent (plus or minus 2 percent).

Gold Tier
ACA complaint plans in the individual or small group market with an actuarial value of 80 percent (plus or minus 2 percent).

Silver Tier
ACA-complaint plans in the individual or small group market with an actuarial value of 70 percent (plus or minus 2 percent).

Bronze Tier
ACA complaint plans in the individual or small group market with an actuarial value of 60 percent (plus or minus 2 percent).

Catastrophic Tier
ACA complaint plans in the individual market that qualify for a high-deductible health benefit plan. Enrollment is limited to individuals under age 30 or qualify for a hardship exemption. Catastrophic plans are not eligible for premium subsidies through a state or federal health exchange.

Silver Tier
ACA-compliant plans in the individual or small group market with an actuarial value of **70 percent (±2 percent)**.

Bronze Tier
ACA-compliant plans in the individual or small group market with an actuarial value of **60 percent (±2 percent)**.

Catastrophic Tier
ACA-compliant plans in the individual market that qualify as high-deductible health benefit plans. Enrollment is limited to individuals under age 30 or those who qualify for a hardship exemption. Catastrophic plans are not eligible for premium subsidies through state or federal health exchange.

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