

2024

Medical Contract



## GROUP APPLICATION

**Product** SelectHealth Med  
**Employer** Weber County  
**Employer Address** 2380 Washington Blvd., Ogden, UT 84401

### Affiliated Businesses/Subsidiaries Covered by this Application

Employer is hereby applying for, and agreeing to, the terms of the attached Group Health Insurance Contract with **SelectHealth, Inc., 5381 Green Street, Murray, Utah 84123**. SelectHealth is entering into this Contract in reliance upon the underwriting information supplied by the employer, which shall be considered to be material representations of fact by employer to SelectHealth. SelectHealth and employer agree upon the following:

1. **Monthly Premiums.** On or before the first day of each month, the following designated Premiums shall be paid to SelectHealth:
  - \$808.00 for each single party enrollment
  - \$1901.70 for each employee plus spouse enrollment
  - \$1901.70 for each employee plus child enrollment
  - \$2303.30 for each employee plus children enrollment
  - \$2303.30 for each family enrollment
2. **Eligibility, Prepayment and Enrollment Criteria.** In order to be Eligible, employees and their Dependents must meet the criteria for participation and enrollment specified in this Group Application and elsewhere in the Contract. A person may only be considered an employee if employer withholds and pays to the government Social Security and Medicare taxes and income tax withholding on the employee's wages.
  - 2.1 Employees must be scheduled to work 30 hours per week to be Eligible for coverage under the Plan, unless the employer is required to offer them coverage under the Affordable Care Act.

During the Employer Waiting Period, the employee must work the minimum required hours except for paid time off or time the employee does not work due to health status, a medical condition, the receipt of health care, or disability. SelectHealth may require documentation to verify the number of hours an employee has worked.
  - 2.2 Portion of Premium employer must contribute:

Applicable contributions and categories as specified by employer.
  - 2.3 Children are eligible to the age of 26 except where the child meets the criteria for disabled children specified in Section 2 – "Eligibility" of the Certificate.
  - 2.4 Retirees are covered.

Eligible Retirees may receive Health Insurance Benefits as specified below, provided they meet the following requisite criteria:

    - (A) Eligible Retirees under age 60 who are otherwise eligible for retirement from County service under the State's Non-Contributory Retirement Program and Elected Officials

(regardless of their age) who qualify under the definition of Eligible Retirees, may receive five years of Health Insurance Benefits as defined herein.

- (B) Eligible Retirees who are under age 65 but over 60 who are otherwise eligible for retirement may receive Health Insurance Benefits for the number of months equal to the number of months they have remaining from the time they retire until they reach age 65. Upon reaching age 65, the Eligible Retiree may receive Medicare supplement benefits paid by the County for the number of months remaining in the five-year period so that they receive a total of five years of Health Insurance Benefits and Medicare supplement benefits.
- (C) The Retired Employee shall pay any difference between the County's contribution and the actual cost of the plan as well as any other costs attributable to the Retired Employee as defined herein. Such payment shall be made on an annual basis and shall be due by January 15th for the benefit year. If payment is not received by the due date, coverage shall be terminated and the employee shall not be allowed to reinstate coverage.
- (D) Health Insurance Benefits shall be the same as currently carried by the Eligible Retiree, i.e., family, two-party or single. If the Eligible Retiree has no Health Insurance Benefits paid in whole or in part by the County at the time of retirement, none may be offered or provided. The County shall not provide an increased benefit level because the Eligible Retiree changes his/her family status. However, if the Eligible Retiree's family status changes and dependent coverage is no longer needed, the Retired Employee shall notify the County within 30 days so that excess coverage may be terminated. If the Retired Employee fails to notify the County within 30 days of change in coverage, he shall reimburse the County for the total cost of coverage the County has paid for excess coverage.

- 2.5 Domestic partners are not covered. If covered, refer to the Domestic Partner Rider in Appendix A "Optional Benefits" of the Certificate.
- 2.6 Eligible employees may be granted up to a 90 day leave of absence by employer or up to the time allowed for a qualifying leave under the Family Medical Leave Act. Leave time can only be accrued and used by the employee using the leave time. Leave banks beyond what is required by the FMLA, i.e. where employees share or purchase leave time from other employees, are not allowed.
- 2.7 The Initial Eligibility Period is 31 days.
- 2.8 There is no Employer Waiting Period and the Effective Date is the first day of the next calendar month following the date of employment.
- 2.9 Leased employees and independent contractors are not Eligible for coverage by SelectHealth.
- 2.10 Coverage will terminate on the end of the calendar month in which the Subscriber and/or Dependents lose Eligibility. However, when a Dependent child ceases to be a Dependent, coverage will terminate at the end of the month in which Dependent status is lost. When a loss of Eligibility is not reported in a timely fashion as required by the Contract, and federal or state law prevents SelectHealth from retroactively terminating coverage, SelectHealth has the discretion to determine the prospective date of termination. SelectHealth also has the discretion to determine the date of termination for Rescissions.

- 3. **Duration of Contract.** This Contract is effective on January 1, 2024 to December 31, 2024, for a term of 12 months.

**Product:**                    **SelectHealth Med**

**Acknowledged and agreed:**

Employer: Weber County

By: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**SelectHealth, Inc.**

By: 

Printed Name: Todd Trettin

Title: CFO and President Large Group Commercial Markets

Date: 11/13/2023



# medical

contract

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## **SECTION 1 INTRODUCTION**

### **1.1 Contract**

This group health insurance contract (Contract) is made between **SelectHealth, Inc.** (we or us) and the employer indicated in the Group Application (you). In exchange for your payment of Premium, we provide defined healthcare Benefits to Members. Any payment of Premium will constitute your agreement to the terms of the Contract, regardless of whether you have actually signed the Group Application.

### **1.2 SelectHealth**

**SelectHealth is an HMO licensed by the State of Utah located at 5381 Green Street, Murray, Utah 84123.** We are affiliated with Intermountain Health, but are a separate company. The Contract does not involve Intermountain Health or any other affiliated Intermountain Health companies, or their officers or employees. Such companies are not responsible for our obligations or actions.

### **1.3 Agency**

You do not have the authority to act as our agent. We are not your agent for any purpose. You agree to act in a timely and diligent manner as the agent of your Subscribers for certain purposes, such as enrollment and termination procedures, providing consent to release information, and agreeing to the conditions in the Contract.

### **1.4 Administration of Contract**

We may adopt reasonable policies, rules, and procedures to help in the administration of the Contract. You agree to abide by all such reasonable policies, rules, and procedures that are not inconsistent with the Contract.

### **1.5 ERISA and SelectHealth's Authority**

If the Contract is part of an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), you or your designated employee(s) will be the plan administrator and in that capacity hereby delegate to us the following discretionary authority:

Benefits under the Contract will be paid only if we decide in our discretion that the Claimant is entitled to them. We also have discretion to determine Eligibility for Benefits and to interpret the terms and conditions of the benefit plan. Our determinations under this reservation of discretion do not prohibit or prevent a Claimant from seeking judicial review in federal court.

The reservation of discretion made under this provision only establishes the scope of review that a federal court will apply when a Claimant seeks judicial review of our determination of Eligibility for Benefits, the payment of Benefits, or interpretation of the terms and conditions applicable to the health benefit plan.

We are an insurance company that insures the Employer Plan and the federal court will determine the level of discretion that it will accord our determinations.

If the Contract is not part of an employee benefit plan subject to ERISA, this Provision 1.5 does not apply and is not considered part of the Contract.

### **1.6 Term**

The term of the Contract is specified in the Group Application. However, your coverage is guaranteed renewable to the extent required by the Affordable Care Act.

## **SECTION 2 PREMIUM**

### **2.1 Employer Responsibility**

Coverage under the Contract is contingent upon your timely payment of Premium. The monthly Premium amount and due date are set forth in the Group Application. Your obligation to make Premium payments is not contingent upon your ability to collect any Subscriber contributions.

### **2.2 Premium Rates**

The Premium rates specified in the Group Application will remain the same until the end of the Contract term. However, we may reasonably modify the Premium if federal or state laws or regulations mandate that we adjust Benefits under the Contract.

### **2.3 Grace Period**

There is a 30-day Grace Period for the payment of Premium. We will continue to pay Benefits during the Grace Period, but you will be responsible for reimbursing us for the amount of any Benefits paid if you fail to pay Premium.

### **2.4 Refund of Premium**

We are entitled to offset from any refund the amount of any claims paid for such individuals before you notified us that they were not Eligible.

## **SECTION 3 COVERAGE**

### **3.1 Certificate of Coverage**

We will provide you with a copy of each applicable Certificate of Coverage, which describes the Benefits offered under the Contract in exchange for your payment of Premium.

## **3.2 Administrative Processes**

We establish reasonable administrative processes for claims adjudication, Member Services, Healthcare Management, and other functions. Members and Participating Providers and Facilities are required to cooperate with these processes when obtaining and providing Covered Services.

## **3.3 No Vested Rights**

No Member has a vested right to any Covered Services. Changes to the Contract may be made without consulting with, or obtaining the consent of, Members. The rights and interest of Members at any particular time depend on the Contract terms in effect at that time.

## **SECTION 4 ELIGIBILITY AND ENROLLMENT**

### **4.1 Eligibility**

In consultation with us, you decide which categories of employees, retirees and Dependents are Eligible to become Members and establish related Eligibility requirements. The Eligibility criteria are specified in the Certificate of Coverage and the Group Application. You may not change, extend, expand, or waive the Eligibility criteria without first obtaining the advance, written approval of an officer of SelectHealth. Only individuals who continuously satisfy the Eligibility criteria of the Contract may be enrolled and continue as Members. You, your Subscribers, and their Dependents are responsible for obtaining and submitting to us evidence of Eligibility.

### **4.2 Changes in Member Information or Eligibility**

You must notify us within 60 days whenever there is a change in a Member's situation that may affect Eligibility or enrollment. This includes the following events:

- a. Adoption of a child, birth of a child, or gaining legal guardianship of a child;
- b. Child loses Dependent status;



- c. Death;
- d. Divorce;
- e. Marriage;
- f. Involuntary loss of other coverage;
- g. Member called to active military duty;
- h. You receive a Qualified Medical Child Support Order (QMCSO);
- i. Reduction in employment hours;
- j. Subscriber takes, returns from, or does not return from a leave of absence;
- k. Termination of employment; and
- l. Other events as required by federal law.

If you fail to notify us within 60 days of a Member's termination from employment or other event that results in the loss of a Member's Eligibility, you agree to promptly pay us any amounts paid as Benefits for such Member before we were notified.

### **4.3 Enrollment**

In order for an Eligible individual to receive Benefits, you must enroll the individual, we must accept the individual as a Member, and you must pay the applicable Premiums. You agree to limit enrollment to Subscribers and their Dependents. You are responsible for submitting the enrollment materials we require.

### **4.4 Enrolling a Dependent Because of a Court Order**

We will enroll Dependents as the result of a valid court order. Compliance with, and administration of, court orders, including Qualified Medical Child Support Orders (QMCSO's), is your responsibility. When you direct us to enroll an individual on the basis of a QMCSO, we reserve the right to review and confirm that the order is qualified.

## **4.5 COBRA or Utah mini-COBRA Coverage (Continuation Coverage)**

Continuation Coverage is your obligation. We are not the administrator of Continuation Coverage procedures and requirements. We agree to assist you in providing Continuation Coverage in certain circumstances. It is your responsibility to timely: notify persons entitled to Continuation Coverage, notify us of such individuals, and collect and submit to us all applicable Premiums. If the Contract is terminated, Continuation Coverage with us will terminate. You are responsible for obtaining substitute coverage. You may engage the services of a third-party contractor to assist with the administration of Continuation Coverage.

### **4.5.1 Minimum Extent**

Continuation Coverage will only be provided for the minimum time and only to the minimum extent required by applicable state and federal law. We will not provide Continuation Coverage if you or the Member fails to strictly comply with all applicable notice and other requirements and deadlines.

### **4.5.2 Documentation**

You are required to provide sufficient documentation of a Member's eligibility for Continuation Coverage. We determine whether the documentation is sufficient.

## **4.6 Right to Decline Enrollment**

We may decline to enroll individuals who do not satisfy the Eligibility criteria of the Contract.

## **SECTION 5 RESPONSIBILITIES OF THE PARTIES**

### **5.1 Compliance**

Each party is responsible for its own compliance with applicable laws, rules, and regulations. For you, this includes the reporting and disclosure requirements of ERISA, all applicable requirements under Titles I and II of HIPAA, and any other state and federal requirements that apply to the Employer Plan. You must notify us when you receive Medicare secondary payer information.

SelectHealth agrees that it will make available the machine-readable files required by the Transparency in Coverage Rule and implementing regulations in the required format and timelines.

### **5.2 Indemnification**

We agree to defend and indemnify you from and against any claims or other liability based upon our failure to comply with our obligations under the Contract.

You agree to defend and indemnify us from and against any claims or other liability based upon your failure to comply with your obligations under the Contract.

### **5.3 Reports**

We will help you comply with applicable federal reporting requirements by providing you with necessary Benefits information in our possession.

### **5.4 Internal Revenue Code (IRC) Section 6055 Reporting**

You agree to request the Social Security Numbers of your Employees and their Dependents, and provide this information to us, in the time and manner required by IRC Section 6055.

## **5.5 Summary of Benefits and Coverage (SBC)**

We agree to provide you with an SBC as defined by the Affordable Care Act (ACA). You agree to distribute the SBC to eligible individuals in the time and manner required by applicable law. We agree to provide the Uniform Glossary of Terms, as defined by the ACA, on our website. We also agree to distribute the SBC and Uniform Glossary of Terms created by us to those Members who contact us directly. You agree to indemnify and hold us harmless in the event that you fail to make any required distributions of the SBC, make any modifications to the SBC, or decide to use your own SBC.

## **SECTION 6 TERMINATION**

### **6.1 Reasons for Termination**

The Contract, and coverage for all Members under the Contract, can terminate for the reasons listed below.

#### **6.1.1 Termination by Employer**

You may terminate the Contract by providing us with written notice prior to the date you wish coverage to end. If you properly notify us, coverage will terminate on the last day of the month for which Premium has been paid. We will not accept retroactive termination dates.

#### **6.1.2 Termination of Employer Group by SelectHealth**

Your coverage under the Contract may be terminated for any of the following reasons:

- a. You fail to pay Premiums in accordance with the Contract. Partial payment will be treated as nonpayment unless we, at our sole discretion, indicate otherwise in writing;
- b. You perform an act or practice that constitutes fraud or make an intentional misrepresentation of material fact under the terms of the coverage;

- c. No Members live, reside, or work in the Service Area;
- d. Your membership in an association, through which the Contract was made available, ceases;
- e. We cease to offer this particular health benefit product in accordance with applicable state and federal law. In such instance, we will give you at least 90 days advance notice;
- f. We withdraw from the market in accordance with applicable state and federal law. In such instance, we will give you at least 180 days advance notice; or
- g. You fail to satisfy our minimum participation requirements, if applicable.

### **6.1.3 Employer Notice of Termination to Subscribers**

It is your responsibility to provide Subscribers a 30-day written notice of the Contract's termination. We will provide you a sample notice upon request.

## **6.2 Rescission**

Rescission may only occur for fraud or intentional misrepresentation of material fact. You agree to only request a Member's Rescission in these limited circumstances and to hold SelectHealth harmless for any improper Rescission that you request.

## **6.3 Liability for Services After Termination**

We do not cover Services obtained after the date of termination, regardless of when a condition arose and despite care or treatment anticipated or already in progress.

## **SECTION 7 GENERAL**

### **7.1 Binding Effect**

The Contract contains the entire agreement between the parties. In the event you have received a written proposal, your compliance with the minimum enrollment and underwriting factors set forth in the proposal is a condition to the effectiveness of the Contract. The Contract is binding upon you, us, Members and their heirs, personal representatives and assignees.

### **7.2 Partial Invalidity**

If any provision of the Contract is held to be unenforceable, it will be deemed to be omitted and the remaining provisions shall continue in full force and effect.

### **7.3 Non-Assignability**

The parties to the Contract agree that they may not transfer or assign their rights or obligations without the advance written approval of the other party.

### **7.4 Choice of Law**

The Contract will be interpreted and enforced according to the laws and regulations of the State of Utah and any applicable federal laws or regulations. If an inconsistency exists between the Contract and any applicable law, the Contract will be construed to include the minimum requirements of the applicable law.

### **7.5 Right to Audit Employer Records**

We reserve the right to audit your personnel and/or payroll records to verify the status and Eligibility of Members.

### **7.6 Term**

The term of the Contract is specified in the Group Application.

## **7.7 Circumstances Beyond Control**

Neither party will be responsible for a delay in performing its obligations under the Contract due to circumstances reasonably beyond its control, such as natural disaster, epidemic, riot, war, terrorism, or nuclear release.

## **7.8 Workers' Compensation Insurance**

The Contract does not provide or replace workers' compensation coverage for your employees.

## **7.9 No Waiver**

Failure by either party to insist upon strict compliance with any part of the Contract or with any procedure or requirement will not result in a waiver of its right to insist upon strict compliance in any other situation.

## **7.10 Notices**

All required notices shall be sent by at least first-class mail.

- a. Any notice we are required to send will be sufficient if mailed to the address we have on record.
- b. Any notice we are required to send to a Dependent will be sufficient if given to the Subscriber.
- c. Any notice you are required to send to us will be sufficient if mailed to the principal office of SelectHealth in Murray, Utah.
- d. We do not provide COBRA notification services.

## **SECTION 8 DEFINITIONS**

The Contract contains certain defined terms that are capitalized in the text and described in this section. Words that are not defined have their usual meaning in everyday language.

## **8.1 Affordable Care Act (ACA)**

The Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 and associated regulations.

## **8.2 Benefit(s)**

The payments and privileges to which Members are entitled by the Contract.

## **8.3 Certificate of Coverage (Certificate)**

The document(s), considered part of the Contract, which describe(s) the terms and conditions of the health insurance Benefits with us. The Member Payment Summary and any endorsements are attached to, and considered part of, the Certificate.

## **8.4 COBRA Coverage**

Coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

## **8.5 Continuation Coverage**

COBRA Coverage and/or Utah mini-COBRA coverage.

## **8.6 Contract**

The group health insurance contract, including the Group Application and the Certificate of Coverage.

## **8.7 Covered Services**

The Services listed in the Certificate in Section 8 Covered Services and applicable Optional Benefits and not excluded in the Certificate in Section 10 Limitations and Exclusions.

## **8.8 Dependents**

A Subscriber's lawful spouse and any child who meets the Eligibility criteria set forth in the Certificate in Section 2 Eligibility, and the Group Application.

## **8.9 Effective Date**

The date on which coverage for a Member begins.

## **8.10 Eligible, Eligibility**

In order to be Eligible, a Subscriber and his/her dependents must meet the criteria for participation specified in the Group Application and in the Certificate in Section 2 Eligibility.

## **8.11 Employer Waiting Period**

The time period that a Subscriber and any Dependents must wait after becoming Eligible for coverage before the Effective Date. Subject to approval by us, you specify the length of this period in the Group Application.

## **8.12 Employer Plan**

The group health plan sponsored by you and insured under the Contract.

## **8.13 ERISA**

The Employee Retirement Income Security Act (ERISA), a federal law governing employee benefit plans.

## **8.14 Exclusion(s)**

Situations and Services that are not covered by us under the Plan. Most Exclusions are set forth in the Certificate in Section 10 Limitations and Exclusions, but other provisions throughout the Certificate and the Contract may have the effect of excluding coverage in particular situations.

## **8.15 Facility**

An institution that provides certain healthcare Services within specific licensure requirements.

## **8.16 Group Application**

A form we use both as your application for coverage and to specify group-specific details of coverage. The Group Application may contain modifications to the language of the Contract. It also demonstrates your acceptance of the Contract. Other documents, such as Endorsements, may be incorporated by reference into the Group Application.

## **8.17 Grace Period**

A specified period of time after a Premium is due during which coverage under the Contract continues and you may pay the Premium.

## **8.18 Limitation(s)**

Situations and Services in which coverage is limited by us under the Plan. Most Limitations are set forth in the Certificate in Section 10 Limitations and Exclusions, but other provisions throughout the Certificate and the Contract may have the effect of limiting coverage in particular situations.

## **8.19 Member**

A Subscriber and any Dependents, when properly enrolled in the Plan and accepted by us.

## **8.20 Member Payment Summary**

A summary of Benefits by category of service, attached to and considered part of the Certificate.

## **8.21 Optional Benefit**

Additional coverage purchased by you as noted in the Certificate that modifies Limitations, Exclusions, and/or Eligibility.

## **8.22 Plan**

The specific combination of Covered Services, Limitations, Exclusions, and other requirements agreed upon between you and us as set forth in the Certificate and the Contract.

## **8.23 Plan Sponsor**

As defined in ERISA. The Plan Sponsor is typically the employer.

## **8.24 Premium(s)**

The amount you periodically pay to us as consideration for providing Benefits under the Plan. The Premium is specified in the Group Application.

## **8.25 Provider**

A vendor of healthcare Services licensed by the state where Services are provided and that provides Services within the scope of its license.

## **8.26 Qualified Medical Child Support Order**

A court order for the medical support of a child as defined in ERISA.

## **8.27 Rescission**

A cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required Premiums or contributions towards the cost of coverage.

## **8.28 Service Area**

As defined in the Certificate(s) of Coverage.

## **8.29 Service(s)**

Services, care, tests, treatments, drugs, medications, supplies, or equipment.

## **8.30 Subscriber**

The individual with an employment or other defined relationship to the Plan Sponsor, through whom Dependents may be enrolled. Subscribers are also Members.

## **8.31 Utah mini-COBRA**

Continuation coverage required by Utah law for employers with fewer than 20 employees.



**MEMBER PAYMENT SUMMARY**

	<b>IN-NETWORK</b> When using In-Network Providers, you are responsible to pay the amounts in this column.	<b>OUT-OF-NETWORK</b> When using Out-of-Network Providers, you are responsible to pay the amounts in this column.
<b>MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET<sup>5,6</sup></b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Self Only Coverage, 1 person enrolled - per calendar Year		
Deductible	\$1,500	\$4,000
Out-of-Pocket Maximum	\$5,000	\$10,000
Family Coverage, 2 or more enrolled - per calendar Year		
Deductible - per person/family	\$1500/\$3000	\$4000/\$8000
Out-of-Pocket Maximum - per person/family	\$5000/\$10000	\$10000/\$20000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)		
<b>INPATIENT SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Medical, Surgical and Hospice <sup>4</sup>	20% after Deductible	40% after Deductible
Hospital Level Care at Home <sup>4</sup>	20% after Deductible	Not Covered
Skilled Nursing Facility <sup>4</sup> - Up to 60 days per calendar Year	20% after Deductible	40% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational <sup>4</sup> Up to 40 days per calendar Year for all therapy types combined	20% after Deductible	40% after Deductible
Physician's Fees - (Medical, Surgical, Maternity, Anesthesia)	20% after Deductible	40% after Deductible
<b>PROFESSIONAL SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP) <sup>1</sup>	\$40	40% after Deductible
Primary Care Provider (PCP) Virtual Visits <sup>1</sup>	Covered 100%	Not Covered
Specialist/Secondary Care Provider (SCP) <sup>1</sup>	\$60	40% after Deductible
Allergy Tests	See Office Visits Above	Not Covered
Allergy Treatment and Serum	20%	Not Covered
Major Surgery	20%	40% after Deductible
Physician's Fees - (Medical, Surgical, Maternity, Anesthesia)	20% after Deductible	40% after Deductible
<b>PREVENTIVE SERVICES AS OUTLINED BY THE ACA<sup>2,3</sup></b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Primary Care Provider (PCP) <sup>1</sup>	Covered 100%	Not Covered
Specialist/Secondary Care Provider (SCP) <sup>1</sup>	Covered 100%	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Not Covered
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	Not Covered
Diagnostic Tests: Minor	Covered 100%	Not Covered
Other Preventive Services	Covered 100%	Not Covered
<b>VISION SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Preventive Eye Exams	Covered 100%	Not Covered
All Other Eye Exams	\$60	40% after Deductible
<b>OUTPATIENT SERVICES<sup>4</sup></b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Outpatient Facility	20% after Deductible	40% after Deductible
Ambulatory Surgical Center	10% after Deductible	40% after Deductible
Imaging Center	10% after Deductible	40% after Deductible
Ambulance (Air or Ground) - <i>Emergencies Only</i>	20% after Deductible	See In-Network Benefit
Emergency Room	\$500 after Deductible	See In-Network Benefit
Intermountain InstaCare <sup>®</sup> Facilities, Urgent Care Facilities	\$60	40% after Deductible
Intermountain KidsCare <sup>®</sup> Facilities	\$40	Not Available
Intermountain Connect Care <sup>®</sup>	Covered 100%	Not Available
Radiation	20% after Deductible	40% after Deductible
Dialysis	20% after Deductible	40% after Deductible
Diagnostic Tests: Minor <sup>2</sup>	Covered 100%	40% after Deductible
Diagnostic Tests: Major <sup>2</sup>	20% after Deductible	40% after Deductible
Home Health, Hospice, Outpatient Private Nurse	20% after Deductible	40% after Deductible
Outpatient Cardiac Rehab	Covered 100%	40% after Deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	\$60 after Deductible	40% after Deductible



**MEMBER PAYMENT SUMMARY**

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>MISCELLANEOUS SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Durable Medical Equipment (DME) <sup>4</sup>	20% after Deductible	40% after Deductible
Miscellaneous Medical Supplies (MMS) <sup>3</sup>	20% after Deductible	40% after Deductible
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Maternity and Adoption <sup>4,7</sup>	See Professional, Inpatient or Outpatient	40% after Deductible
Cochlear Implants or Auditory Osseointegrated Devices <sup>2,4</sup> <i>One device every 36 months per ear</i>	See Professional, Inpatient or Outpatient	Not Covered
Infertility - <i>Select Services</i>	50% after Deductible	Not Covered
TMJ (Temporomandibular Joint) Services - <i>Up to \$2,000 lifetime</i>	See Professional, Inpatient or Outpatient	Not Covered
<b>OPTIONAL BENEFITS</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Mental Health and Chemical Dependency <sup>4</sup>		
Office Visits	\$40	40% after Deductible
Virtual Visits	Covered 100%	40% after Deductible
Inpatient	20% after Deductible	40% after Deductible
Outpatient	20%	40% after Deductible
Residential Treatment <sup>2</sup>	20% after Deductible	40% after Deductible
Chiropractic <i>(up to 20 visits per calendar Year)</i>	\$40	Not Covered
Injectable Drugs, Chemotherapy, and Specialty Medications <sup>4</sup>	20% after Deductible	40% after Deductible
Bariatric Surgery <i>(Up to one surgery/lifetime)</i> <sup>4</sup>	See Professional, Inpatient or Outpatient	Not Covered
<b>PRESCRIPTION DRUGS</b>		
Pharmacy Deductible - Per Person per calendar Year		\$200
Prescription Drug List (formulary)		RxSelect <sup>®</sup>
Prescription Drugs - <i>Up to 30 Day Supply of Covered Medications</i> <sup>4</sup>		
Tier 1		\$20
Tier 2		\$45 after pharmacy Deductible
Tier 3		\$65 after pharmacy Deductible
Tier 4		\$100 after pharmacy Deductible
Maintenance Drugs - <i>90 Day Supply (Mail-Order, Retail90<sup>®</sup>)-selected drugs</i> <sup>4</sup>		
Tier 1		\$20
Tier 2		\$90 after pharmacy Deductible
Tier 3		\$195 after pharmacy Deductible
Generic Substitution Required		Generic required or must pay Copay plus cost difference between name brand and generic

1 Refer to [selecthealth.org/findadoctor](https://selecthealth.org/findadoctor) to identify whether a Provider is a primary or secondary care Provider.  
 2 Refer to your Certificate of Coverage for more information.  
 3 Frequency and/or quantity limitations apply to some Preventive care and MMS Services.  
 4 Preauthorization is required for certain Services. Benefits may be reduced or denied if you do not preauthorize certain Services with Out-of-Network Providers. Please refer to Section 11--" Healthcare Management", in your Certificate of Coverage, for details.  
**5 All Deductible/Copay/Coinsurance amounts are based on the Allowed Amount and not on billed charges. Out-of-Network Providers or Facilities may not accept the Allowed Amount for Covered Services. When this occurs, you may be responsible for Excess Charges.**  
 6 Certain Services as noted on this document and in your Certificate of Coverage are not subject to the Deductible.  
 7 SelectHealth provides a \$4000 adoption indemnity as outlined by the state of Utah. Medical Deductible, Copay, or Coinsurance listed under the benefit applies and may exhaust the benefits prior to any plan payments.  
 \* Not applied to Medical Out-of-Pocket Maximum.  
 Insulin for the treatment of diabetes is subject to a maximum copay of \$28 for short-acting and \$92 for long-acting, per 30-day prescription.  
 All Covered Services obtained outside the United States, except for routine, Urgent, or Emergency conditions require preauthorization.

To contact Member Services, call 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., Saturdays, from 9:00 a.m. to 2:00 p.m. TTY users should call 711.  
**Benefits are administered and underwritten by SelectHealth, Inc. SM (domiciled in Utah).**





# medical

certificate of coverage

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**APPENDIX A OPTIONAL BENEFITS**

# Fair Treatment Notice



Select Health obeys Federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

We provide free:

- Aid to those with disabilities to help them talk with us. This may be sign language interpreters or info in other formats (large print, audio, electronic).
- Help for those whose first language is not English, such as interpreters or member materials in other languages.

Need help? Call Select Health Member Services at **800-538-5038**.

If you feel you've been treated unfairly, call Select Health 504/Civil Rights Coordinator at **1-844-208-9012** (TTY Users: 711) or the Compliance Hotline at **1-800-442-4845** (TTY Users: 711). You may also call the Office for Civil Rights at **1-800-368-1019** (TTY Users: **1-800-537-7697**).

## Language Access Services

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Select Health.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 Select Health

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Select Health.

통지: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Select Health. 번호로 전화해 주십시오.

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। Select Health मा फोन गर्नुहोस्।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Select Health.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: Select Health.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните Select Health.

ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez Select Health.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。Select Health. まで、お電話にてご連絡ください。

ማሳሰቢያ: ከማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎቶች ያለክፍያ ለእርስዎ ይገኛሉ። Select Health ን ያናግሩ።

ПАЖЊА: Ако говорите Српски, бесплатне услуге помоћи за језик, биће вам доступне. Контактирајте Select Health.

تامدخ لكل رفوتت سف، یبرع ترحت تنك اذا: هی بننت  
Select Health. اب ل ص ت ا. اناجم فیوغلل ا قذع اسم ل ا

تامدخ، دی ن کی م تب ح ص ین ک دراو ار نابز هب رگا: هجوت  
اب. ت س امش رای تخ ارد ناگیار تروص ب، ینابز کم ک  
دی ری گ ب س ام ت Select Health

หมายเหตุ: หากคุณพูด ใ้ภาษา, การบริการภาษา โดย  
ไม่มีค่าใช้จ่าย มีพร้อมบริการให้กับคุณ ติดต่อ Select  
Health

**Select Health: 1-800-538-5038**

## **SECTION 1 INTRODUCTION**

### **1.1 This Certificate**

This Certificate of Coverage describes the terms and conditions of the health insurance Benefits provided under the Group Health Insurance Contract. Please read it carefully and keep it for future reference. Technical terms are capitalized and described in Section 16 Definitions. Your Member Payment Summary, which contains a quick summary of the Benefits by category of service, is attached to and considered part of this Certificate.

### **1.2 SelectHealth, Inc.**

SelectHealth is an HMO licensed by and **domiciled in the State of Utah and is located at 5381 Green Street, Murray, Utah 84123**. SelectHealth is affiliated with Intermountain Health, but is a separate company. The Contract does not involve Intermountain Health or any other affiliated Intermountain Health companies, or their officers or employees. Such companies are not responsible to you or any other Members for the obligations or actions of SelectHealth.

### **1.3 Managed Care**

SelectHealth provides managed healthcare coverage. Such management necessarily limits some choices of Providers and Facilities. The management features and procedures are described by this Certificate. The Plan is intended to meet basic healthcare needs, but not necessarily to satisfy every healthcare need or every desire Members may have for Services.

### **1.4 Your Agreement**

As a condition to enrollment and to receiving Benefits from SelectHealth, you (the Subscriber) and every other Member enrolled through your coverage (your Dependents) agree to the managed care features that are a part of the Plan in which you are enrolled and all of the other terms and conditions of this Certificate and the Contract.

### **1.5 No Vested Rights**

You are only entitled to receive Benefits while the Contract is in effect and you, and your Dependents, if applicable, are properly enrolled and recognized by SelectHealth as Members. You do not have any permanent or vested interest in any Benefits under the Plan. Benefits may change as the Contract is renewed or modified from year to year. Unless otherwise expressly stated in this Certificate, all Benefits end when the Contract ends.

### **1.6 Term**

The term of the Contract is specified in the Group Application. However, your coverage is guaranteed renewable to the extent required by the Affordable Care Act.

### **1.7 Administration**

SelectHealth establishes reasonable rules, regulations, policies, procedures, and protocols to help it in the administration of your Benefits. You are subject to these administrative practices when receiving Benefits, but they do not change the express provisions of this Certificate or the Contract.

### **1.8 Non-Assignment**

Benefits are not assignable or transferable. Any attempted assignment or transfer by any Member of the right to receive payment from SelectHealth will be invalid unless approved in advance in writing by SelectHealth.

### **1.9 Notices**

Any notice required of SelectHealth under the Contract will be sufficient if mailed to you at the address appearing on the records of SelectHealth. Notice to your Dependents will be sufficient if given to you. Any notice to SelectHealth will be sufficient if mailed to the principal office of SelectHealth. All required notices must be sent by at least first class mail.

## 1.10 Nondiscrimination

SelectHealth will not discriminate against any Member based on race, sex, religion, national origin, or any other basis forbidden by law. SelectHealth will not terminate or refuse to enroll any Member because of the health status or the healthcare needs of the Member or because he or she exercised any right under the SelectHealth complaint resolution system.

## 1.11 Questions

If you have questions about your Benefits, call Member Services at 800-538-5038, or visit [selecthealth.org](http://selecthealth.org). Member Services can also provide you with a provider directory and information about In-Network Providers, such as name, address, phone number, professional qualifications, specialty, medical school attended, residency completed, and board certification status. SelectHealth offers foreign language assistance. The provider directory also includes information about receiving care after business hours.

## 1.12 Benefit Changes

SelectHealth employees often respond to inquiries regarding coverage as part of their job responsibilities. These employees do not have the authority to extend or modify the Benefits provided by the Plan.

- a. In the event of a discrepancy between information given by a SelectHealth employee and the written terms of the Contract, the terms of the Contract will control.
- b. Any changes or modifications that would increase your Benefits must be provided in writing and signed by the president, vice president, or medical director of SelectHealth.
- c. Administrative errors will not invalidate Benefits otherwise in force or give rise to rights or Benefits not otherwise provided for by the Plan.

## SECTION 2 ELIGIBILITY

### 2.1 General

Your employer decides, in consultation with SelectHealth, which categories of its employees, retirees, and their Dependents are Eligible for Benefits, and establishes the other Eligibility requirements of the Plan. These Eligibility requirements are described in this section and in the Group Application of the Contract. In order to become and remain a Member, you and your Dependents must continuously satisfy these requirements. No one, including your employer, may change, extend, expand, or waive the Eligibility requirements without first obtaining the advance, written approval of an officer of SelectHealth.

### 2.2 Subscriber Eligibility

You are Eligible for Benefits as set forth in the Group Application. During the Employer Waiting Period, you must work the specified minimum required hours except for paid time off and hours you do not work due to a medical condition, the receipt of healthcare, your health status or disability. SelectHealth may require payroll reports from your employer to verify the number of hours you have worked as well as documentation from you to verify hours that you did not work due to paid time off, a medical condition, the receipt of healthcare, your health status or disability.

### 2.3 Dependent Eligibility

Unless stated otherwise in the Group Application, your Dependents are:

#### 2.3.1 Spouse

Your lawful spouse. Eligibility may not be established retroactively.

### **2.3.2 Children**

The children (by birth or adoption, and children placed for adoption or under legal guardianship through testamentary appointment or court order, but not under temporary guardianship or guardianship for school residency purposes) of you or your lawful spouse, who are younger than age 26.

### **2.3.3 Disabled Children**

Unmarried Dependent children who meet the Eligibility requirements in Subsection 2.3.2 may enroll or remain enrolled as Dependents after reaching age 26 as long as they:

- a. Are unable to engage in substantial gainful employment to the degree they can achieve economic independence due to medically determinable physical or mental impairment which can be expected to last for a continuous period of not less than 12 months or result in death;
- b. Are chiefly dependent upon you or your lawful spouse for support and maintenance since they reached age 26; and
- c. Have been continuously enrolled in some form of healthcare coverage, with no break in coverage of more than 63 days since the date they reached age 26.

SelectHealth may require you to provide proof of the above elements and dependency within 30 days of the Effective Date or the date the child reaches age 26 and annually after the two-year period following the child's 26th birthday.

## **2.4 Court-Ordered Dependent Coverage**

When you or your lawful spouse are required by a court or administrative order to provide health insurance coverage for a child, the child will be enrolled in your family coverage according to SelectHealth guidelines and only to the minimum extent required pursuant to Utah Code Annotated 31A-22-610 through 611. If you are not enrolled for coverage at the time the court or administrative order becomes effective, only you and the affected Dependent will be allowed to enroll for coverage. For more information about SelectHealth guidelines, please call Member Services.

### **2.4.1 Qualified Medical Child Support Order (QMCSO)**

A QMCSO can be issued by a court of law or by a state or local child welfare agency. In order for the medical child support order to be qualified, the order must specify the following:

- a. Your name and last known mailing address (if any) and the name and mailing address of each alternate recipient covered by the order;
- b. A reasonable description of the type of coverage to be provided, or the manner in which the coverage will be determined; and
- c. The period to which the order applies.

### **2.4.2 National Medical Support Notice (NMSN)**

An NMSN is a QMCSO issued by a state or local child welfare agency to withhold from your income any contributions required by the Plan to provide health insurance coverage for an Eligible child.

### **2.4.3 Eligibility and Enrollment**

You and the Dependent child must be Eligible for coverage, unless specifically required otherwise by applicable law. You and/or the Dependent child will be enrolled without regard to an Annual Open Enrollment restriction and will be subject to applicable Employer Waiting Period requirements. SelectHealth will not recognize Dependent Eligibility for a former spouse as the result of a court order.

### **2.4.4 Duration of Coverage**

Court-ordered coverage for a Dependent child who is otherwise eligible for coverage will be provided until the court order is no longer in effect.

## **SECTION 3 ENROLLMENT**

### **3.1 General**

You may enroll yourself and your Dependents in the Plan during the Initial Eligibility Period, under a Special Enrollment Right, or, if offered by your employer, during an Annual Open Enrollment.

You and your Dependents will not be considered enrolled until:

- a. All enrollment information is provided to SelectHealth; and
- b. The Premium has been paid to SelectHealth by your employer.

## 3.2 Enrollment Process

Unless separately agreed to in writing by SelectHealth and your employer, you must enroll on an Application accepted by SelectHealth. You and your Dependents are responsible for obtaining and submitting to SelectHealth evidence of Eligibility and all other information required by SelectHealth in the enrollment process. You enroll yourself and any Dependents by completing, signing, and submitting an Application and any other required enrollment materials to SelectHealth.

## 3.3 Effective Date of Coverage

Coverage for you and your Dependents will take effect as follows:

### 3.3.1 Annual Open Enrollment

Coverage elected during an Annual Open Enrollment will take effect on the day the Contract is effective.

### 3.3.2 Newly Eligible Employees

Coverage you elect as a newly Eligible employee will take effect as specified in the Group Application if SelectHealth receives a properly completed Application.

If you do not enroll in the Plan for yourself and/or your Dependents during the Initial Eligibility Period, you may not enroll until an Annual Open Enrollment unless you experience an event that creates a Special Enrollment Right.

### 3.3.3 Court or Administrative Order

When you or your lawful spouse are required by a court or administrative order to provide health insurance coverage for a child, the Effective Date of coverage will be the later of:

- a. The start date indicated in the order;

- b. The date any applicable Employer Waiting Period is satisfied; or
- c. The date SelectHealth receives the order.

## 3.4 Special Enrollment Rights

SelectHealth provides Special Enrollment Rights in the following circumstances:

### 3.4.1 Loss of Other Coverage

If you do not enroll in the Plan for yourself and/or your Dependents when initially Eligible, you may enroll at a time other than an Annual Open Enrollment if each of the following conditions are met:

- a. You initially declined to enroll in the Plan due to the existence of other health plan coverage;
- b. The loss of the other health plan coverage occurred because of a loss of eligibility (this Special Enrollment Right will not apply if the other coverage is lost due to nonpayment of Premiums). One exception to this rule exists: if a Dependent is enrolled on another group health plan and the Annual Open Enrollment periods of the two plans do not coincide, the Dependent may voluntarily drop coverage under their health plan's open enrollment and a special enrollment period will be permitted under the Plan in order to avoid a gap in coverage; and
- c. You and/or your Dependents who lost the other coverage must enroll in the Plan within 60 days after the date the other coverage is lost.

Proof of loss of the other coverage must be submitted to SelectHealth as soon as reasonably possible. Proof of loss of other coverage must be submitted before any Benefits will be paid.

Coverage of any Members properly enrolled under this Special Enrollment Right will be effective on the date the other coverage was lost.

### 3.4.2 New Dependents

If you are enrolled in the Plan (or are Eligible to be covered but previously declined to enroll), and gain a Dependent through marriage, birth, adoption, placement for adoption or placement under legal guardianship with you or your lawful spouse, then you may enroll the Dependents (and yourself, if applicable) in the Plan. In the case of birth, adoption or placement for adoption of a child, you may also enroll your Eligible spouse, even if he or she is not newly Eligible as a Dependent. However, this Special Enrollment Right is only available by enrolling within 60 days of the marriage, birth, adoption, placement for adoption or placement under legal guardianship (there is an exception for enrolling a newborn, adopted child, or child placed for adoption or under legal guardianship if enrolling the child does not change the Premium, as explained in Section 3.5 Enrolling a Newborn, Adopted Child, or Child Placed for Adoption or Under Legal Guardianship).

Coverage of any Members properly enrolled under this Special Enrollment Right will be effective:

- a. As of the date of marriage;
- b. As of the date of birth;
- c. If the child is less than 31 days old when adopted or placed for adoption, as of the date of birth; if the child is more than 31 days old when adopted or placed for adoption, as of the child's date of placement; or
- d. As of the later of:
  - i. The effective date of the guardianship court order or testamentary appointment; or
  - ii. The date the guardianship court order or testamentary appointment is received by SelectHealth.

### 3.4.3 Qualification for a Subsidy Through Utah's Premium Partnership

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

### 3.4.4 Loss of Medicaid or CHIP Coverage

If you and/or your Eligible Dependents lose coverage under a Medicaid or CHIP plan due to loss of eligibility, you may enroll in the Plan if application is made within 60 days. If you enroll within 60 days, the Effective Date of coverage is the first day after your Medicaid or CHIP coverage ended.

### 3.4.5 As Required by State or Federal Law

SelectHealth will recognize other special enrollment rights as required by state or federal law.

## 3.5 Enrolling a Newborn, Adopted Child, or Child Placed for Adoption or Under Legal Guardianship

You must enroll your newborn, adopted child, child placed for adoption or child under legal guardianship according to the following requirements:

- a. If enrolling the child requires additional Premium, you must enroll the child within 60 days of the child's birth, adoption, or placement for adoption or under legal guardianship.
- b. If enrolling the child does not change the Premium, you must enroll the child within 31 days from the date SelectHealth mails notification that a claim for Services was received for the child.

If the child is not enrolled within these time frames, then you may not enroll the child until an Annual Open Enrollment or if you experience an event that creates a Special Enrollment Right.

If you lose Eligibility for coverage before the end of the applicable time frame listed in (a) or (b) above, you are still allowed to enroll the child within the applicable time frame. However, the child will only be covered from the moment of birth, adoption, placement for adoption or under legal guardianship until the date that you lost Eligibility for coverage.



### **3.6 Leave of Absence**

If you are granted a temporary leave by your employer, you and any Dependents may continue to be enrolled with SelectHealth for up to the length of time specified in the Group Application, as long as the monthly Premiums for your coverage are paid to SelectHealth by your employer. Military personnel called into active duty will continue to be covered to the extent required by law. A leave of absence may not be treated retroactively as a termination of employment.

### **3.7 Family Medical Leave Act**

If you are on a leave required by the Family Medical Leave Act (FMLA), SelectHealth will administer your coverage as follows:

- a. You and your enrolled Dependents may continue your coverage with SelectHealth to the minimum extent required by the FMLA as long as applicable Premiums continue to be paid to SelectHealth by your employer.
- b. If Premiums are not paid, your coverage will be terminated. Upon your return to work, you and any previously enrolled Dependents who are still Eligible will be prospectively reinstated if the applicable Premium for you is paid to SelectHealth by your employer within 30 days. SelectHealth will not be responsible for any claims incurred by you or your Dependents during this break in coverage.

Any non-FMLA leave of absence granted by your employer that could have been classified as FMLA leave will be considered by SelectHealth as an FMLA leave of absence.

## **SECTION 4 TERMINATION**

### **4.1 Group Termination**

Coverage under the Plan for you and your Dependents will terminate when the Contract terminates.

#### **4.1.1 Termination by Employer**

Your employer may terminate the Contract, with or without cause, by providing SelectHealth with written notice of termination not less than 30 days before the proposed termination date.

#### **4.1.2 Termination of Employer Group by SelectHealth**

SelectHealth may terminate the Contract for any of the following reasons:

- a. Nonpayment of applicable Premiums;
- b. Fraud or intentional misrepresentation of material fact to SelectHealth by your employer in any matter related to the Contract or the administration of the Plan;
- c. Your employer's coverage under the Contract is through an association and your employer terminates membership in the association;
- d. Your employer fails to satisfy the minimum group participation and/or employer contribution requirements of SelectHealth;
- e. No employees live, reside, or work in the Service Area;
- f. SelectHealth elects to discontinue offering a particular health benefit plan. If that happens, you will be given at least 90 days advance notice; or
- g. SelectHealth withdraws from the market and discontinues all of its health benefit plans. If that happens, you will be given at least 180 days advance notice.

### **4.2 Individual Termination**

Your coverage under the Plan may terminate even though the Contract with your employer remains in force.

#### **4.2.1 Termination Date**

If you and/or your enrolled Dependents lose Eligibility, then coverage will terminate either on the date Eligibility is lost or the end of the month in which Eligibility is lost, as specified in the Group Application. However, when a Dependent child ceases to be a Dependent, coverage will terminate at the end of the month in which Dependent status is lost. When a loss of Eligibility is not reported in a timely fashion as required by the Contract, and federal or state law prevents SelectHealth from retroactively terminating coverage, SelectHealth has the discretion to determine the prospective date of termination. SelectHealth also has the discretion to determine the date of termination for Rescissions.

#### **4.2.2 Fraud or Misrepresentation**

- a. Made During Enrollment:
  - i. Coverage for you and/or your Dependents may be terminated or Rescinded during the two-year period after you enroll if you or they make an intentional misrepresentation of material fact in connection with insurability.
  - ii. Coverage for you and/or your Dependents may be terminated or Rescinded at any time if you or they make any fraudulent misrepresentation in connection with insurability.
  - iii. Please Note: If coverage is Rescinded as described above, the termination is retroactive to the Effective Date of coverage.
- b. Made After Enrollment: Coverage for you and/or your Dependents may be terminated or Rescinded if you or they commit fraud or make an intentional misrepresentation of material fact in connection with Benefits or Eligibility. At the discretion of SelectHealth, the Rescission may be effective retroactively to the date of the fraud or misrepresentation.

- c. If coverage for you or your Dependent is terminated or Rescinded for fraud or intentional misrepresentation of material fact, you or they are allowed to reenroll 12 months after the date of the termination, provided the Contract is still in force. You will be given notice of this provision at the time of termination.
- d. The termination from the Plan of a Dependent for cause does not necessarily affect your Eligibility or enrollment or the Eligibility or enrollment of your other Dependents.

#### **4.2.3 Leaving the Service Area**

Coverage for you and/or your Dependents terminates if you no longer live, work or reside in the Service Area except when allowed by SelectHealth policy.

#### **4.2.4 Annual Open Enrollment**

You can drop coverage for yourself and any Dependents during an Annual Open Enrollment.

#### **4.2.5 Nonpayment of Premium or Contributions**

SelectHealth may terminate coverage for you and/or your Dependents for nonpayment of applicable Premiums or contributions. Termination may be retroactive to the end of the Grace Period, and SelectHealth may recover from you and/or your Dependent(s) the amount of any Benefits you or they received during the period of lost coverage.

#### **4.2.6 Court or Administrative Order**

In cases of court or administrative orders that grant a divorce or annul/declare void a marriage, subject to SelectHealth policy, the effective date of the change will be the date the court or administrative order was signed by the court or administrative agency.

### **4.3 Member Receiving Treatment at Termination**

All Benefits under the Plan terminate when the Contract terminates, including coverage for Members hospitalized or otherwise within a course of care or treatment. All Services received after the date of termination are the responsibility of the Member and not the responsibility of SelectHealth no matter when the condition arose and despite care or treatment anticipated or already in progress.

### **4.4 Reinstatement**

Members terminated from coverage for cause may not be reinstated without the written approval of SelectHealth.

## **SECTION 5 CONTINUATION COVERAGE**

If your coverage terminates, you or your enrolled Dependents may be entitled to continue and/or convert coverage. For detailed information about your rights and obligations under your Employer's Plan and under federal law, contact your employer.

### **5.1 COBRA or Utah mini-COBRA (Continuation Coverage)**

You and/or your Dependents may have the right to temporarily continue your coverage under the Plan when coverage is lost due to certain events. The federal law that governs this right is called COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1986) and generally applies to employers with 20 or more employees. For employers with fewer than 20 employees, Utah law provides for mini-COBRA coverage.

#### **5.1.1 Employer's Obligation**

Continuation Coverage is an employer obligation. SelectHealth is not the administrator of Continuation Coverage procedures and requirements. SelectHealth has contractually agreed to assist your employer in providing Continuation Coverage in certain circumstances. It is your employer's responsibility to do the following in a timely manner:

- a. Notify persons entitled to Continuation Coverage;
- b. Notify SelectHealth of such individuals; and
- c. Collect and submit to SelectHealth all applicable Premiums.

If the Contract is terminated, your Continuation Coverage with SelectHealth will terminate. Your employer is responsible for obtaining substitute coverage.

### **5.2 Minimum Extent**

Continuation Coverage will only be provided for the minimum time and only to the minimum extent required by applicable federal law or pursuant to Utah Code Annotated 31A-22-722. SelectHealth will not provide Continuation Coverage if you, your Dependents, or your employer fails to strictly comply with all applicable notices and other requirements and deadlines.

## **SECTION 6 PROVIDERS/NETWORKS**

### **6.1 Providers and Facilities**

SelectHealth contracts with certain Providers and Facilities (known as In-Network Providers and In-Network Facilities) to provide Covered Services within the Service Area. Not all available Providers and Facilities and not all categories of Providers and Facilities are invited to contract with SelectHealth.

If you need access to primary care, specialty care, Mental Health/Chemical Dependency (if a Covered Service), or Hospital services, call SelectHealth Member Advocates at 800-515-2220.

You can also find the most current list of Providers online. Visit [selecthealth.org/findadoctor](http://selecthealth.org/findadoctor), or call Member Services at 800-538-5038 to request a copy of the provider directory.

#### **6.1.1 In-Network Providers and Facilities**

You receive a higher level of Benefits (known as In-Network Benefits) when you obtain Covered Services from an In-Network Provider or Facility. Refer to your Member Payment Summary for details.

### 6.1.2 Out-of-Network Providers and Facilities

In most cases, you receive a lower level of Benefits (known as Out-of-Network Benefits) when you obtain Covered Services from a Out-of-Network Provider or Facility. Refer to your Member Payment Summary for details.

### 6.1.3 Other Networks

You receive In-Network Benefits when you obtain Services from Providers in the following networks:

- a. SelectHealth Med in Utah and Nevada or SelectHealth Care in Utah;
- b. SelectHealth in Idaho; and
- c. Other networks as listed on SelectHealth.org.

Contact Member Services for additional information.

## 6.2 Access to Healthcare Providers

Regardless of network status, you may be entitled to In-Network Benefits for healthcare Services from the following Providers if you live or reside within 30 paved road miles of the listed Providers, or if you live or reside in closer proximity to the listed Providers than to other In-Network Providers:

Independent Hospital(s)  
Beaver Valley Hospital, Beaver, Beaver County, Utah  
Blue Mountain Hospital, Blanding, San Juan County, Utah  
Central Valley Medical Center, Nephi, Juab County, Utah  
Gunnison Valley Hospital, Gunnison, Sanpete County, Utah  
Kane County Hospital, Kanab, Kane County, Utah  
Milford Valley Memorial Hospital, Milford, Beaver County, Utah  
Moab Regional Hospital, Moab, Grand County, Utah  
San Juan Hospital, Monticello, San Juan County, Utah  
Uintah Basin Medical Center, Roosevelt, Duchesne County, Utah

Federally Qualified Health Centers

Bear Lake Community Health Center, Garden City, Carbon County, Utah  
Bear River Health Clinic, Tremonton, Box Elder County, Utah  
Blanding Family Chiropractic, Blanding, San Juan County, Utah  
Blanding Family Practice Community Health Center, Blanding, San Juan County, Utah  
Blanding Family Vision Center, Blanding, San Juan County, Utah  
Box Elder Community Health Center, Brigham City, Box Elder County, Utah  
Brigham City Community Health Center, Brigham City, Box Elder County, Utah  
Carbon Medical Service Association -- Helper Clinic, Helper, Carbon County, Utah  
Carbon Medical Service Association, Sunnyside, Carbon County, Utah  
Cedar Community Health Center, Cedar City, Iron County, Utah  
Family Healthcare, Cedar City, Iron County, Utah  
Green River Medical Center, Green River, Emery County, Utah  
Kanosh Community Health Center, Kanosh, Millard County, Utah  
Kazan Memorial Clinic, Escalante, Garfield County, Utah  
Koosharem Community Health Center, Richfield, Sevier County, Utah  
Montezuma Creek Health Center, Montezuma Creek, San Juan County, Utah  
Mountainlands Community Health Center, Vernal, Uintah County, Utah  
Southwest WCHC Mental Health, Panguitch, Garfield County, Utah  
Wayne County Medical Clinic, Bicknell, Wayne County, Utah  
Wayne Community Health Center, Hanksville, Wayne County, Utah

This list may change periodically, please check on our website or call for verification.

If you have questions concerning your rights to see a Provider on this list, call Member Services at 800-538-5038. If SelectHealth does not resolve your problem, you may contact the Office of Consumer Health Assistance in the Utah Insurance Department.

### **6.3 Providers and Facilities not Agents/Employees of SelectHealth**

Providers contract independently with SelectHealth or an affiliated network and are not agents or employees of SelectHealth. They are entitled and required to exercise independent professional medical judgment in providing Covered Services. SelectHealth and its affiliated network(s) makes a reasonable effort to credential In-Network Providers and Facilities, but do not guarantee the quality of Services rendered by Providers and Facilities or the outcomes of medical care or health-related Services. Providers and Facilities, not SelectHealth, are solely responsible for their actions, or failures to act, in providing Services to you.

Providers and Facilities are not authorized to speak on behalf of SelectHealth or to cause SelectHealth to be legally bound by what they say. A recommendation, order, or referral from a Provider or Facility, including In-Network Providers and Facilities, does not guarantee coverage by SelectHealth.

Providers and Facilities do not have authority, either intentionally or unintentionally, to modify the terms and conditions of the Plan. Benefits are determined by the provisions of the Contract.

### **6.4 Payment**

SelectHealth may pay Providers in one or more ways, such as discounted fee-for-service, capitation (fixed payment per Member per month), and payment of a year-end withhold.

#### **6.4.1 Incentives**

Some payment methods may encourage Providers to reduce unnecessary healthcare costs and efficiently utilize healthcare resources. No payment method is ever intended to encourage a Provider to limit Medically Necessary care.

#### **6.4.2 Payments to Members**

SelectHealth reserves the right to make payments directly to you or your Dependents instead of to Out-of-Network Providers and/or Facilities.

### **6.5 Provider/Patient Relationship**

Providers and Facilities are responsible for establishing and maintaining appropriate Provider/patient relationships with you, and SelectHealth does not interfere with those relationships. SelectHealth is only involved in decisions about what Services will be covered and paid for by SelectHealth under the Plan. Decisions about your Services should be made between you and your Provider without reference to coverage under the Plan.

### **6.6 Continuity of Care**

SelectHealth will provide you with 30 days' notice of In-Network Provider or Facility termination if you or your Dependent is receiving ongoing care from that Provider or Facility. However, if SelectHealth does not receive adequate notice of a Provider or Facility termination, SelectHealth will notify you within 30 days of receiving notice that the Provider or Facility is no longer In-Network with SelectHealth.

If you or your Dependent is under the care of a Provider or Facility when participation changes, SelectHealth will continue to treat the Provider or Facility as an In-Network Provider/Facility until the completion of the care (not to exceed 90 days), or until you or your Dependent is transferred to another In-Network Provider or Facility, whichever occurs first. This does not apply when a Provider is terminated from the network for failure to meet applicable quality standards or for fraud. Continuity of care treatment is eligible for coverage if you or your Dependent are:

- a. undergoing a course of treatment from the Provider or Facility for a serious and complex condition;
- b. undergoing a course of institutional or inpatient care from the Provider or Facility;
- c. scheduled to undergo non-elective surgery from the Provider or Facility, including receipt of postoperative care from such Provider or Facility with respect to such surgery;
- d. pregnant and undergoing a course of treatment for pregnancy from the Provider or Facility (any trimester); and

- e. determined to have a life expectancy of six months or less and are receiving treatment for such illness from the Provider or Facility until the Member's death.

To continue care, the In-Network Provider or Facility must not have been terminated by SelectHealth for quality reasons, remain in the Service Area, and agree to do all of the following:

- a. Accept the Allowed Amount as payment in full;
- b. Follow SelectHealth's Healthcare Management Program policies and procedures;
- c. Continue treating you and/or your Dependent; and
- d. Share information with SelectHealth regarding the treatment plan.

## **SECTION 7 ABOUT YOUR BENEFITS**

### **7.1 General**

You and your Dependents are entitled to receive Benefits while you are enrolled with SelectHealth and while the Contract is in effect. This section describes those Benefits in greater detail.

### **7.2 Member Payment Summary**

Your Member Payment Summary lists variable information about your specific Plan. This includes information about Copay, Coinsurance, and/or Deductible requirements, Preauthorization requirements, visit limits, Limitations on the use of Out-of-Network Providers and Facilities, and expenses that do not count against your Out-of-Pocket Maximum.

### **7.3 Identification (ID) Cards**

You will be given SelectHealth ID cards that will provide certain information about the Plan in which you are enrolled. Providers and Facilities may require the presentation of the ID card plus one other reliable form of identification as a condition to providing Services. The ID card does not guarantee Benefits.

If you or your enrolled Dependents permit the use of your ID card by any other person, the card will be confiscated by SelectHealth or by a Provider or Facility and all rights under the Plan will be immediately terminated for you and/or your Dependents.

### **7.4 Medical Necessity**

To qualify for Benefits, Covered Services must be Medically Necessary. Medical Necessity is determined by the Medical Director of SelectHealth or another Physician designated by SelectHealth. A recommendation, order, or referral from a Provider or Facility, including In-Network Providers and Facilities, does not guarantee Medical Necessity.

### **7.5 Benefit Changes**

Your Benefits may change if the Contract changes. Your employer is responsible for providing at least 30 days advance written notice of such changes.

### **7.6 Calendar-Year or Plan-Year Basis**

Your Member Payment Summary will indicate if your Benefits are calculated on a calendar-Year or plan-Year basis. Out-of-Pocket Maximums, Limitations, and Deductibles that are calculated on a calendar-Year basis start over each January 1st. Out-of-Pocket Maximums, Limitations, and Deductibles that are calculated on a plan-Year basis start over each Year on the renewal date of the Contract.

### **7.7 Lifetime Maximums**

Your Member Payment Summary will specify any applicable Lifetime Maximums.

## 7.8 Two Benefit Levels

### 7.8.1 In-Network Benefits

You receive a higher level of Benefits (known as In-Network Benefits) when you obtain Covered Services from an In-Network Provider or Facility. In-Network Providers and Facilities have agreed to accept the Allowed Amount and will not bill you for Excess Charges.

### 7.8.2 Out-of-Network Benefits

In most cases, you receive a lower level of Benefits (known as Out-of-Network Benefits) when you obtain Covered Services from an Out-of-Network Provider or Facility; and some Services are not covered when received from an Out-of-Network Provider or Facility. Out-of-Network Providers or Facilities have not agreed to accept the Allowed Amount for Covered Services. When this occurs, you are responsible to pay for any charges that exceed the amount that SelectHealth pays for Covered Services. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

## 7.9 Emergency Conditions

If you experience an emergency, call 911 or go to the nearest Hospital.

In-Network Benefits apply to emergency room Services regardless of whether they are received at an In-Network Facility or Out-of-Network Facility.

If you or your Dependent is hospitalized for an emergency:

- a. You or your representative must contact SelectHealth once the condition has been stabilized, or as soon as reasonably possible; and
- b. If you are in an Out-of-Network Facility, once the Emergency condition has been stabilized, you may be asked to transfer to an In-Network Facility in order to continue receiving In-Network Benefits.

## 7.10 Urgent Conditions

In-Network Benefits apply to Services received for Urgent Conditions rendered by an In-Network Provider or Facility. In-Network Benefits also apply to Services received for Urgent Conditions rendered by an Out-of-Network Provider or Facility when you are outside of the Service area, or within the Service Area when you are more than 40 miles away from any In-Network Provider or Facility.

## 7.11 Surprise Billing Protections

When certain Services are received from Out-of-Network Providers, you or your Dependents will only be responsible for cost sharing at an In-Network Benefit level. To the extent required by the No Surprises Act (NSA), this is applicable for air ambulance and emergency Services from Out-of-Network Providers, including post-stabilization care, and Services received from Out-of-Network Providers at an In-Network Facility. In these circumstances, cost sharing amounts will be based on the qualifying payment amount (as defined by the NSA). If you or your Dependents consent to waive balance billing protections for Services obtained by an Out-of-Network Provider at an In-Network Facility by signing a waiver as allowed by the NSA, the protections of the NSA will not apply. Out-of-Network Providers may initiate a dispute resolution process if they do not agree with the Allowed Amount. The outcome of that process may change the Allowed Amount.

## 7.12 Out-of-Area Benefits and Services

Except as otherwise noted in the Contract, Out-of-Network Benefits apply for Covered Services rendered by Out-of-Network Providers or Facilities outside of SelectHealth's Service Area.

If you are traveling outside of the country and need Urgent or Emergency care, visit the nearest doctor or Hospital. You may need to pay for the Service and then seek reimbursement. If the Service is covered, you will be reimbursed the Allowed Amount minus your Copay/Coinsurance and/or Deductible. Some Services received outside of the U.S. require

preauthorization. Call Member Services at 800-538-5038 for details.

### 7.13 Third Party Payments

SelectHealth will accept third-party Premium payments from the following entities as required by state and federal law:

- a. Ryan White HIV/AIDS Program;
- b. Indian tribes, tribal organizations, or urban Indian organizations; and
- c. Local, state, or federal government programs, including grantees directed by a government program to make payments on its behalf.
- d. Your family and friends.
- e. SelectHealth will also accept Premium payments from not-for-profit organizations when the organization:
  - i. Provides assistance based on your financial need;
  - ii. Is not a healthcare provider; and
  - iii. Is not financially interested.

An organization is financially interested when it receives the majority of its funding from entities with a pecuniary interest in the payment of health insurance claims, or the organization is subject to the direct or indirect control of an entity with a pecuniary interest in the payment of health insurance claims.

When you make a payment directly to us, we will not require certification or verification of the source of the funds.

If SelectHealth refuses an appropriate premium payment from a third party, we will notify you in writing of the reason for refusing the payment and your right to contact or file a complaint with the Utah Insurance Department.

Third-party payments (including discounts and coupons) may not apply towards your Deductible and Out-of-Pocket Maximum.

### 7.14 Deductible Waiver

In addition to the Services listed on your Member Payment Summary, the Deductible is waived for the following Services:

- a. Retinopathy screening for diabetes;
- b. Hemoglobin A1c testing for diabetes;
- c. Peak flow meter for asthma;
- d. International Normalized Ratio (INR) testing for liver disease and/or bleeding disorders; and
- e. Low-density Lipoprotein (LDL) testing for heart disease.

## SECTION 8 COVERED SERVICES

You and your Dependents are entitled to receive Benefits for Covered Services while you are enrolled with SelectHealth and while the Contract is in effect. This section describes those Covered Services (except for pharmacy Covered Services, which are separately described in Section 9 Prescription Drug Benefits). Certain Services must be Preauthorized; failure to obtain Preauthorization for these Services may result in a reduction or denial of Benefits. Refer to Section 11 Healthcare Management for a list of Services that must be Preauthorized.

Benefits are limited. Services must satisfy all of the requirements of the Contract to be covered by SelectHealth. For additional information affecting Covered Services, refer to your Member Payment Summary and Section 10 Limitations and Exclusions. In addition to this Certificate, you can find further information about your Benefits by doing any of the following:

- a. Log in to your SelectHealth account at [selecthealth.org](http://selecthealth.org);
- b. Refer to your Provider & Facility Directory; or
- c. Call Member Services at 800-538-5038.



## 8.1 Facility Services

### 8.1.1 Emergency Room (ER)

If you are admitted directly to the Hospital because of the condition for which emergency room Services were sought, the emergency room Copay, if applicable, will be waived.

### 8.1.2 Inpatient Hospital

- a. Semiprivate room accommodations and other Hospital-related Services ordinarily furnished and billed by the Hospital.
- b. Private room accommodations in connection with a medical condition requiring isolation. If you choose a private room when a semiprivate room is available, or isolation is not necessary, you are responsible for paying the difference between the Hospital's semiprivate room rate and the private room rate. However, you will not be responsible for the additional charge if the Hospital only provides private room accommodations or if a private room is the only room available.
- c. Intensive care unit.
- d. Preadmission testing.
- e. Short-term inpatient detoxification provided by a SelectHealth-approved treatment Facility for alcohol/drug dependency.
- f. Maternity/obstetrical Services.
- g. Services in connection with an otherwise covered inpatient Hospital stay.

### 8.1.3 Nutritional Therapy

Medical nutritional therapy Services are covered up to five visits per Year as a Preventive Service, regardless of diagnosis. Subsequent visits are covered as a medical Benefit.

Weight management as part of a program approved by SelectHealth is also covered once per year.

### 8.1.4 Outpatient Facility and Ambulatory Surgical Facility

Outpatient surgical and medical Services.

### 8.1.5 Skilled Nursing Facility

Only when Services cannot be provided adequately through a home health program.

### 8.1.6 Urgent Care Facility

## 8.2 Provider Services

### 8.2.1 After-Hours Visits

Office visits and minor surgery provided after the Provider's regular business hours.

### 8.2.2 Anesthesia

Only:

- a. General anesthesia, deep anesthesia, and Monitored Anesthesia Care (MAC) pursuant to SelectHealth policy when administered in connection with otherwise Covered Services and by a Physician certified as an anesthesiologist or by a Certified Registered Nurse Anesthetist (CRNA); and
- b. Dental anesthesia when rendered by an In-Network Provider according to SelectHealth policy.

### 8.2.3 Dental Services

Only:

- a. When rendered to diagnose or treat medical complications of a dental procedure and administered under the direction of a medical Provider whose primary practice is not dentistry or oral surgery.
- b. When SelectHealth determines the following to be Medically Necessary:
  - i. Maxillary and/or mandibular procedures;
  - ii. Upper/lower jaw augmentation or reduction procedures, including developmental corrections or altering of vertical dimension;
  - iii. Orthognathic Services; or
  - iv. Services for Congenital Oligodontia/Anodontia.

- c. For repairs of physical damage to sound natural teeth, crowns, and the natural supporting structures surrounding teeth when:
  - i. Such damage is a direct result of an accident independent of disease or bodily infirmity or any other cause;
  - ii. Medical advice, diagnosis, care, or treatment was recommended or received for the injury at the time of the accident; and
  - iii. Repairs are initiated within one year of the date of the accident.

Bleaching to restore teeth to pre-accident condition is limited to \$200.

Orthodontia and the replacement/repair of dental appliances are not covered, even after an accident. Repairs for physical damage resulting from biting or chewing are not covered.

#### **8.2.4 Dietary Products**

Only in the following limited circumstances:

- a. For hereditary metabolic disorders when:
  - i. You or your Dependent has an error of amino acid or urea cycle metabolism;
  - ii. The product is specifically formulated and used for the treatment of errors of amino acid or urea cycle metabolism; and
  - iii. The product is used under the direction of a Physician, and its use remains under the supervision of the Physician.
- b. Certain enteral formulas according to SelectHealth policy.

#### **8.2.5 Genetic Counseling**

Only when rendered by an In-Network Provider.

#### **8.2.6 Genetic Testing**

Only when ordered or recommended by a medical geneticist, a genetic counselor, or a provider with recognized expertise in the area being assessed and only when all of the following criteria are met:

- a. Diagnostic results from physical examination, pedigree analysis, and conventional testing are inconclusive and a definitive diagnosis is uncertain;
- b. The clinical utility of all requested genes and gene mutations must be established; and
- c. The clinical record indicates how test results will guide decisions regarding disease treatment, prevention, or management.

#### **8.2.7 Home Visits**

#### **8.2.8 Infertility**

Services to diagnose Infertility are only covered in limited circumstances, including fulguration of ova ducts, hysteroscopy, hysterosalpingogram, certain laboratory tests, diagnostic laparoscopy, and some imaging studies.

#### **8.2.9 Major Surgery**

#### **8.2.10 Mastectomy/Reconstructive Services**

In accordance with the Women's Health and Cancer Rights Act (WHCRA), SelectHealth covers mastectomies and reconstructive surgery after a mastectomy. If you are receiving Benefits in connection with a mastectomy, coverage for reconstructive surgery, including modifications or revisions, will be provided according to SelectHealth's Healthcare Management Program criteria and in a manner determined in consultation with you and the attending Physician, for:

- a. All stages of reconstruction on the breast on which the mastectomy was performed;
- b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- c. Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Prophylactic mastectomies are covered in limited circumstances in accordance with SelectHealth's medical policy.

Benefits are subject to the same Deductibles, Copays, and Coinsurance amounts applicable to other medical and surgical procedures covered by the Plan.

### **8.2.11 Medical/Surgical**

In an inpatient, outpatient, or Ambulatory Surgical Facility.

### **8.2.12 Maternity Services**

Prenatal care, labor and delivery, and postnatal care, including complications of delivery. Newborns are subject to their own separate cost sharing, including Deductibles, Coinsurance, Copays, and Out-of-Pockets Maximums.

### **8.2.13 Office Visits**

For consultation, diagnosis, and treatment.

### **8.2.14 Preventive Services**

### **8.2.15 Sleep Studies**

### **8.2.16 Sterilization Procedures**

## **8.3 Miscellaneous Services**

### **8.3.1 Adoption Indemnity Benefit**

SelectHealth provides an adoption indemnity Benefit as required pursuant to Utah Code Annotated 31A-22-610.1. In order to receive this Benefit, the child must be placed with you for adoption within 90 days of the child's birth. You must submit a claim for the Benefit within one year from the date of placement.

If you adopt more than one child from the same birth (e.g., twins), only one adoption indemnity Benefit applies. If you and/or your spouse are covered by multiple plans, SelectHealth will cover a prorated share of the adoption indemnity Benefit.

This Benefit is subject to Coinsurance, Copays, and Deductibles applicable to the maternity Benefit as indicated in your Member Payment Summary.

### **8.3.2 Ambulance/Transportation Services**

Transport by a licensed service to the nearest Facility expected to have appropriate Services for the treatment of your condition. Only for Emergency Conditions and not when you could safely be transported by other means. Air ambulance transportation only when ground ambulance is either not available or, in the opinion of responding medical professionals, would cause an unreasonable risk of harm because of increased travel time. Transportation services in nonemergency situations must be approved in advance by SelectHealth.

### **8.3.3 Approved Clinical Trials**

Services for an Approved Clinical Trial only to the extent required by federal or state law and only when the Member is:

- a. Eligible to participate in the trial according to the trial protocol;
- b. The treatment is for cancer or another life-threatening disease (any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted); and
- c. Either:
  - i. The referring health care professional is an In-Network Provider and has concluded that the Member's participation in such trial would be appropriate; or
  - ii. The Subscriber or Member provides medical and scientific information establishing that the Member's participation in such trial would be appropriate.

### **8.3.4 Bariatric Surgery**

Only when rendered at a Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program accredited facility.

### **8.3.5 Chemotherapy, Radiation Therapy, and Dialysis**

### **8.3.6 Chiropractic Benefits**

Chiropractic Benefits for neuromuscular disorders are covered except for the following:

- a. Chiropractic appliances;
- b. Services for treatment of non-neuromusculoskeletal disorders;
- c. Professional radiology services (reading of an X-ray); and
- d. Services for children ages eight and under.

### **8.3.7 Cochlear Implants and Osseointegrated Auditory Devices**

Only in limited circumstances that satisfy SelectHealth criteria.

### **8.3.8 Durable Medical Equipment (DME)**

Only:

- a. When used in conjunction with an otherwise covered condition and when:
  - i. Prescribed by a Provider;
  - ii. Primarily used for medical purposes and not for convenience, personal comfort, or other nontherapeutic purposes;
  - iii. Required for Activities of Daily Living;
  - iv. Not for duplication or replacement of lost, damaged, or stolen items; and
  - v. Not attached to a home or vehicle.
- b. Batteries only when used to power a wheelchair, an insulin pump for treatment of diabetes, or for a covered Cochlear Implant.
- c. Continuous passive motion therapy for any indication for up to 21 days of continuous coverage from the first day applied.

Certain DME items can only be rented. Others may be subject to a rental period prior to purchasing. SelectHealth will not provide payment for rental costs exceeding the purchase price. For covered rental DME that is subsequently purchased,

cumulative rental costs are deducted from the purchase price.

### **8.3.9 Habilitation Therapy Services**

When Mental Health/Chemical Dependency is a Covered Service, visit limits for Habilitation Services, if indicated on your Member Payment Summary, do not apply when the primary diagnosis is Mental Health/Chemical Dependency.

### **8.3.10 Home Healthcare**

- a. When you:
  - i. Have a condition that requires the services of a licensed Provider;
  - ii. Are home bound for medical reasons;
  - iii. Are physically unable to obtain necessary medical care on an outpatient basis; and
  - iv. Are under the care of a Physician.
- b. In order to be considered home bound, you must either:
  - i. Have a medical condition that restricts your ability to leave the home without the assistance of another individual or supportive device or because absences from the home are medically contraindicated; or
  - ii. Leave the home only to receive medical treatment that cannot be provided in your home or other treatments that require equipment that cannot be made available in your home or infrequently and for short periods of time for nonmedical purposes.

You are not considered home bound if you leave the home regularly for social activities, drive a car, or do regular grocery or other shopping, work or business.

### **8.3.11 Hospice Care**

### **8.3.12 Injectable Drugs and Specialty Medications**

Up to a 30-day supply of injectable drugs or specialty medications may be covered. Infused drugs must be administered by an In-Network Provider. Most specialty oral and self-injectable medications must be obtained from an In-Network specialty pharmacy. Call Member Services to obtain information on participating drug vendors.

### **8.3.13 Miscellaneous Medical Supplies (MMS)**

Only when prescribed by a Provider and not generally usable in the absence of an illness or injury. Only 90 days of diabetic supplies may be purchased at a time.

### **8.3.14 Organ Transplants**

- a. Only if:
  - i. Provided by In-Network Providers in an In-Network Facility unless otherwise approved in writing in advance by SelectHealth.
- b. And only the following:
  - i. Bone marrow as outlined in SelectHealth criteria;
  - ii. Combined heart/lung;
  - iii. Combined pancreas/kidney;
  - iv. Cornea;
  - v. Heart;
  - vi. Kidney (but only to the extent not covered by any government program);
  - vii. Liver;
  - viii. Pancreas after kidney;
  - ix. Single or double lung and
  - x. Small bowel.

For covered transplants, organ harvesting from donors is covered. Services for both the donor and the recipient are only covered under the recipient's coverage.

Costs of a chartered service if transportation to a transplant site cannot be accomplished within four hours by commercial carrier.

### **8.3.15 Orthotics and Other Corrective Appliances for the Foot**

Not covered unless they are part of a lower foot brace, and they are prescribed as part of a specific treatment associated with recent, related surgery.

### **8.3.16 Osteoporosis Screening**

Only central bone density testing (DEXA scan)

### **8.3.17 Private Duty Nursing**

On a short-term, outpatient basis during a transition of care when ordered by a Provider. Not available for Respite Care or Custodial Care.

### **8.3.18 Rehabilitation Therapy**

Physical, occupational, and speech rehabilitative therapy when required to correct an impairment caused by a covered accident or illness or to restore an individual's ability to perform Activities of Daily Living. When Mental Health/Chemical Dependency is a Covered Service, visit limits for Rehabilitation Services, if indicated on your Member Payment Summary, do not apply when the primary diagnosis is Mental Health/Chemical Dependency.

### **8.3.19 TeleHealth**

Services are covered in accordance with SelectHealth's medical policy. Except for Mental Health/Chemical Dependency, telehealth Services are only covered when rendered by an In-Network Provider. Interprofessional assessment or consultation between Providers as part of your treatment are payable under your office visit Benefit.

### **8.3.20 Temporomandibular Joint (TMJ)**

### **8.3.21 Tobacco Cessation**

Screening for tobacco use and up to two quit attempts per year, including:

- a. Four tobacco cessation counseling sessions; and

- b. All Food and Drug (FDA) approved tobacco cessation medications, both prescription and over-the-counter medications for a 90-day treatment regimen when prescribed by an In-Network Provider

### 8.3.22 Vein Procedures

Only when performed at an accredited vein clinic or facility.

### 8.3.23 Vision Aids

Only:

- a. Contacts if diagnosed with keratoconus, congenital cataracts, or when used as a bandage after eye trauma/injury; or
- b. Monofocal intraocular lenses after cataract surgery.

## 8.4 Prescription Drug Services

Refer to Section 9 Prescription Drug Benefits for details.

## SECTION 9 PRESCRIPTION DRUG BENEFITS

This section includes important information about how to use your Prescription Drug Benefits. Note: this section does not apply to you if your Member Payment Summary indicates that your Plan does not provide Prescription Drug Benefits.

### 9.1 Prescription Drug Benefit Resources

In addition to this Certificate, you can find additional information about your Pharmacy Benefits by doing any of the following:

- a. Log in to your SelectHealth account at [selecthealth.org](http://selecthealth.org) and use Pharmacy Tools;
- b. Visit [selecthealth.org/pharmacy](http://selecthealth.org/pharmacy);
- c. Refer to your Provider & Facility Directory; or
- d. Call Member Services at 800-538-5038.

## 9.2 Use In-Network Pharmacies

To get the most from your Prescription Drug Benefits, use an In-Network Pharmacy and present your ID card when filing a prescription. SelectHealth contracts with pharmacy chains on a national basis and with independent pharmacies in Utah.

If you use an Out-of-Network Pharmacy, you must pay full price for the drug and submit to SelectHealth a Prescription Reimbursement Form with your itemized pharmacy receipt. If the drug is covered, you will be reimbursed the Allowed Amount minus your Copay/Coinsurance and/or Deductible.

## 9.3 Tiered Benefits

There are tiers (or levels) of covered prescriptions listed on your ID card and Member Payment Summary. This tiered Benefit allows you to choose the drugs that best meet your medical needs while encouraging you and your Provider to discuss treatment options and choose lower-tier drugs when therapeutically appropriate.

Drugs on each tier are selected by an expert panel of Physicians and pharmacists and may change periodically. To determine which tier a drug is assigned to, call Member Services or log in to your SelectHealth account.

## 9.4 Filling Your Prescription

### 9.4.1 Copay/Coinsurance

You generally will be charged one Copay/Coinsurance per covered prescription up to a 30-day supply at a retail pharmacy. If your Provider prescribes a dose of a medication that is not available, you will be charged a Copay for each strength of the medication.

### 9.4.2 Quantity and Day Supply

Prescriptions are subject to SelectHealth quantity and day-supply Limitations that have been defined based upon FDA guidance or evidence-based literature. The most current information can be found by logging in to your SelectHealth account.

### 9.4.3 Refills

Except for schedule II controlled substances, refills are allowed after 75 percent of the last refill has been used for a 30-day supply, and 50 percent for a 10-day supply. Some exceptions may apply, and the timing of refill limits may be adjusted as market dynamics change. Call Pharmacy Services for more information.

## 9.5 Generic Drug Substitution Required

Your Member Payment Summary will indicate if generic substitution is required. When generic substitution is required, if you purchase a brand-name drug instead of a Generic Drug, then you must pay the difference between the Allowed Amount for the Generic Drug and the Allowed Amount for the brand-name drug, plus your Copay/Coinsurance or Deductible. The difference in cost between the Generic Drug and brand-name drug will not apply to your pharmacy Deductible or Out-of-Pocket Maximum. Based upon clinical circumstances determined by SelectHealth's Pharmacy and Therapeutics Committee, some Prescription Drugs are excluded from this requirement.

## 9.6 Maintenance Drugs

SelectHealth offers a maintenance drug Benefit, allowing you to obtain a 90-day supply of certain drugs. This Benefit is available for maintenance drugs if you:

- a. Have been using the drug for at least one month;
- b. Expect to continue using the drug for the next year; and
- c. Have filled the drug at least once within the past six months.

Maintenance drugs are identified by the letter (M) on the Prescription Drug List. You have two options when filling prescriptions under the maintenance drug Benefit: (1) Retail90SM, which is available at certain retail pharmacies; and (2) mail order. Please refer to your Member Payment Summary or contact Member Services to verify if the 90-day maintenance drug Benefit is available on your Plan.

## 9.7 Preauthorization of Prescription Drugs

There are certain drugs that require Preauthorization by your Provider to be covered by SelectHealth. Prescription drugs that require Preauthorization are identified on the Prescription Drug List. The letters (PA) appear next to each drug that requires Preauthorization. Preauthorization is also required if the drug is prescribed in excess of the Plan limits (quantity, duration of use, maximum dose, etc.). The most current information can be found at the SelectHealth website.

To obtain Preauthorization for these drugs, please have your Provider call SelectHealth Pharmacy Services at 800-442-3129.

If your Provider prescribes a drug that requires Preauthorization, you should verify that Preauthorization has been obtained before purchasing the medication. You may still buy these drugs if they are not Preauthorized, but they will not be covered and you will have to pay the full price.

## 9.8 Step Therapy

Certain drugs require your Provider to first prescribe an alternative drug preferred by SelectHealth. This process is called step therapy. The alternative drug is generally a more cost-effective therapy that does not compromise clinical quality. If your Provider feels that the alternative drug does not meet your needs, SelectHealth may cover the drug without step therapy if SelectHealth determines it is Medically Necessary.

Prescription drugs that require step therapy are identified on the Prescription Drug List. The letters (ST) appear next to each drug that requires step therapy.

## 9.9 Coordination of Benefits (COB)

If you have other health insurance that is your primary coverage, claims must be submitted first to your primary insurance carrier before being submitted to SelectHealth. In some circumstances, your secondary policy may pay a portion of your out-of-pocket expense. When you mail a secondary claim to SelectHealth, you must include a Prescription Reimbursement Form and the pharmacy receipt in order for SelectHealth to process your claim. In some circumstances, an Explanation of Benefits (EOB) from your primary carrier may also be required.

## 9.10 Inappropriate Prescription Practices

In the interest of safety for our Members, SelectHealth reserves the right to not cover certain prescription drugs.

- a. These drugs include:
  - i. Narcotic analgesics;
  - ii. Other addictive or potentially addictive drugs; and
  - iii. Drugs prescribed in quantities, dosages, or usages that are outside the usual standard of care for the medication in question.
- b. These drugs are not covered when they are prescribed:
  - i. Outside the usual standard of care for the practitioner prescribing the drug;
  - ii. In a manner inconsistent with accepted medical practice; or
  - iii. For indications that are Experimental and/or Investigational.

This exclusion is subject to review by the SelectHealth Drug Utilization Panel and certification by a practicing clinician who is familiar with the drug and its appropriate use.

## 9.11 Prescription Drug Benefit Abuse

SelectHealth may limit the availability and filling of any Prescription Drug that is susceptible to abuse. SelectHealth may require you to:

- a. Obtain prescriptions in limited dosages and supplies;
- b. Obtain prescriptions only from a specified Provider;
- c. Obtain written prescriptions for opioids and other controlled substances from In-Network Providers;
- d. Fill your prescriptions at a specified pharmacy;
- e. Participate in specified treatment for any underlying medical problem (such as a pain management program);
- f. Complete a drug treatment program; or
- g. Adhere to any other specified limitation or program designed to reduce or eliminate drug abuse or dependence.

If you seek to obtain drugs in amounts in excess of what is Medically Necessary, such as making repeated emergency room/urgent care visits to obtain drugs, SelectHealth may deny coverage of any medication susceptible of abuse.

SelectHealth may terminate you from coverage if you make an intentional misrepresentation of material fact in connection with obtaining or attempting to obtain drugs, such as by intentionally misrepresenting your condition, other medications, healthcare encounters, or other medically relevant information. At the discretion of SelectHealth, you may be permitted to retain your coverage if you comply with specified conditions.



## 9.12 Pharmacy Injectable Drugs and Specialty Medications

Injectable drugs and specialty medications must be provided by an In-Network Provider unless otherwise approved in writing in advance by SelectHealth. Most drugs received in a Provider's office or Facility are covered by your medical Benefits. For more specific information, please contact Member Services. Infusion therapy is only covered at preapproved infusion locations.

## 9.13 Prescription Drug List (PDL)

The PDL is a list containing the most commonly prescribed drugs in their most common strengths and formulations. It is not a complete list of all drugs covered by your Formulary. Drugs not included on the PDL may be covered at reduced benefits, or not covered at all, by your Plan. For a printed copy of your PDL, contact Pharmacy Member Services at 1-800-538-5038. To view an electronic copy of the PDL or to search a complete list of drugs covered by your Formulary, visit [selecthealth.org/pharmacy/pharmacy-benefits](http://selecthealth.org/pharmacy/pharmacy-benefits).

## 9.14 Exceptions Process

If your Provider believes that you require a certain drug that is not on your Formulary, normally requires step therapy, or exceeds a Quantity Limit, he or she may request an exception through the Preauthorization process.

## 9.15 Prescriptions Dispensed in a Provider's Office

Prescriptions dispensed in a Provider's office are not covered unless expressly approved by SelectHealth.

## 9.16 Disclaimer

SelectHealth refers to many of the drugs in this Certificate by their respective trademarks. SelectHealth does not own these trademarks. The manufacturer or supplier of each drug owns the drug's trademark. By listing these drugs, SelectHealth does not endorse or sponsor any drug, manufacturer, or supplier. Conversely, these manufacturers and suppliers do not endorse or sponsor any SelectHealth service or Plan, nor are they affiliated with SelectHealth.

## SECTION 10 LIMITATIONS AND EXCLUSIONS

Unless otherwise noted in your Member Payment Summary or Appendix A Optional Benefits, the following Limitations and Exclusions apply.

### 10.1 Abortions/Termination of Pregnancy

Abortions are not covered except:

- a. When determined by SelectHealth to be Medically Necessary to save the life of the mother; or
- b. Where the pregnancy was caused by a rape or incest if evidence of the rape or incest is presented either from medical records or through the review of a police report or the filing of charges that a crime has been committed.

Medical complications resulting from an abortion are covered. Treatment of a miscarriage/spontaneous abortion (occurring from natural causes) is covered.

### 10.2 Acupuncture/Acupressure

Acupuncture and acupressure Services are not covered.

### 10.3 Administrative Services/Charges

Services obtained for administrative purposes are not covered. Such administrative purposes include Services obtained for or pursuant to legal proceedings, employment, continuing or obtaining insurance coverage, governmental licensure, home health recertification, travel, military service, school, or institutional requirements.

Provider and Facility charges for completing insurance forms, duplication services, interest (except where required by Utah Administrative Code R590-192), finance charges, late fees, shipping and handling, missed appointments, and other administrative charges are not covered.

### 10.4 Allergy Tests/Treatments

- a. The following allergy tests are not covered:
  - i. Cytotoxic Test (Bryan's Test);
  - ii. Leukocyte Histamine Release Test;
  - iii. Mediator Release Test (MRT);
  - iv. Passive Cutaneous Transfer Test (P-K Test);
  - v. Provocative Conjunctival Test;
  - vi. Provocative Nasal Test;
  - vii. Rebeck Skin Window Test;
  - viii. Rinkel Test;
  - ix. Subcutaneous Provocative Food and Chemical Test; and
  - x. Sublingual Provocative Food and Chemical Test.
- b. The following allergy treatments are not covered:
  - i. Allergoids;
  - ii. Autogenous urine immunization;
  - iii. LEAP therapy;
  - iv. Medical devices (filtering air cleaner, electrostatic air cleaner, air conditioners etc.);
  - v. Neutralization therapy;

- vi. Photo-inactivated extracts; and
- vii. Polymerized extracts.

### 10.5 Biofeedback/Neurofeedback

Biofeedback/neurofeedback is not covered.

### 10.6 Birthing Centers and Home Childbirth

Childbirth in any place other than a Hospital or a birthing center connected to a Hospital either through a bridge, ramp, or adjacent to the labor and delivery unit is not covered. This includes all Provider and/or Facility charges related to the delivery.

### 10.7 Certain Cancer Therapies

Neutron beam therapy is not covered.

Proton beam therapy is not covered except in the following limited circumstances:

- a. Chordomas or chondrosarcomas arising at the base of the skull or along the axial skeleton without distant metastases;
- b. Other central nervous system tumors located near vital structures;
- c. Pituitary neoplasms;
- d. Uveal melanomas confined to the globe (not distant metastases); or
- e. In accordance with SelectHealth medical policy.

Proton beam therapy is not covered for treatment of prostate cancer.

### 10.8 Claims After One Year

Claims are denied if submitted more than one year after the Services were provided unless notice was given, or proof of loss was filed, as soon as reasonably possible. Adjustments or corrections to claims can be made only if the supporting information is submitted within one year after the claim was first processed by SelectHealth unless the additional information relating to the claim was filed as soon as reasonably possible.

When SelectHealth is the secondary payer, coordination of benefits (COB) will be performed only if the supporting information is submitted to SelectHealth within one year after the claim was processed by the primary plan unless the information was provided as soon as reasonably possible.

## **10.9 Complementary and Alternative Medicine (CAM)**

Complementary, alternative and nontraditional Services are not covered. Such Services include botanicals, homeopathy, homeopathic drugs, certain bioidentical hormones, massage therapies, aromatherapies, yoga, hypnosis, rolfing, and thermography.

### **10.10 Custodial Care**

Custodial Care is not covered.

### **10.11 Debarred Providers**

Services from Providers debarred by any state or federal health care program are not covered.

### **10.12 Dry Needling**

Dry needling procedures are not covered.

### **10.13 Duplication of Coverage**

The following are not covered:

- a. Services that are covered by, or would have been covered, if you or your Dependents had enrolled and maintained coverage in automobile insurance, including no-fault type coverage up to the minimum amount required by law. In the event of a claim, you should provide a copy of the Personal Injury Protection (PIP) documentation from the automobile insurance carrier.
- b. Services that are covered by, or would have been covered, if your employer had enrolled and maintained coverage in, Workers' Compensation insurance.

- c. Services for which you have obtained a payment, settlement, judgment, or other recovery for future payment intended as compensation.
- d. Services received by you or one of your Dependents while incarcerated in a prison, jail, or other correctional facility at the time Services are provided, including care provided outside of a correctional facility to a person who has been arrested or is under a court order of incarceration.

### **10.14 Exercise Equipment or Fitness Training**

Fitness training, conditioning, exercise equipment, hot tubs, and membership fees to a spa or health club are not covered.

### **10.15 Experimental and/or Investigational Services**

Except for Approved Clinical Trials, Experimental and/or Investigational Services are not covered.

### **10.16 Eye Surgery, Refractive**

Radial keratotomy, LASIK, or other eye surgeries performed primarily to correct refractive errors are not covered.

### **10.17 Food Supplements**

Except for Dietary Products, as described in Section 8 Covered Services, food supplements and substitutes are not covered.

### **10.18 Hearing Aids**

Except for cochlear implants and osseointegrated auditory devices, as described in Section 8 Covered Services, the purchase, fitting, or ongoing evaluation of hearing aids, appliances, or any other procedure or device intended to establish or improve hearing or sound recognition is not covered.

## 10.19 Home Health Aides

Services provided by a home health aide are not covered.

## 10.20 Immunizations

The following immunizations are not covered: anthrax, BCG (tuberculosis), cholera, plague, typhoid, and yellow fever.

## 10.21 Mental Health

Inpatient and outpatient mental health and chemical dependency services are not covered. This Exclusion does not apply if your Member Payment Summary indicates that your Plan includes the Mental Health/Chemical Dependency Optional Benefit.

## 10.22 Non-Covered Service in Conjunction with a Covered Service

When a non-Covered Service is performed as part of the same operation or process as a Covered Service, only charges relating to the Covered Service will be considered. Allowed Amounts may be calculated and fairly apportioned to exclude any charges related to the non-Covered Service.

## 10.23 Pain Management Services

The following Services are not covered:

- a. Prolotherapy;
- b. Radiofrequency ablation of dorsal root ganglion; and
- c. IV pamidronate therapy for the treatment of reflex sympathetic dystrophy.

## 10.24 Prescription Drugs/Injectable Drugs and Specialty Medications

The following are not covered:

- a. Appetite suppressants and weight loss drugs;

- b. Certain drugs with a therapeutic over-the-counter (OTC) equivalent;
- c. Certain off-label drug usage, unless the use has been approved by a SelectHealth Medical Director or clinical pharmacist;
- d. Compound drugs when alternative products are available commercially;
- e. Cosmetic health and beauty aids;
- f. Drugs not on your Formulary;
- g. Drugs purchased from Out-of-Network Providers over the Internet;
- h. Drugs purchased through a foreign pharmacy. However, please call Member Services if you have a special need for medications from a foreign pharmacy (for example, for an emergency while traveling out of the country);
- i. Flu symptom drugs, except when approved by an expert panel of Physicians and SelectHealth;
- j. Human growth hormone for the treatment of idiopathic short stature;
- k. Infertility drugs;
- l. Medical foods;
- m. Drugs not meeting the minimum levels of evidence based upon one or more of the following:
  - i. Food and Drug Administration (FDA) approval;
  - ii. The drug has no active ingredient and/or clinically relevant studies as determined by the SelectHealth Pharmacy & Therapeutics Committee;
  - iii. Nationally recognized compendium sources currently utilized by SelectHealth;
  - iv. National Comprehensive Cancer Network (NCCN); or
  - v. As defined within SelectHealth's Preauthorization criteria or medical policy.
- n. Drugs used for infertility purposes;

- o. Minerals, fluoride, and vitamins other than prenatal or when determined to be Medically Necessary to treat a specifically diagnosed disease;
- p. Non-Sedating Antihistamines;
- q. Over-the-counter (OTC) drugs, except as required by the Patient Protection and Affordable Care Act (ACA), or when all of the following conditions are met:
  - i. The OTC drug is listed on a SelectHealth Formulary as a covered drug;
  - ii. The SelectHealth Pharmacy & Therapeutics Committee has approved the OTC medication as a medically appropriate substitution of a Prescription Drug; and
  - iii. You or your Dependent has obtained a prescription for the OTC drug from a licensed Provider and filled the prescription at an In-Network Pharmacy.
- r. Pharmaceuticals approved by the Food and Drug Administration as a medical device;
- s. Prescription Drugs used for cosmetic purposes;
- t. Prescription drugs used to inhibit and/or suppress drowsiness, sleepiness, tiredness, or exhaustion, unless preauthorized by the Plan;
- u. Prescriptions written by a licensed dentist, except for the prevention of infection or pain in conjunction with a dental procedure;
- v. Raw powders or chemical ingredients are not covered unless specifically approved by SelectHealth or submitted as part of a compounded prescription;
- w. Replacement of lost, stolen, or damaged drugs;
- x. Sexual dysfunction drugs. This Exclusion does not apply if your Member Payment Summary indicates that your Plan includes the Sexual Dysfunction Optional Benefit; and
- y. Travel-related medications, including preventive medication for the purpose of travel to other countries. See Immunizations in Section 10 Limitations and Exclusions.

### **10.25 Reconstructive, Corrective, and Cosmetic Services**

- a. Except as described in Section 8 - Covered Services, Services provided for the following reasons are not covered:
  - i. To improve form or appearance;
  - ii. To correct a deformity, whether congenital or acquired, without restoring physical function;
  - iii. To cope with psychological factors such as poor self-image or difficult social relations;
  - iv. As the result of an accident unless the Service is reconstructive and rendered within five years of the cause or onset of the injury, illness, or therapeutic intervention, or a planned, staged series of Services (as specifically documented in the Member's medical record) is initiated within the five-year period; or
  - v. To revise a scar, whether acquired through injury or surgery, except when the primary purpose is to improve or correct a functional impairment.
- b. Treatment for venous telangiectasia (spider veins).

### **10.26 Related Provider Services**

Services provided, ordered, and/or directed for you or your Dependent by an immediate family member are not covered.

### **10.27 Respite Care**

Respite Care is not covered.

## 10.28 Robot-Assisted Surgery

Direct costs for the use of a robot for robot-assisted surgery are not covered.

## 10.29 Sexual Dysfunction

Services related to sexual dysfunction are not covered. This Exclusion does not apply if your Member Payment Summary indicates that your Plan includes the Sexual Dysfunction Optional Benefit.

## 10.30 Specialty Services

Coverage for specific specialty Services may be restricted to only those Providers who are board certified or have other formal training that is considered necessary to perform those Services.

## 10.31 Specific Services

The following Services are not covered:

- a. Anodyne infrared device for any indication;
- b. Auditory brain implantation;
- c. Automated home blood pressure monitoring equipment;
- d. Chronic intermittent insulin IV therapy/metabolic activation therapy;
- e. Coblation therapy of the soft tissues of the mouth, nose, throat, or tongue;
- f. Computer-assisted interpretation of X-rays (except mammograms);
- g. Computer-assisted navigation for orthopedic procedures;
- h. Cryoablation therapy for plantar fasciitis and Morton's neuroma;
- i. Extracorporeal shock wave therapy for musculoskeletal indications;
- j. Freestanding/home cervical traction;
- k. Incontinence supplies;
- l. Infrared light coagulation for the treatment of hemorrhoids;
- m. Interferential/neuromuscular stimulators;

- n. Intimal Media Thickness (IMT) testing to assess risk of coronary disease;
- o. Magnetic Source Imaging (MSI);
- p. Manipulation under anesthesia for treatment of back and pelvic pain;
- q. Mole mapping;
- r. Nonsurgical spinal decompression therapy (e.g., VAX-D or DRS therapy);
- s. Nucleoplasty or other forms of percutaneous disc decompression;
- t. Oncofertility;
- u. Pediatric/infant scales;
- v. Peripheral nerve stimulation for occipital neuralgia and chronic headaches;
- w. Platelet Rich Plasma or other blood derived therapies for orthopedic procedures;
- x. Pressure Specified Sensory Device (PSSD) for neuropathy testing;
- y. Prolotherapy;
- z. Radiofrequency ablation for lateral epicondylitis;
- aa. Radiofrequency ablation of the dorsal root ganglion;
- bb. Virtual colonoscopy as a screening for colon cancer; and
- cc. Whole body scanning.

## 10.32 Terrorism or Nuclear Release

Services for an illness, injury, or connected disability are not covered when caused by or arising out of an act of international or domestic terrorism, as defined by United States Code, Title 18, Section 2331, or from an accidental, negligent, or intentional release of nuclear material or nuclear byproduct material as defined by United States Code, Title 18, Section 831.

## 10.33 Travel-related Expenses

Costs associated with travel to a local or distant medical provider, including accommodation and meal costs, are not covered.

## 10.34 War

Services for an illness, injury, or connected disability are not covered when caused by or arising out of a war or an act of war (whether or not declared) or service in the armed services of any country.

## SECTION 11 HEALTHCARE MANAGEMENT

SelectHealth works to manage costs while protecting the quality of care. The Healthcare Management Program reviews three aspects of medical care: appropriateness of the care setting, Medical Necessity, and appropriateness of Hospital lengths of stay. You benefit from this process because it reduces unnecessary medical expenses, enabling SelectHealth to maintain reasonable Premium rates. The Healthcare Management process takes several forms.

### 11.1 Preauthorization

Preauthorization is prior approval from SelectHealth for certain Services and is considered a Preservice Claim (refer to Section 12 Claims and Appeals). Preauthorization is not required when SelectHealth is your secondary plan. Obtaining Preauthorization does not guarantee coverage. Your Benefits for the Preauthorized Services are subject to the Eligibility requirements, Limitations, Exclusions and all other provisions of the Plan. Preauthorization requirements for Prescription Drugs are also found in Section 9 – Prescription Drug Benefits.

#### 11.1.1 Services Requiring Preauthorization

Preauthorization is required for the following Services:

- a. Adenoidectomy;
- b. All admissions to facilities, including rehabilitation, transitional care, skilled nursing, and all hospitalizations that are not for Urgent or Emergency Conditions;
- c. All nonroutine obstetrics admissions, maternity stays longer than two days for a normal delivery or longer than four days for a cesarean section, and deliveries outside of the Service Area;
- d. All Services obtained outside of the United States unless for Routine Care, an Urgent, or an Emergency Condition;
- e. Bariatric surgery;
- f. Certain advanced imaging including Magnetic Resonance Imaging (MRI), Computerized Tomography (CT) scans, Positron Emission Tomography (PET) scans, and cardiac imaging;
- g. Certain genetic testing;
- h. Certain Home Healthcare;
- i. Certain medical oncology drugs;
- j. Certain ultrasounds;
- k. Certain radiation therapies;
- l. Certain sleep studies;
- m. Certain vein procedures;
- n. Cochlear Implants and Osseointegrated Auditory Devices;
- o. Continuous glucose monitors;
- p. Dental anesthesia;
- q. Hospice Care and Private Duty Nursing;
- r. Hospital level care at home;
- s. Hysterectomy;
- t. Insulin pumps;
- u. Joint replacement;
- v. Outpatient Rehabilitative and Habilitative Services after 20 visits per therapy type, per Year;
- w. Organ Transplants;
- x. Pain management/pain clinic Services;
- y. Surgeries on vertebral bodies, vertebral joints, spinal discs;
- z. The following Durable Medical Equipment:
  - i. Continuous Positive Airway Pressure (CPAP) and Bilevel Positive Airway Pressure (BiPAP);
  - ii. Prosthetics (except eye prosthetics);
  - iii. Negative pressure wound therapy electrical pump (wound vac);

- iv. Motorized or customized wheelchairs; and
- v. DME with a purchase price over \$5,000;
- aa. The medications listed on [selecthealth.org/pharmacy/pharmacy-benefits](http://selecthealth.org/pharmacy/pharmacy-benefits). You may also request this list by calling Pharmacy Services at 800-538-5038.
- bb. Tonsillectomy;

In addition to these Services, In-Network Providers must Preauthorize other Services as specified in SelectHealth medical policy.

### **11.1.2 Who is responsible for obtaining Preauthorization**

In-Network Providers and Facilities are responsible for obtaining Preauthorization on your behalf; however, you should verify that they have obtained Preauthorization prior to receiving Services.

You are responsible for obtaining Preauthorization when using a Out-of-Network Provider or Facility.

### **11.1.3 How to request Preauthorization**

If you need to request Preauthorization, call Member Services at 800-538-5038. Generally, preauthorization is valid for up to six months.

You should call SelectHealth as soon as you know you will be using an Out-of-Network Provider or Facility for any of the Services listed.

### **11.1.4 Penalties**

If you fail to obtain Preauthorization when required, Benefits may be reduced or denied if you do not Preauthorize certain Services. If reduced, the Allowed Amount will be cut by 50 percent and Benefits will apply to what remains according to regular Plan guidelines. You will be responsible for the 50 percent penalty, your Copay, Coinsurance, and Deductible, and you may be responsible for any amount that exceeds the Allowed Amount.

### **11.1.5 Statement of Rights Under the Newborns' and Mothers' Health Protection Act**

Group health plans and health insurance issuers generally may not, under federal law, 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 cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## **11.2 Case Management**

If you have certain serious or chronic conditions (such as spinal cord injuries, diabetes, asthma, or premature births), SelectHealth will work with you and your family, your Provider, and community resources to coordinate a comprehensive plan of care. This integrated approach helps you obtain appropriate care in cost-effective settings and reduces some of the burden that you and your family might otherwise face.

## **11.3 Benefit Exceptions**

On a case-by-case basis, SelectHealth may extend or add Benefits that are not otherwise expressly covered or are limited by the Plan. In making this decision, SelectHealth will consider the medical appropriateness and cost effectiveness of the proposed exception.

When making such exceptions, SelectHealth reserves the right to specify the Providers, Facilities, and circumstances in which the additional care will be provided and to limit payment for additional Services to the amount SelectHealth would have paid had the Service been provided in accordance with the other provisions of the Plan. Benefits paid under this section are subject to all other Member payment obligations of the Plan such as Copays, Coinsurance, and Deductibles.



## **11.4 Second Opinions/Physical Examinations**

After enrollment, SelectHealth has the right to request that you be examined by a mutually agreed upon Provider concerning a claim, a second opinion request, or a request for Preauthorization. SelectHealth will be responsible for paying for any such physical examination.

## **11.5 Medical Policies**

SelectHealth has developed medical policies to serve as guidelines for coverage decisions. These guidelines detail when certain Services are considered Medically Necessary or Experimental and/or Investigational by SelectHealth. Medical policies do not supersede the express provisions of this Certificate. Coverage decisions are subject to all terms and conditions of the applicable Plan, including specific Exclusions and Limitations. Because medical policies are based on constantly changing science, they are periodically reviewed and updated by SelectHealth. For questions about SelectHealth's medical policies, call Member Services at 800-538-5038.

## **SECTION 12 CLAIMS AND APPEALS**

### **12.1 Administrative Consistency**

SelectHealth will follow administrative processes and safeguards designed to ensure and to verify that Benefit claim determinations are made in accordance with the provisions of the Plan and that its provisions have been applied consistently with respect to similarly situated Claimants.

### **12.2 Claims and Appeals Definitions**

This section uses the following additional (capitalized) defined terms:

#### **12.2.1 Adverse Benefit Determination**

Any of the following: a Rescission of coverage or a denial, reduction, or termination of a claim for Benefits, or a failure to provide or make payment for such a claim in whole or in part, including determinations related to a Claimant's Eligibility, the application of a review under SelectHealth Healthcare Management Program, and determinations that particular Services are Experimental and/or Investigational or not Medically Necessary or appropriate.

#### **12.2.2 Appeal(s)**

Review by SelectHealth of an Adverse Benefit Determination.

#### **12.2.3 Authorized Representative**

Someone you have designated to represent you in the claims or Appeals process. To designate an Authorized Representative, you must provide written authorization on a form provided by the Appeals Department or Member Services. However, where an Urgent Preservice Claim is involved, a healthcare professional with knowledge of the medical condition will be permitted to act as your Authorized Representative without a prior written authorization. In this section, the words you and your include your Authorized Representative.

#### **12.2.4 Benefit Determination**

The decision by SelectHealth regarding the acceptance or denial of a claim for Benefits.

#### **12.2.5 Claimant**

Any Subscriber or Member making a claim for Benefits. Claimants may file claims themselves or may act through an Authorized Representative. In this section, the words you and your are used interchangeably with Claimant.

#### **12.2.6 Concurrent Care Decisions**

Decisions by SelectHealth regarding coverage of an ongoing course of treatment that has been approved in advance.

### **12.2.7 External Review**

A review by an outside entity, at no cost to the Member, of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination).

### **12.2.8 Final Internal Adverse Benefit Determination**

An Adverse Benefit Determination that has been upheld by SelectHealth at the completion of the mandatory Appeals process.

### **12.2.9 Independent Review Organization (IRO)**

An entity that conducts independent External Reviews.

### **12.2.10 Postservice Appeal**

A request to change an Adverse Benefit Determination for Services you have already received.

### **12.2.11 Postservice Claim**

Any claim related to Services you have already received.

### **12.2.12 Preservice Appeal**

A request to change an Adverse Benefit Determination on a Preservice Claim.

### **12.2.13 Preservice Claim**

Any claim that requires approval prior to obtaining Services for you to receive full Benefits. For example, a request for Preauthorization under the Healthcare Management program is a Preservice Claim.

### **12.2.14 Urgent Preservice Claim**

Any Preservice Claim that, if subject to the normal timeframes for determination, could seriously jeopardize your life, health or ability to regain maximum function or that, in the opinion of your treating Physician, would subject you to severe pain that could not be adequately managed without the requested Services. Whether a claim is an Urgent Preservice Claim will be determined by an individual acting on behalf of SelectHealth applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that your treating Physician determines is an Urgent Preservice Claim will be treated as such.

## **12.3 How to File a Claim for Benefits**

### **12.3.1 Urgent Preservice Claims**

In order to file an Urgent Preservice Claim, you must provide SelectHealth with:

- a. Information sufficient to determine to what extent Benefits are covered by the Plan; and
- b. A description of the medical circumstances that give rise to the need for expedited review.

Under certain circumstances provided by federal law, if you fail to follow the proper procedures for filing an Urgent Preservice Claim, SelectHealth will notify you of the failure and the proper procedures to be followed. SelectHealth will notify you as soon as reasonably possible, but no later than 24 hours after receiving the claim. This notice may be verbal unless you specifically request otherwise in writing.

Notice of a Benefit Determination will be provided as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receipt of the claim. However, if SelectHealth gives you notice of an incomplete claim, the notice will give you at least 48 hours to provide the requested information. SelectHealth will then provide a notice of Benefit Determination within 48 hours after receiving the specified information or the end of the period of time given you to provide the information, whichever occurs first. If the Benefit Determination is provided verbally, it will be followed in writing no later than three days after the verbal notice.

If the Urgent Preservice Claim involves a Concurrent Care Decision, notice of the Benefit Determination will be provided as soon as possible but no later than 24 hours after receipt of your claim for extension of treatment or care, as long as the claim is made at least 24 hours before the prescribed period of time expires or the prescribed number of treatments ends.

### **12.3.2 Other Preservice Claims**

The procedure for filing most Preservice Claims (Preauthorization) is set forth in Section 11 Healthcare Management. If there is any other Benefit that would be subject to a Preservice Claim, you may file a claim for that Benefit by contacting Member Services. Under certain circumstances provided by federal law, if you fail to follow the proper procedures for filing a Preservice Claim, SelectHealth will provide notice of the failure and the proper procedures to be followed. This notification will be provided as soon as reasonably possible, but no later than five days after receipt of the claim, and may be verbal unless you specifically request it in writing.

Notice of a Benefit Determination will be provided in writing within a reasonable period appropriate to the medical circumstances, but no later than 15 days after receipt of the claim. However, SelectHealth may extend this period for up to an additional 15 days if SelectHealth: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 15-day period, of the circumstances requiring the extension and the date by which SelectHealth expects to render a decision. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information, and you will be given 60 days from your receipt of the notice to provide the requested information.

Notice of an Adverse Benefit Determination regarding a Concurrent Care Decision will be provided sufficiently in advance of any termination or reduction of Benefits to allow you to Appeal and obtain a determination before the Benefit is reduced or terminates.

### **12.3.3 Postservice Claims**

- a. In-Network Providers and Facilities. In-Network Providers and Facilities file Postservice Claims with SelectHealth and SelectHealth makes payment to the Providers and Facilities.
- b. Out-of-Network Providers and Facilities. Out-of-Network Providers and Facilities are not required to file claims with SelectHealth. If an Out-of-Network Provider or Facility does not submit a Postservice Claim to SelectHealth or you pay the Out-of-Network Provider or Facility, you must submit the claim in writing in a form approved by SelectHealth. Call Member Services or your employer to find out what information is needed to submit a Postservice Claim. All claims must be received by SelectHealth within a 12-month period from the date of the expense or as soon as reasonably possible. Claims received outside of this timeframe will be denied. Failure to file a claim does not bar recovery under the policy if SelectHealth fails to show it was prejudiced by the failure.

Notice of Adverse Benefit Determinations will be provided in writing within a reasonable period of time, but no later than 30 days after receipt of the claim. However, SelectHealth may extend this period for up to an additional 15 days if SelectHealth: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which SelectHealth expects to render a decision.

The applicable time period for the Benefit Determination begins when your claim is filed in accordance with SelectHealth's procedures, even if you have not submitted all the information necessary to make a Benefit Determination.

## 12.4 Problem Solving

SelectHealth is committed to making sure that any concerns or problems regarding your claims are investigated and resolved as soon as possible. Many situations can be resolved informally by a Member Services representative. Call Member Services at 800-538-5038 or send a secure email via your SelectHealth account. SelectHealth offers foreign language assistance.

## 12.5 Formal Appeals

If you are not satisfied with the result of working with Member Services, you may file a written formal Appeal of any Adverse Benefit Determination. Written formal Appeals should be sent to the SelectHealth Appeals Department. As the delegated claims review fiduciary under your Employer's Plan, SelectHealth will conduct a full and fair review of your Appeal and has final discretionary authority and responsibility for deciding all matters regarding Eligibility and coverage.

### 12.5.1 General Rules and Procedures

You will have the opportunity to submit written comments, documents, records, and other information relating to your Appeal. SelectHealth will consider this information regardless of whether it was considered in the Adverse Benefit Determination.

During an Appeal, no deference will be afforded to the Adverse Benefit Determination, and decisions will be made by fiduciaries who did not make the Adverse Benefit Determination and who do not report to anyone who did. If the Adverse Benefit Determination was based on medical judgment, including determinations that Services are Experimental and/or Investigational or not Medically Necessary, the fiduciaries during any Appeal will consult with a medical professional with appropriate training and experience in the appropriate field of medicine and who was neither consulted in connection with the Adverse Benefit Determination nor is the subordinate of such an individual. Upon request, you will be provided the identification of any medical expert(s) whose advice was obtained on behalf of SelectHealth in connection with the Adverse Benefit Determination, whether or not the advice was relied upon in making the Adverse Benefit Determination.

Before SelectHealth can issue a Final Internal Adverse Benefit Determination, you will be provided with any new or additional evidence or rationale considered, relied upon, or generated by SelectHealth in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of a Final Internal Benefit Determination is required to be provided to give you a reasonable opportunity to respond prior to the date.

### 12.5.2 Form and Timing

All requests for an Appeal of an Adverse Benefit Determination (other than those involving an Urgent Preservice Claim) must be in writing and should include a copy of the Adverse Benefit Determination and any other pertinent information that you want SelectHealth to review in conjunction with your Appeal. Send all information to the SelectHealth Appeals Department at the following address:

**Appeals Department**  
**P.O. Box 30192**  
**Salt Lake City, Utah 84130-0192**

You may Appeal an Adverse Benefit Determination of an Urgent Preservice Claim on an expedited basis either verbally or in writing. You may Appeal verbally by calling the SelectHealth Appeals Department at 844-208-9012, by fax at 801-442-0762, or by emailing [appeals@imail.org](mailto:appeals@imail.org).

You must file a formal Appeal within 180 days from the date you received notification of the Adverse Benefit Determination.

Appeals that do not comply with the above requirements are not subject to review by SelectHealth or legal challenge.

### **12.5.3 Appeals Process**

The Appeals process includes both mandatory and voluntary reviews. You must exhaust all mandatory reviews before you may pursue civil action, including, if applicable, under ERISA Section 502(a). It is your choice, however, whether or not to seek voluntary review, and you are not required to do so before pursuing civil action. SelectHealth agrees that any statute of limitations or other legal defense based on timeliness is suspended during the time that any voluntary Appeal is pending. Your decision whether or not to seek voluntary review will have no effect on your rights to any other Benefits. SelectHealth will provide you, upon request, sufficient information to enable you to make an informed decision about whether or not to engage in a voluntary review.

After a mandatory review process, you may choose to pursue civil action, including, if applicable, under ERISA Section 502(a). Failure to properly pursue the mandatory Appeals process may result in a waiver of the right to challenge the original decision of SelectHealth.

### **12.5.4 Preservice Appeals**

The process for appealing a Preservice Claim provides one mandatory review, possible voluntary reviews, and the right to pursue civil action, including, if applicable, under ERISA Section 502(a).

### **Mandatory Review**

Your Appeal will be investigated by the Appeals Department. All relevant, available information will be reviewed. The Appeals Department will notify you in writing of the Appeal decision within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after the receipt of your Appeal. However, SelectHealth may extend this period if SelectHealth: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which SelectHealth expects to render a decision.

If your Appeal involves an Urgent Preservice Claim, you may request an expedited review. You will be notified of the Appeal decision on an expedited review as soon as possible, taking into account the medical circumstances, but no later than 72 hours after the receipt of your Appeal. A decision communicated verbally will be followed up in writing.

### **Voluntary Review**

After completing the mandatory review process described above, you may pursue a voluntary External Review or a voluntary internal review. However, External Review is only available in the circumstances described below. If you choose to pursue a voluntary External Review, you may not pursue the voluntary internal review process.

## **Voluntary External Review**

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, or a Rescission of coverage. To request an External Review, you must complete the Independent Review Request Form. For a copy of this form, or for other questions, contact the Utah Insurance Commissioner by mail at 4315 S 2700 W Ste 2300 Taylorsville, UT 84129; by phone at 801-957-9200; or electronically at [healthappeals.uid@utah.gov](mailto:healthappeals.uid@utah.gov). An External Review request must be made within 180 days from the date the Appeals Department notifies you of the Final Internal Adverse Benefit Determination. An authorization to obtain medical records may be required. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. The IRO will provide written notice of its decision within 45 days after receipt of the request. There is no additional cost for requesting an External Review.

If your Appeal involves an Urgent Preservice Claim, you may request an expedited review. You will be notified by the IRO of the Appeal decision on an expedited review as soon as possible, taking into account the medical circumstances, but no later than 72 hours after the receipt of your Appeal. A decision communicated verbally will be followed up in writing.

If you pursue a voluntary External Review, it will be your last level of Appeal.

## **Voluntary Internal Review**

If you choose to pursue the voluntary internal review process, you may request a review of your Appeal. Depending on the nature of the Appeal, it will be considered by the Administrative and Clinical Appeal Review Committee. Such a request must be made in writing to the Appeals Department within 60 days of the date the Appeals Department notifies you of the Final Internal Adverse Benefit Determination. SelectHealth will notify you of the result of the review in writing within 30 days of the date you requested the review. However, SelectHealth may extend this period if SelectHealth: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which SelectHealth expects to render a decision.

### **12.5.5 Postservice Appeals**

The process for appealing a Postservice Claim provides one mandatory review, possible voluntary reviews, and the right to pursue civil action, including, if applicable, under ERISA Section 502(a).

#### **Mandatory Review**

Your Appeal will be investigated by the Appeals Department. All relevant information will be reviewed. The Appeals Department will notify you in writing of the Appeal decision within a reasonable period of time appropriate to the medical circumstances, but no later than 60 days after the receipt of your Appeal. However, SelectHealth may extend this period if SelectHealth: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 60-day period, of the circumstances requiring the extension and the date by which SelectHealth expects to render a decision.

## **Voluntary Review**

After completing the mandatory review process described above, you may pursue either a voluntary External Review or a voluntary internal review. However, External Review is only available in the circumstances described below. If you choose to pursue the voluntary External Review process, you may not pursue the voluntary internal review process.

## **Voluntary External Review**

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, a Rescission of coverage, or any Adverse Benefit Determination relating to a surprise medical bill or surprise air ambulance bill subject to the No Surprises Act. To request an External Review you must complete the Independent Review Request Form. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. For a copy of this form, or for other questions, contact the Utah Insurance Commissioner by mail at 4315 S 2700 W Ste 2300 Taylorsville, UT 84129; by phone at 801-957-9200; or electronically at [healthappeals.uid@utah.gov](mailto:healthappeals.uid@utah.gov). An External Review request must be made within 180 days from the date SelectHealth sends the Final Internal Adverse Benefit Determination. An authorization to obtain medical records may be required. The IRO will provide written notice of its decision within 45 days after receipt of the request. There is no additional cost for requesting an External Review.

If you pursue a voluntary External Review, it will be your last level of Appeal.

## **Voluntary Internal Review**

If you choose to pursue the voluntary internal review process, you may request a review of your Appeal. Depending on the nature of the Appeal, it will be considered by the Administrative and Clinical Appeal Review Committee. Such a request must be made in writing to the Appeals Department within 60 days of the date the Appeals Department notifies you of the Final Internal Adverse Benefit Determination. SelectHealth will notify you of the result of the review in writing within 30 days of the date you requested the review. However, SelectHealth may extend this period if SelectHealth: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which SelectHealth expects to render a decision.

## **SECTION 13 OTHER PROVISIONS AFFECTING YOUR BENEFITS**

### **13.1 Coordination of Benefits (COB)**

When you or your Dependents have healthcare coverage under more than one health benefit plan, SelectHealth will coordinate Benefits with the other healthcare coverage according to the COB rules set forth in Utah Administrative Code R590-131.

#### **13.1.1 Required Cooperation**

You are required to cooperate with SelectHealth in administering COB. Cooperation may include providing notice of other health benefit coverage, copies of divorce decrees, bills and payment notices from other payers, and/or signing documents required by SelectHealth to administer COB. Failure to cooperate may result in the denial of claims.

#### **13.1.2 Direct Payments**

SelectHealth may make a direct payment to another health benefit plan when the other plan has made a payment that was the responsibility of SelectHealth. This amount will be treated as though it was a Benefit paid by the Plan, and SelectHealth will not have to pay that amount again.

## **13.2 Subrogation, Reimbursement and Recovery**

### **13.2.1 Payment of Claims When Another Person or Entity is Liable**

When you or your Dependents have an illness or injury caused by another, a person or entity, regardless of whether the person or entity is also an insured under the Plan or any other insurance policy (hereinafter a Recovery Party), the Recovery Party or an insurer for the Recovery Party may be liable for damages or may be willing to pay money in settlement of a claim. This Plan does not cover Benefits for Services you or your Dependents receive for illnesses and injuries when the medical expenses are the responsibility of, or are paid by, a Recovery Party who has caused the illness or injury or a Recovery Party insurer. In situations where SelectHealth determines that a Recovery Party may be liable for your or your Dependent's medical expenses, SelectHealth may nonetheless agree to conditionally pay the claims relating to such expenses in advance pending a final determination of a) whether a Recovery Party or you are responsible for such expenses instead of SelectHealth; and/or b) the claims are excluded from coverage under this Plan. Each Member agrees to reimburse SelectHealth for such conditional payments when a final determination is made by SelectHealth that it is not responsible for the payment of such claims.

### **13.2.2 SelectHealth's Recovery Rights**

If SelectHealth pays benefits under this Plan for an illness or injury and SelectHealth determines that a Recovery Party is or may be responsible or liable for damages to you or your Dependents, SelectHealth has the right to recover Benefits paid under this Plan and is subrogated to all and any of your or your Dependent's rights to recover from the Recovery Party and to any money paid in settlement of a claim, but only up to the amount of the Benefits provided by the Plan. SelectHealth is entitled to reimbursement and/or recovery under this section 13.2 from any judgment, award, and other types of recovery or settlement received by you, your Dependents and/or your or your Dependent's representatives, regardless of whether the recovery is characterized as relating to medical expenses. SelectHealth is entitled to reimbursement even if

you or your covered Dependent is not made whole or fully compensated by the recovery. You and your Dependents are required by this Plan, and agree, to promptly notify SelectHealth when the terms of this Section 13.2 might apply.

If the person for whom Plan Benefits are paid is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this section 13.2 regardless of whether the minor's representative has access to or control of the recovered funds. The provisions of this section 13.2 are binding upon you and your Dependents and binding upon your and your Dependent's guardians, heirs, executors, assigns and other representatives.



### **13.2.3 Agreement by Members**

As a condition to receiving Benefits under the Plan, you and your Dependent(s) agree (a) that SelectHealth is automatically subrogated to, and has a right to receive restitution from, any right of recovery you may have against a Recovery Party as the result of an accident, illness, injury, or other condition involving the Recovery Party (hereinafter a Recovery Event) that causes you or your Dependents to obtain Covered Services that are paid for by SelectHealth; (b) that SelectHealth is entitled to receive as restitution the proceeds of any judgment, settlement, or other payment paid or payable in satisfaction of any claim or potential claim that you or your Dependents have or could assert against a Recovery Party to the extent of all Benefits paid by SelectHealth or payable in the future because of the Recovery Event; (c) not to bring or assert a make whole, common fund, collateral source or other apportionment action or claim in contravention of SelectHealth's rights described in this section 13.2; (d) not to spend or otherwise disburse funds received under a settlement agreement or from an insurance company or other Recovery Party until such time as SelectHealth has been paid or reimbursed for the amounts due to SelectHealth under this section 13.2; (e) to cooperate with SelectHealth to effectuate the terms of this section 13.2 and to do whatever may be necessary to secure the recovery by SelectHealth of the amount of the Benefits paid, including execution of all appropriate papers, furnishing of information and assistance; and (f) not to interfere with SelectHealth's rights under this Section 13.2 and not to take any action that prejudices SelectHealth's rights under this Section 13.2, including settling a dispute with a Recovery Party without protecting SelectHealth's rights under this Section 13.2.

If requested to do so by SelectHealth, you and your Dependents must execute a written recovery agreement as a condition of payment on claims arising from injuries or illnesses caused by third parties. If your Dependent is so injured or has such an illness, both you and your Dependent are required to execute the written recovery agreement. If the injured or ill person is a minor or legally incompetent, the written recovery agreement must be executed by the person's parent(s), managing conservator and/or guardian. If you or your Dependent has died, your or your Dependent's legal representative must execute the agreement. Any

Plan benefits paid must be returned to SelectHealth immediately in the event that SelectHealth requests that a written recovery agreement be signed and there is a failure or refusal to execute the recovery agreement. SelectHealth's rights, however, are not waived if SelectHealth does not request a written recovery agreement under this section 13.2.

### **13.2.4 Constructive Trust and First Lien**

Any funds you and/or your Dependents (or your or your Dependent's agent or attorney) recover by way of settlement, judgment, or other award from a Recovery Party or from your or your Dependent's own insurance due to a Recovery Event shall be held by you and/or your Dependents (or your or your Dependent's agent or attorney) in a constructive trust for the benefit of SelectHealth until SelectHealth's rights under this section 13.2 have been satisfied.

SelectHealth will have, and you and your Dependents grant, a first lien upon any recovery, whether by settlement, judgment, arbitration or mediation, that you or your covered Dependents receive or are entitled to receive from any source, regardless of whether you or your covered Dependents receive a full or partial recovery. Any settlement or recovery received shall first be deemed to be reimbursement of medical expenses paid under this Plan. These first priority rights will not be reduced due to you or your covered Dependent's own negligence. You and/or your Dependents (or your or your Dependent's agent or attorney) will be personally liable for the restitution amount required under this section 13.2 to the extent that SelectHealth does not recover that amount due to a failure by you and/or your Dependents (or your or your Dependent's agent or attorney) to follow the required process.

### **13.2.5 Rights to Intervene and Sue**

SelectHealth shall have the right to intervene in any lawsuit, threatened lawsuit, or settlement negotiation involving a Recovery Party for purposes of asserting and collecting SelectHealth's restitution and other interests described in this section 13.2. SelectHealth shall have the right to bring a lawsuit against, or assert a counterclaim or cross-claim against, you (or your agent or attorney) for purposes of collecting restitution or other interests under this section 13.2, to enforce the constructive trust required by this section 13.2, and/or take any other action to collect funds from you.

SelectHealth is entitled to institute these actions in its own name or in your or your Dependent's name or to join any action brought by you, your Dependents or your representatives, with or without specific consent, and to participate in any judgment, award or settlement to the extent of SelectHealth's interest. You and your Dependents must notify SelectHealth before filing any suit or settling any claim so as to enable SelectHealth to participate in the suit or settlement to protect and enforce SelectHealth's rights under this subrogation provision. You and your Dependents agree to keep SelectHealth fully informed and advised of all developments in any such suit or settlement negotiations.

The amount that SelectHealth is entitled to recover from you and your Dependents under this section 13.2 is specifically unreduced by any attorney, legal or other fees and costs incurred by you or your Dependents in seeking recovery from a Recovery Party or Recovery Party insurer, except if SelectHealth specifically agrees in writing to participate in these fees.

If you or your Dependents fail to fully cooperate with SelectHealth or its designated agents in asserting its rights under this section 13.2, SelectHealth may reduce or deny coverage under the Plan and offset against any future claims. Further, SelectHealth may compromise with you or your Dependents on any issue involving subrogation/restitution in a way that includes you or your Dependents surrendering the right to receive further Services under the Plan.

### **13.2.6 Special Subrogation Rules for Utah**

Notwithstanding anything else in this Section 13.2 to the contrary, SelectHealth's rights under this section

13.2, when SelectHealth is asserting rights against underinsured/uninsured motorist coverage subject to Utah Code Annotated sections 31A-22-305 or 31A-22-305.3 shall be limited to situations in which you or your Dependents have been made whole.

## **13.3 Excess Payment**

SelectHealth will have the right to recover any payment made in excess of the obligations of SelectHealth under the Contract. Such recoveries are limited to a time period of 12 months (or 24 months for a COB error) from the date a payment is made unless the recovery is due to fraud or intentional misrepresentation of material fact by you or your Dependents. This right of recovery will apply to payments made to you, your Dependents, your employer, Providers, or Facilities. If an excess payment is made by SelectHealth to you, you agree to promptly refund the amount of the excess. SelectHealth may, at its sole discretion, offset any future Benefits against any overpayment. SelectHealth may recover excess payment made to a provider by withholding other amounts payable to the provider from any plan under which SelectHealth makes payment.

## **SECTION 14 SUBSCRIBER RESPONSIBILITIES**

As a condition to receiving Benefits, you are required to:

### **14.1 Payment**

Pay applicable contributions to your employer, and pay the Coinsurance, Copay, and/or Deductible amounts listed in your Member Payment Summary to your Provider(s) and/or Facilities.

### **14.2 Changes in Eligibility or Contact Information**

Notify your employer when there is a change in your situation that may affect your Eligibility, the Eligibility of your Dependents, or if your contact information changes. Your employer has agreed to notify SelectHealth of these changes.

### **14.3 Other Coverage**

Notify SelectHealth if you or your Dependents obtain other healthcare coverage. This information is necessary to accurately process and coordinate your claims.

### **14.4 Information/Records**

Provide SelectHealth all information necessary to administer your coverage, including the medical history and records for you and your Dependents and, if requested, your social security number(s).

### **14.5 Notification of Members**

Notify your enrolled Dependents of all Benefit and other Plan changes.

## **SECTION 15 EMPLOYER RESPONSIBILITIES**

### **15.1 Enrollment**

Your employer makes initial Eligibility decisions and communicates them to SelectHealth. SelectHealth reserves the right to verify that the Eligibility requirements of the Contract are satisfied. Your employer is obligated to promptly notify SelectHealth whenever there is a change in your situation that may affect your Eligibility or the Eligibility of your Dependents. This includes FMLA and other leaves of absence.

### **15.2 Payment**

All enrollments are conditioned upon the timely payment of Premiums to SelectHealth.

### **15.3 Contract**

The Contract is with your employer, and only your employer can change or terminate it. Your employer is responsible for notifying you of any changes to the Plan and for providing you at least 30 days written notice if the Contract is terminated for any reason.

### **15.4 Compliance**

Your employer is responsible for complying with all reporting, disclosure, and other requirements for your Employer's Plan under federal law.

## **SECTION 16 DEFINITIONS**

This Certificate of Coverage contains certain defined terms that are capitalized in the text and described in this section. Words that are not defined have their usual meaning in everyday language.

### **16.1 Activities of Daily Living**

Eating, personal hygiene, dressing, and similar activities that prepare an individual to participate in work or school. Activities of Daily Living do not include recreational, professional, or school-related sporting activities.

### **16.2 Affordable Care Act (ACA)**

The Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 and associated regulations.

### **16.3 Allowed Amount**

The dollar amount allowed by SelectHealth for a specific Covered Service.

### **16.4 Ambulatory Surgical Facility**

A Facility licensed by the state where Services are provided to render surgical treatment and recovery on an outpatient basis to sick or injured persons under the direction of a Physician. Such a Facility does not provide inpatient Services.

### **16.5 Annual Open Enrollment**

A period of time each year that may be offered by your employer during which you are given the opportunity to enroll yourself and your Dependents in the Plan.

## 16.6 Anodontia

The condition of congenitally missing all teeth, either primary or permanent.

## 16.7 Application

The form on which you apply for coverage under the Plan.

## 16.8 Approved Clinical Trials

A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease (any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted) and is described in any of the following:

- a. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - i. The National Institutes of Health.
  - ii. The Centers for Disease Control and Prevention.
  - iii. The Agency for Health Care Research and Quality.
  - iv. The Centers for Medicare & Medicaid Services.
  - v. Cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.
  - vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - vii. Any of the following if the appropriate review and approval through a system of peer review has been attained:
    - 1) The Department of Veterans Affairs.
    - 2) The Department of Defense.
    - 3) The Department of Energy.

- b. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- c. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

## 16.9 Autism Spectrum Disorder

Autism Spectrum Disorder includes disorders characterized by delays in the development of multiple basic functions, including socialization and communication.

## 16.10 Benefit(s)

The payments and privileges to which you are entitled by this Certificate and the Contract.

## 16.11 Certificate of Coverage (Certificate)

This document, which describes the terms and conditions of the health insurance Benefits provided by your employer's Group Health Insurance Contract with SelectHealth. Your Member Payment Summary is attached to and considered part of this Certificate.

## 16.12 COBRA Coverage

Coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

## 16.13 Coinsurance

A percentage of the Allowed Amount stated in your Member Payment Summary that you must pay for Covered Services to the Provider and/or Facility.

## 16.14 Continuation Coverage

COBRA Coverage and/or Utah mini-COBRA coverage.

## 16.15 Contraceptive

A Service for a woman that temporarily or permanently prevents pregnancy by interfering with ovulation, fertilization, or implantation. The Food and Drug Administration identifies the following contraceptive methods: sterilization surgery; surgical sterilization implant; implantable rod; intrauterine device (IUD) copper; IUD with progestin; shot/injection; oral contraceptives (combined pill); oral contraceptives (progestin only); oral contraceptives extended/continuous use; patch; vaginal contraceptive ring; diaphragm; sponge; cervical cap; female condom; spermicide; and emergency contraception.

## 16.16 Contract

The Group Health Insurance Contract between SelectHealth and your employer.

## 16.17 Copay (Copayment)

A fixed amount stated in your Member Payment Summary that you must pay for Covered Services to a Provider or Facility.

## 16.18 Covered Services

The Services listed as covered in Section 8 Covered Services, Section 9 Prescription Drug Benefits, Section 10 Limitations and Exclusions, and applicable Optional Benefits, and not excluded by this Certificate.

## 16.19 Custodial Care

Services provided primarily to maintain rather than improve a Member's condition or for the purpose of controlling or changing the Member's environment. Services requested for the convenience of the Member or the Member's family that do not require the training and technical skills of a licensed Nurse or other licensed Provider, such as convalescent care, rest cures, nursing home services, etc. Services that are provided principally for personal hygiene or for assistance in daily activities.

## 16.20 Deductible(s)

An amount stated in your Member Payment Summary that you must pay each Year for Covered Services before SelectHealth makes any payment. Some categories of Benefits may be subject to separate Deductibles.

## 16.21 Dental Services

Services rendered to the teeth, the tooth pulp, the gums, or the bony structure supporting the teeth.

## 16.22 Dependents

Your Eligible dependents as set forth in Section 2 Eligibility.

## 16.23 Durable Medical Equipment (DME)

Medical equipment that is able to withstand repeated use and is generally not useful in the absence of an illness or injury.

## 16.24 Effective Date

The date on which coverage for you and/or your Dependents begins.

## 16.25 Eligible, Eligibility

In order to be Eligible, you or your Dependents must meet the criteria for participation specified in Section 2 Eligibility and in the Group Application.

## 16.26 Emergency Condition(s)

A condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to reasonably expect that failure to obtain immediate medical care could result in:

- a. Placing a Member's health in serious jeopardy;

- b. Placing the health of a pregnant woman or her unborn child in serious jeopardy;
- c. Serious impairment to bodily functions; or
- d. Serious dysfunction of any bodily organ or part.

### **16.27 Employer Waiting Period**

The period that you must wait after becoming Eligible for coverage before your Effective Date. Subject to approval by SelectHealth, your employer specifies the length of this period in the Group Application.

### **16.28 Employer's Plan**

The group health plan sponsored by your employer and insured under the Contract.

### **16.29 Endorsement**

A document that amends the Contract.

### **16.30 ERISA**

The Employee Retirement Income Security Act (ERISA), a federal law governing employee benefit plans.

### **16.31 Excess Charges**

Charges from Providers and Facilities that exceed the Allowed Amount for Covered Services. Except as prohibited under state or federal law, you are responsible to pay for Excess Charges from Out-of-Network Providers and Facilities. These charges do not apply to your Out-of-Pocket Maximum.

### **16.32 Exclusion(s)**

Situations and Services that are not covered by SelectHealth under the Plan. Most Exclusions are set forth in Section 10 Limitations and Exclusions, but other provisions throughout this Certificate and the Contract may have the effect of excluding coverage in particular situations.

### **16.33 Experimental and/or Investigational**

A Service for which one or more of the following apply:

- a. It cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use;
- b. It is the subject of a current investigational new drug or new device application on file with the FDA;
- c. It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial;
- d. It is being or should be delivered or provided subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS); or
- e. If the predominant opinion among appropriate experts as expressed in the peer-reviewed medical literature is that further research is necessary in order to define safety, toxicity, effectiveness, or comparative effectiveness, or there is no clear medical consensus about the role and value of the Service.

### **16.34 Facility**

An institution that provides certain healthcare Services within specific licensure requirements.

### **16.35 Formulary**

The Prescription Drugs covered by your Plan.

### **16.36 Generic Drug(s)**

A medication that has the same active ingredients, safety, dosage, quality, and strength as its brand-name counterpart. Both the brand-name drug and the Generic Drug must get approval from the FDA before they can be sold.

### **16.37 Group Application**

A form used by SelectHealth both as an application for coverage by your employer and to specify group-specific details of coverage. The Group Application may contain modifications to the language of the Contract. It also demonstrates your employer's acceptance of the Contract. Other documents, such as Endorsements, may be incorporated by reference into the Group Application.

### **16.38 Group Health Insurance Contract**

The agreement between your employer and SelectHealth that contains the terms and conditions under which SelectHealth provides group insurance coverage to you and your Dependents. The Group Application and this Certificate are part of the Group Health Insurance Contract. If your employer is not directly sponsoring the Plan, references to employer throughout the Certificate of Coverage can also include the party contracting with SelectHealth for Benefits provided to you.

### **16.39 Habilitation Services**

Health care services that help a person keep, learn, or improve skills and functioning for daily living. Habilitative services may include physical therapy, occupational therapy, speech-language pathology, and other services.

### **16.40 Healthcare Management Program**

A program designed to help you obtain quality, cost-effective, and medically appropriate care, as described in Section 11 Healthcare Management.

### **16.41 Home Healthcare**

Services provided to Members at their home by a licensed Provider who works for an organization that is licensed by the state where Services are provided.

### **16.42 Hospice Care**

Supportive care provided on an inpatient or outpatient basis to a terminally ill Member not expected to live more than six months.

### **16.43 Hospital**

A Facility that is licensed by the state in which Services are provided that is legally operated for the medical care and treatment of sick or injured individuals.

A Facility that is licensed and operating within the scope of such license, which:

- a. Operates primarily for the admission, acute care, and treatment of injured or sick persons as inpatients;
- b. Has a 24-hour-a-day nursing service by or under the supervision of a graduate registered Nurse (R.N.) or a licensed practical Nurse (L.P.N.);
- c. Has a staff of one or more licensed Physicians available at all times; and
- d. Provides organized facilities for diagnosis and surgery either on its premises or in facilities available to the Hospital on a contractual prearranged basis.

### **16.44 Infertility**

A condition resulting from a disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the male or female reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery.

## 16.45 Injectable Drugs and Specialty Medications

A class of drugs that may be administered orally, as a single injection, intravenous infusion or in an inhaled/nebulized solution. Injectable drugs and specialty medications include all or some of the following:

- a. Are often products of a living organism or produced by a living organism through genetic manipulation of the organism's natural function;
- b. Are generally used to treat an ongoing chronic illness;
- c. Require special training to administer;
- d. Have special storage and handling requirements;
- e. Are typically limited in their supply and distribution to patients or Providers; and
- f. Often have additional monitoring requirements.

Certain drugs used in a Provider's office to treat common medical conditions (such as intramuscular penicillin) are not considered Injectable Drugs and specialty medications, because they are widely available, distributed without limitation, and are not the product of bioengineering.

## 16.46 Initial Eligibility Period

The period determined by SelectHealth and your employer during which you may enroll yourself and your Dependents in the Plan. The Initial Eligibility Period is identified in the Group Application.

## 16.47 In-Network Benefits

The higher level of Benefits available to you when you obtain Covered Services from an In-Network Provider or Facility.

## 16.48 In-Network Facility

Facilities under contract with SelectHealth to accept Allowed Amounts as payment in full for Covered Services.

## 16.49 In-Network Pharmacies

Pharmacies under contract with SelectHealth to accept Allowed Amounts as payment in full for Covered Services.

## 16.50 In-Network Providers

Providers under contract with SelectHealth to accept Allowed Amounts as payment in full for Covered Services.

## 16.51 Lifetime Maximum

The maximum accumulated amount that SelectHealth will pay for certain Covered Services (as allowed by the Affordable Care Act) during a Member's lifetime. This includes all amounts paid on behalf of the Member under any prior health benefit plans insured by SelectHealth (including those sponsored by former employers) or any of its affiliated or subsidiary companies. In addition, some categories of Benefits are subject to a separate lifetime maximum amount. If applicable, lifetime maximums are specified in your Member Payment Summary.

## 16.52 Limitation(s)

Situations and Services in which coverage is limited by SelectHealth under the Plan. Most Limitations are set forth in Section 10 Limitations and Exclusions, but other provisions throughout this Certificate and the Contract may have the effect of limiting coverage in particular situations.

## 16.53 Major Diagnostic Tests

Diagnostic tests categorized as major by SelectHealth. SelectHealth categorizes tests based on several considerations such as the invasiveness and complexity of the test, the level of expertise required to interpret or perform the test, and where the test is commonly performed. Examples of common major diagnostic tests are:

- a. Cardiac nuclear studies or cardiovascular procedures such as coronary angiograms;
- b. Gene-based testing and genetic testing;



- c. Imaging studies such as MRIs, CT scans, and PET scans; and
- d. Neurologic studies such as EMGs and nerve conduction studies.

If you have a question about the category of a particular test, please contact Member Services.

### **16.54 Major Surgery**

A surgical procedure having one or more of the following characteristics:

- a. Performed within or upon the contents of the abdominal, pelvic, cranial or thoracic cavities;
- b. Typically requiring general anesthesia;
- c. Has a level of difficulty or length of time to perform which constitutes a hazard to life or function of an organ or tissue; or
- d. Requires the special training to perform.

### **16.55 Maximum Annual Out-of-Network Payment**

The maximum accumulated amount SelectHealth will pay each Year for Covered Services applied to the Out-of-Network Benefit.

The limit includes all amounts paid on behalf of the Member under any prior Plans provided by SelectHealth or any of its affiliated or subsidiary companies for any one Year. The Maximum Annual Out-of-Network Payment amount is specified in your Member Payment Summary.

### **16.56 Medical Director**

The Physician(s) designated as such by SelectHealth.

### **16.57 Medical Necessity/Medically Necessary**

Services that a prudent healthcare professional would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

- a. In accordance with generally accepted standards of medical practice in the United States;
- b. Clinically appropriate in terms of type, frequency, extent, site, and duration; and
- c. Not primarily for the convenience of the patient, Physician, or other Provider.

When a medical question-of-fact exists, Medical Necessity shall include the most appropriate available supply or level of service for the Member in question, considering potential benefit and harm to the Member.

Medical Necessity is determined by the treating Physician and by SelectHealth's Medical Director or his or her designee. The fact that a Provider or Facility, even a In-Network Provider or Facility, may prescribe, order, recommend, or approve a Service does not make it Medically Necessary, even if it is not listed as an Exclusion or Limitation. FDA approval, or other regulatory approval, does not establish Medical Necessity.

### **16.58 Member**

You and your Dependents, when properly enrolled in the Plan and accepted by SelectHealth.

### **16.59 Member Payment Summary**

A summary of your Benefits by category of service, attached to and considered part of this Certificate.

### **16.60 Mental Health/Chemical Dependency**

Emotional conditions or chemical dependency listed as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders, as periodically revised, and which require professional intervention.

### **16.61 Minor Diagnostic Tests**

Tests not categorized as Major Diagnostic Tests. Examples of common minor diagnostic tests are:

- a. Bone density tests;
- b. Certain EKGs;

- c. Echocardiograms;
- d. Common blood and urine tests;
- e. Simple X-rays such as chest and long bone X-rays; and
- f. Spirometry/pulmonary function testing.

### **16.62 Miscellaneous Medical Supplies (MMS)**

Supplies that are disposable or designed for temporary use.

### **16.63 Nurse**

A graduate Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who is licensed by the state where Services are provided to provide medical care and treatment under the supervision of a Physician.

### **16.64 Oligodontia**

The condition of congenitally missing more than six teeth, not including third molars or wisdom teeth.

### **16.65 Optional Benefit**

Additional coverage purchased by your employer as noted in your Member Payment Summary that modifies Limitations, Exclusions, and/or Eligibility.

### **16.66 Out-of-Network Benefits**

A lower level of Benefits available for Covered Services obtained from a Out-of-Network Provider or Facility, even when such Services are not available through In-Network Providers or Facilities.

### **16.67 Out-of-Network Facility**

Healthcare Facilities that are not under contract with SelectHealth.

### **16.68 Out-of-Network Pharmacies**

Pharmacies that are not under contract with SelectHealth.

### **16.69 Out-of-Network Provider**

Providers that are not under contract with SelectHealth.

### **16.70 Out-of-Pocket Maximum**

The maximum amount specified in your Member Payment Summary that you must pay each Year to Providers and/or Facilities as Deductibles, Copays, and Coinsurance. Except when otherwise noted in your Member Payment Summary, SelectHealth will pay 100 percent of Allowed Amounts during the remainder of the Year once the Out-of-Pocket Maximum is satisfied. Some categories of Benefits may be subject to separate Out-of-Pocket Maximum amounts. Payments you make for Excess Charges, non-Covered Services, and certain categories of Services specified in your Member Payment Summary are not applied to the Out-of-Pocket Maximum.

### **16.71 Physician**

A doctor of medicine or osteopathy who is licensed by the state in which he or she provides Services and who practices within the scope of his or her license.

### **16.72 Plan**

The specific combination of Covered Services, Limitations, Exclusions, and other requirements agreed upon between SelectHealth and your employer as set forth in this Certificate and the Contract.

### **16.73 Plan Sponsor**

As defined in ERISA. The Plan Sponsor is typically your employer.

### **16.74 Preauthorization (Preauthorize)**

Prior approval from SelectHealth for certain Services. Refer to Section 11 Healthcare Management and your Member Payment Summary.

## **16.75 Premium(s)**

The amount your Employer periodically pays to SelectHealth as consideration for providing Benefits under the Plan. The Premium is specified in the Group Application.

## **16.76 Prescription Drugs**

Drugs and medications, including insulin, that by law must be dispensed by a licensed pharmacist and that require a Provider's written prescription.

## **16.77 Preventive Services**

Periodic healthcare that includes screenings, checkups, and patient counseling to prevent illness, disease, or other health problems not previously known to exist in the individual, and as defined by the Affordable Care Act and/or SelectHealth. Some examples of these services are well-child exams, immunizations, pediatric vision screenings, and Contraceptives as required by the ACA. Preventive services also include a Contraceptive that is medically necessary for you as determined by your Provider and evidenced through written documentation submitted to SelectHealth.

## **16.78 Primary Care Physician or Primary Care Provider (PCP)**

A general practitioner who attends to common medical problems, provides Preventive Services, and health maintenance. The following types of Physicians and Providers, and their associated physician assistants and nurse practitioners, are PCPs:

- a. Certified Nurse Midwives;
- b. Family Practice;
- c. Geriatrics;
- d. Internal Medicine;
- e. Obstetrics and Gynecology (OB/GYN); and
- f. Pediatrics.

## **16.79 Private Duty Nursing**

Services rendered by a Nurse to prepare and educate family members and other caregivers on proper procedures for care during the transition from an acute Hospital setting to the home setting.

## **16.80 Provider**

A vendor of healthcare Services licensed by the state where Services are provided and that provides Services within the scope of its license.

## **16.81 Qualified Medical Child Support Order (QMCSO)**

A court order for the medical support of a child as defined in ERISA.

## **16.82 Rehabilitation Services**

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

## **16.83 Rescission (Rescind)**

A cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required Premiums or contributions towards the cost of coverage.

## **16.84 Residential Treatment Center**

A licensed psychiatric facility which provides 24-hour continuous, individually-planned programs of therapeutic treatment and supervision.

## **16.85 Respite Care**

Care provided primarily for relief or rest from caretaking responsibilities.

## 16.86 Routine Care

Care that is intended to monitor identified health conditions or assess new symptoms or signs of possible health conditions in a non-urgent or non-emergency setting.

## 16.87 Secondary Care Provider or Specialist (SCP)

Physicians and other Providers who are not a Primary Care Physician or Primary Care Provider. The following types of Physicians and Providers, and their associated physician assistants and nurse practitioners, are examples of an SCP:

- a. Cardiologists;
- b. Dermatologists;
- c. Neurologists;
- d. Ophthalmologists;
- e. Orthopedic Surgeons; and
- f. Otolaryngologists (ENTs).

## 16.88 Service Area

The geographical area in which SelectHealth arranges for Covered Services for Members from In-Network Providers and Facilities.

The SelectHealth Care Service Area is the State of Utah.

The SelectHealth Med Service Area is the State of Utah.

The SelectHealth Value® Service Area includes the following counties: Box Elder, Davis, Morgan, Salt Lake, Summit, Tooele, Utah, Wasatch, and Weber.

## 16.89 Service(s)

Services, care, tests, treatments, drugs, medications, supplies, or equipment.

## 16.90 Skilled Nursing Facility

A Facility that provides Services that improve, rather than maintain, your health condition, that requires the skills of a Nurse in order to be provided safely and effectively, and that:

- a. Is being operated as required by law;
- b. Is primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a Physician;
- c. Provides 24 hours a day, seven days a week nursing service by or under the supervision of a Registered Nurse (R.N.); and
- d. Maintains a daily medical record of each patient.

A Skilled Nursing Facility is not a place that is primarily used for rest or for the care and treatment of mental diseases or disorders, chemical dependency, alcoholism, Custodial Care, nursing home care, or educational care.

## 16.91 Special Enrollment Right

An opportunity to enroll in the Plan outside of your employer's Annual Open Enrollment period under defined circumstances described in Section 3 Enrollment.

## 16.92 Subscriber

You, the individual with an employment or another defined relationship to the Plan Sponsor, through whom Dependents may be enrolled with SelectHealth.

## 16.93 Urgent Condition(s)

An acute health condition with a sudden, unexpected onset that is not life threatening but that poses a danger to a person's health if not attended by a Physician within 24 hours, e.g., high fevers, possible fractures.

## **16.94 Utah mini-COBRA**

Continuation coverage required by Utah law for employers with fewer than 20 employees.

## **16.95 Year**

Benefits are calculated on either a calendar-year or plan-year basis, as indicated on your Member Payment Summary.

- a. The calendar year begins on January 1 at 12:00 a.m. Mountain Standard Time and ends on December 31, at 11:59 p.m. Mountain Standard Time.
- b. The plan year, if applicable, is indicated in the Group Application.

## **SECTION 17 - OTHER PROGRAMS**

In addition to your Benefits, SelectHealth may offer discount, wellness, and similar incentive programs to members. Program information is available through the SelectHealth website or by contacting SelectHealth.

## **APPENDIX A OPTIONAL BENEFITS**



# appendix A

optional benefits

## **MENTAL HEALTH/CHEMICAL DEPENDENCY OPTIONAL BENEFIT**

### **1. Your Mental Health Benefits**

This Optional Benefit provides mental health and chemical dependency Benefits for the treatment of emotional conditions or chemical dependency listed as a mental disorder in the Diagnostic and Statistical Manual, as periodically revised, and which require professional intervention for as long as Services are considered Medically Necessary. These Benefits are subject to all the provisions, limitations, and exclusions of your medical Benefits that are listed in the Certificate.

If you have any questions regarding any aspect of the Benefits described in this Optional Benefit, please call the Behavioral Health Advocates<sup>SM</sup> weekdays, from 8:00 a.m. to 6:00 p.m. at 800-876-1989.

### **2. Services requiring Preauthorization**

Preauthorization is required for the following mental health services that are not for Emergency Conditions:

- a. Inpatient psychiatric/detoxification admissions;
- b. Residential treatment after the third day of admission;
- c. Day treatment;
- d. Partial hospitalization after 20 visits; and
- e. Intensive outpatient treatment after 35 visits.

If you need to request Preauthorization, call the Behavioral Health Advocates. Refer to Section 11 – “Healthcare Management” of your Certificate of Coverage for additional information.

### **3. Exclusions**

**The following are not covered:**

- a. Behavior modification;
- b. Counseling with a patient’s family, friend(s), employer, school authorities, or

- others, except for approved Medically Necessary collateral visits, with or without the patient present, in connection with otherwise covered treatment of the patient’s mental illness;
- c. Education or training;
- d. Long-term care;
- e. Milieu therapy;
- f. Rest cures;
- g. Self-care or self-help training (nonmedical);
- h. Surgical procedures to remedy a condition diagnosed as psychological, emotional, or mental; and
- i. Services for conduct disorder.





# selecthealth

## 2024 Endorsement to the Certificate of Coverage

Your Employer has renewed its Group Health Insurance Contract with SelectHealth (domiciled in the State of Utah and located at 5381 Green Street, Murray, Utah 84123) for the time period of see group application.

Your Member Payment Summary is replaced with the enclosed Member Payment Summary.

With this renewal, your Certificate of Coverage for the prior Year is still in full force and effect with the following modifications:

***Section 1.2 "SelectHealth, Inc." of the Certificate is replaced with the following:***

**1.2 SelectHealth, Inc.**

SelectHealth is an HMO licensed by and domiciled in the State of Utah and is located at 5381 Green Street, Murray, Utah 84123. SelectHealth is affiliated with Intermountain Health, but is a separate company. The Contract does not involve Intermountain Health or any other affiliated Intermountain Health companies, or their officers or employees. Such companies are not responsible to you or any other Members for the obligations or actions of SelectHealth.

***Section 6.2 "Access to Healthcare Providers" of the Certificate is replaced with the following:***

**6.2 Access to Healthcare Providers**

Regardless of network status, you may be entitled to In-Network Benefits for healthcare Services from the following Providers if you live or reside within 30 paved road miles of the listed Providers, or if you live or reside in closer proximity to the listed Providers than to other In-Network Providers:

- Independent Hospital(s)
- Beaver Valley Hospital, Beaver, Beaver County, Utah
- Blue Mountain Hospital, Blanding, San Juan County, Utah
- Central Valley Medical Center, Nephi, Juab County, Utah
- Gunnison Valley Hospital, Gunnison, Sanpete County, Utah
- Kane County Hospital, Kanab, Kane County, Utah
- Milford Valley Memorial Hospital, Milford, Beaver County, Utah
- Moab Regional Hospital, Moab, Grand County, Utah

San Juan Hospital, Monticello, San Juan County, Utah  
Uintah Basin Medical Center, Roosevelt, Duchesne County, Utah

Federally Qualified Health Centers

Bear Lake Community Health Center, Garden City, Carbon County, Utah  
Bear River Health Clinic, Tremonton, Box Elder County, Utah  
Blanding Family Chiropractic, Blanding, San Juan County, Utah  
Blanding Family Practice Community Health Center, Blanding, San Juan County, Utah  
Blanding Family Vision Center, Blanding, San Juan County, Utah  
Box Elder Community Health Center, Brigham City, Box Elder County, Utah  
Brigham City Community Health Center, Brigham City, Box Elder County, Utah  
Carbon Medical Service Association -- Helper Clinic, Helper, Carbon County, Utah  
Carbon Medical Service Association, Sunnyside, Carbon County, Utah  
Cedar Community Health Center, Cedar City, Iron County, Utah  
Family Healthcare, Cedar City, Iron County, Utah  
Green River Medical Center, Green River, Emery County, Utah  
Kanosh Community Health Center, Kanosh, Millard County, Utah  
Kazan Memorial Clinic, Escalante, Garfield County, Utah  
Koosharem Community Health Center, Richfield, Sevier County, Utah  
Montezuma Creek Health Center, Montezuma Creek, San Juan County, Utah  
Mountainlands Community Health Center, Vernal, Uintah County, Utah  
Southwest WCHC Mental Health, Panguitch, Garfield County, Utah  
Wayne County Medical Clinic, Bicknell, Wayne County, Utah  
Wayne Community Health Center, Hanksville, Wayne County, Utah

This list may change periodically, please check on our website or call for verification.

If you have questions concerning your rights to see a Provider on this list, call Member Services at 800-538-5038. If SelectHealth does not resolve your problem, you may contact the Office of Consumer Health Assistance in the Utah Insurance Department.

***Section 6.6 "Continuity of Care" of the Certificate is replaced with the following:***

**6.6 Continuity of Care**

SelectHealth will provide you with 30 days' notice of In-Network Provider or Facility termination if you or your Dependent is receiving ongoing care from that Provider or Facility. However, if SelectHealth does not receive adequate notice of a Provider or Facility termination, SelectHealth will notify you within 30 days of receiving notice that the Provider or Facility is no longer In-Network with SelectHealth.

If you or your Dependent is under the care of a Provider or Facility when participation changes, SelectHealth will continue to treat the Provider or Facility as an In-Network Provider/Facility until the completion of the care (not to exceed 90 days), or until you or your Dependent is transferred to another In-Network Provider or Facility, whichever occurs first. This does not apply when a Provider is terminated from the network for failure to meet applicable quality standards or for fraud. Continuity of care treatment is eligible for coverage if you or your Dependent are:

- a. undergoing a course of treatment from the Provider or Facility for a serious and complex condition;
- a. undergoing a course of institutional or inpatient care from the Provider or Facility;
- b. scheduled to undergo non-elective surgery from the Provider or Facility, including receipt of postoperative care from such Provider or Facility with respect to such surgery;
- c. pregnant and undergoing a course of treatment for pregnancy from the Provider or Facility (any trimester); and
- d. determined to have a life expectancy of six months or less and are receiving treatment for such illness from the Provider or Facility until the Member's death.

To continue care, the In-Network Provider or Facility must not have been terminated by SelectHealth for quality reasons, remain in the Service Area, and agree to do all of the following:

- a. Accept the Allowed Amount as payment in full;
- b. Follow SelectHealth's Healthcare Management Program policies and procedures;
- c. Continue treating you and/or your Dependent; and
- d. Share information with SelectHealth regarding the treatment plan.

***Section 8.3.8 "Durable Medical Equipment (DME)" of the Certificate is replaced with the following:***

**8.3.8 Durable Medical Equipment (DME)**

Only:

- a. When used in conjunction with an otherwise covered condition and when:
  - i. Prescribed by a Provider;
  - ii. Primarily used for medical purposes and not for convenience, personal comfort, or other nontherapeutic purposes;
  - iii. Required for Activities of Daily Living;
  - iv. Not for duplication or replacement of lost, damaged, or stolen items; and
  - v. Not attached to a home or vehicle.
- b. Batteries only when used to power a wheelchair, an insulin pump for treatment of diabetes, or for a covered Cochlear Implant.
- c. Continuous passive motion therapy for any indication for up to 21 days of continuous coverage from the first day applied.

Certain DME items can only be rented. Others may be subject to a rental period prior to purchasing. SelectHealth will not provide payment for rental costs exceeding the purchase price. For covered rental DME that is subsequently purchased, cumulative rental costs are deducted from the purchase price.

***A new Section 8.3.9 “Habilitation Therapy Services” of the Certificate is added:***

**8.3.9 Habilitation Therapy Services**

When Mental Health/Chemical Dependency is a Covered Service, visit limits for Habilitation Services, if indicated on your Member Payment Summary, do not apply when the primary diagnosis is Mental Health/Chemical Dependency.

***Section 8.3.18 “Rehabilitation Therapy” of the Certificate is replaced with the following:***

**8.3.18 Rehabilitation Therapy**

Physical, occupational, and speech rehabilitative therapy when required to correct an impairment caused by a covered accident or illness or to restore an individual’s ability to perform Activities of Daily Living. When Mental Health/Chemical Dependency is a Covered Service, visit limits for Rehabilitation Services, if indicated on your Member Payment Summary, do not apply when the primary diagnosis is Mental Health/Chemical Dependency.

***Section 10.8 “Certain Illegal Activities” of the Certificate is removed***

***Section 12.5.5 “Postservice Appeals... Voluntary External Review” of the Certificate is replaced with the following:***

**12.5.5 Postservice Appeals... Voluntary External Review**

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, a Rescission of coverage, or any Adverse Benefit Determination relating to a surprise medical bill or surprise air ambulance bill subject to the No Surprises Act. To request an External Review you must complete the Independent Review Request Form. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. For a copy of this form, or for other questions, contact the Utah Insurance Commissioner by mail at 4315 S 2700 W Ste 2300 Taylorsville, UT 84129; by phone at 801-957-9200; or electronically at [healthappeals.uid@utah.gov](mailto:healthappeals.uid@utah.gov). An External Review request must be made within 180 days from the date SelectHealth sends the Final Internal Adverse Benefit Determination. An authorization to obtain medical records may be required. The IRO will provide written notice of its decision within 45 days after receipt of the request. There is no additional cost for requesting an External Review.

If you pursue a voluntary External Review, it will be your last level of Appeal.

***A new Section 16.60 “Mental Health/Chemical Dependency” of the Certificate is added:***

**16.60 Mental Health/Chemical Dependency**

Emotional conditions or chemical dependency listed as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders, as periodically revised, and which require professional intervention.

***Section 16.88 “Service Area” of the Certificate is replaced with the following:***

**16.88 Service Area**

The geographical area in which SelectHealth arranges for Covered Services for Members from In-Network Providers and Facilities.

The SelectHealth Care Service Area is the State of Utah.

The SelectHealth Med Service Area is the State of Utah.

The SelectHealth Value<sup>®</sup> Service Area includes the following counties: Box Elder, Davis, Morgan, Salt Lake, Summit, Tooele, Utah, Wasatch, and Weber.

All other terms and conditions of the Contract remain unchanged.