

**MASTER GROUP CONTRACT**

**Employer Group:** Farm Credit Foundations  
**Group Effective Date:** January 1, 2008  
**Date of Issue:** November 9, 2007  
**Renewal Date:** January 1, 2009

This agreement is between SelectHealth, Inc., a Utah nonprofit corporation doing business as Select Care, or any successor corporation and the "Employer" named above and in the attached Execution Section to this Master Group Contract (herein referred to as the "Contract"). The rights and duties of Members enrolled with SelectHealth through Employer are also determined by this Contract.

Select Care benefits are administered by SelectHealth, Inc.

Questions regarding coverage and the availability and limitations on services should be directed to the SelectHealth, Member Services Department, 4646 West Lake Park Boulevard, Salt Lake City, Utah 84120, toll free telephone number 1-800-538-5038.

**EMPLOYER:** \_\_\_\_\_

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

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

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

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

Address: \_\_\_\_\_  
\_\_\_\_\_

**SelectHealth, Inc.**

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

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

Printed Name: Sidney C. Paulson

Title: President/CEO

Address: 4646 W. Lake Park Blvd.

Salt Lake City, UT 84120

Do Not  
Sign Here

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SELECT CARE**

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## **I. GENERAL STATEMENT OF PURPOSES AND RESPONSIBILITIES.**

- 1.1 General.** This Master Group Contract (herein referred to as the "Contract") creates a contractual relationship between SelectHealth and Employer in which SelectHealth will provide defined health care Benefits to individuals properly enrolled with SelectHealth as the result of their relationship to Employer. This Contract is made in consideration of the payment of Premiums to SelectHealth by the Employer or group sponsor (herein called the "Employer") listed in the Execution Section. This Contract must be accompanied by a completed Execution Section signed by both Employer and an authorized officer of SelectHealth. Any acceptance of Benefits or services under this Contract by Employer for its employees will constitute Employer's agreement to the terms of this Contract and to the terms and conditions in the Execution Section prepared by SelectHealth for Employer's group, regardless of whether the Employer has actually signed this Contract and an Execution Section. Provided that Employer has paid the required first Premium to SelectHealth, this Contract takes effect 12:00 a.m. Mountain Standard time, on the Group Effective Date specified on the first page of this Contract, and shall terminate at 11:59 p.m. on the date for termination specified in this Contract. Continuation of this Contract is contingent upon Employer making all required Premium payments to SelectHealth and with Employer otherwise complying with this Contract.
- 1.1.1 Binding Effect.** This Contract contains the entire agreement and understanding of the parties and it is binding upon the Employer and SelectHealth and their successors and assignees. It is also binding upon Subscribers, Members and their heirs, successors, personal representatives and assignees in regard to the applicable Health Benefit Program and receiving Benefits.
- 1.1.2 Integration.** This Contract, including all matters incorporated herein, contains the entire agreement of the parties. There are no promises, terms, conditions, or obligations other than those contained herein. This Contract including the Execution Section, Member Payment Summary and all Endorsements, exhibits, addenda, or amendments, if any, supersede all prior communications, representations, or agreements, either verbal or written, between the parties. In the event there has been a written proposal supplied to Employer by SelectHealth, the compliance by Employer and its employees' with all minimum enrollment and underwriting factors set forth in the proposal is a condition to the effectiveness of this Contract.
- 1.1.3 Partial Invalidity.** If any provision of this Contract is held to be unenforceable, then the remainder shall remain in full force and effect unless the action materially changes the obligations of the parties or either of them.
- 1.1.4 Non-Assignability.** The parties to this Contract may not transfer or assign their rights or obligations without the advance written approval of the other party except that SelectHealth may designate an affiliated company to administer some or all of the Employer's Health Benefit Program.
- 1.1.5 Modifications.** Upon renewal, as set forth in the Master Group Contract and in the Execution Section, SelectHealth may modify Premium, Benefits, Exclusions, Limitations, and/or services by providing Employer with thirty (30) days advance notice of the change. During the advance notice period, Employer may cancel this Contract by providing SelectHealth with written notice.

This Contract may be modified any time without the consent of Subscribers or Members, and will be modified between SelectHealth and Employer in the manner set forth in this Contract. Any such changes affect the Benefits available to Subscribers and Members under this Contract.

- 1.1.6 Availability of Contract for Review.** Members are entitled to review a copy of this Contract at the offices of the Employer or at the offices of SelectHealth. Members may also request a copy of this Contract from either Employer or SelectHealth.
- 1.1.7 Forms of Reference.** Paragraph headings appearing in this Contract are not to be construed as interpretation of the text, but are inserted only for convenience of reference for the reader. Also, references in this Contract to either gender are intended to include both genders, and references to things in the singular are intended to include the plural, and vice versa, as appropriate.
- 1.2 No Vested Rights.** Members are only entitled to receive Benefits from SelectHealth while this Contract is in effect. Members do not have any permanent or vested interest in any Benefits under this Contract, and Benefits may change or terminate as this Contract is renewed, modified, or terminated from year to year. Members do not have any right to Benefits under this Contract except when this Contract is in effect and they are properly enrolled and recognized by SelectHealth as Members. Unless otherwise expressly stated in this Contract, all Benefits end when this Contract ends. **Members have no right to receive any Benefits from or through SelectHealth except in strict compliance with this entire Contract.**
- 1.3 Acceptance of this Contract.** As a condition to receiving coverage from SelectHealth, Members are presumed and required to accept, comply with, and agree to, the terms of this Contract. Subscribers are also presumed to agree to the terms of this Contract on behalf of their Eligible Dependents who enroll as Members.
- 1.4 HMO.** SelectHealth is licensed by the State of Utah as a Health Maintenance Organization (HMO). It operates according to the laws and regulations of the State Insurance Department that apply to such organizations.
- Except for Emergencies, out-of-area Urgent Conditions, and other exceptions individually approved by SelectHealth, any Covered Services rendered, ordered, or prescribed by Non-Participating Providers or Facilities are not covered. Members have the right to seek, obtain, and pay for care, services, treatments, drugs, medications, supplies, or equipment outside the coverage provided under this Contract. Members also have the right to obtain and pay for other insurance of any kind. **Note: Otherwise covered care, services, treatments, drugs, medications, supplies, or equipment may be subject to the Coordination of Benefits requirements specified in this Contract.**
- 1.5 Providers Not Agents of SelectHealth.** All Providers of Covered Services to Members under this Contract do so as independently contracted Providers and not as agents or employees of SelectHealth. Such Providers are entitled and required to exercise independent professional medical judgment in providing Covered Services to Members.
- 1.5.1** SelectHealth does not promise, represent, warrant, or otherwise guarantee that Covered Services provided to Members by Providers will achieve any particular result or be provided in any particular manner or at any particular level of care.
- 1.5.2** It is understood and agreed that SelectHealth will not be liable for any claim or demand on account of injuries or damages of any kind arising out of or in any manner connected with any conditions or injuries suffered by a Member and resulting from care, services, treatments, drugs, medications, supplies, or equipment rendered, withheld, covered, limited, not covered, or otherwise provided or not under this Contract. Subscribers and Members agree that Providers are solely responsible to Members for care, services, treatments, drugs, medications, supplies, or equipment rendered, limited, or withheld by such Providers.

- 1.5.3 All Providers are responsible to establish independent Provider - patient relationships with Members and to exercise independent professional judgment in providing care to Members without regard to SelectHealth coverage or payment arrangements.
- 1.5.4 Merely because a Physician or other Provider orders or recommends care, services, treatments, drugs, medications, supplies, or equipment for a Member does not mean that SelectHealth will recognize the procedure as being either Medically Necessary or covered by SelectHealth under this Contract. This is true whether the Physician or other Provider is a Participating or Non-Participating Provider.
- 1.6 **Agency.** Neither the Employer (except for the purpose of collecting Premium), nor any SelectHealth Member has authority to act as agent for SelectHealth. SelectHealth is not the agent of Employer for any purpose. For purposes of this Contract, the Employer acts as the agent of its Subscribers (employees) and Subscribers act as the agent of their Eligible Dependent Members.
- 1.6.1 **Employer/Subscriber as Agent.** For purposes such as enrollment, providing consent to release information, and agreeing to the conditions in this Contract that relate to obtaining Covered Services, the Employer, as agent for the Subscribers, and the Subscribers, as agent for their Eligible Dependents, each agree to act as agent in a timely manner and in regard to matters such as, but not limited to, the following:
- a. Payment of Premiums;
  - b. Enrollment and termination procedures;
  - c. Dissemination of information about SelectHealth; and
  - d. Other administrative functions not performed by SelectHealth.
- 1.7 **Agreement Between SelectHealth, Employer, and Members.** As a condition to enrollment and to receiving Benefits from SelectHealth, the Employer, Subscribers, and every Member agree:
- a. to the Agency relationships set forth in this Contract;
  - b. to the managed care features that are a part of the Health Benefit Program in which they are enrolled;
  - c. that SelectHealth will engage in managed care activities in connection with the Covered Services that Members receive under this Contract; and
  - d. to all of the other terms and conditions of this Contract.
- 1.8 **Benefits are Limited. Covered Services under this Contract are limited in defined ways. It is the responsibility of each Subscriber and Member to know their own Benefits, to know the requirements, conditions, Limitations, and Exclusions that apply to their Benefits, and to know the Limitations and requirements that apply to their choice of Health Care Providers and Facilities and the timing of their health care services.**

Members are responsible for payment for any care, service, treatment, drug, medication, supply, or equipment they obtain that is not covered or limited by this Contract, or is obtained from Providers or Facilities who/that are not authorized to be paid by SelectHealth in the circumstances under which the care, service, treatment, drug, medication, supply, or equipment is obtained. Members are not responsible, under any circumstances, to pay for claims that are the responsibility of SelectHealth.

**1.9 Termination of Coverage.** Upon the date specified for termination, all coverage under this Contract will terminate, including but not limited to termination of coverage for conditions, illnesses, injuries, care, services, treatments, drugs, medications, supplies, or equipment that are in process of treatment at the time of termination, and/or care, services, treatments, drugs, medications, supplies, or equipment for conditions that began or existed during the term of this Contract.

**1.9.1 Termination Notice.** In case of any termination, thirty (30) days advance written notice will be provided to Employer in the manner specified by state law and insurance regulations. Unless forbidden by state law, in case of group termination, after receiving notice from SelectHealth, Employer is required to give thirty (30) days advance written notice to the Members enrolled through this Contract.

**1.9.2 Subsequent Coverage.** It is the responsibility of the Member or the Employer to arrange for coverage following the termination of this Contract, including but not limited to obtaining coverage for conditions that would be pre-existing conditions under the subsequent coverage. Members who enroll in other coverage may lose their right to Conversion Coverage.

**1.9.3 Product Discontinuance.** If SelectHealth chooses to discontinue this product, Employer will be given ninety (90) days advance notice.

**1.9.4 Market Withdrawal.** If SelectHealth chooses to withdraw from the market and discontinue all of SelectHealth's health benefit plans, Employers and Members will be given one hundred eighty (180) days advance notice.

**1.10 ERISA and SelectHealth's Authority.** If this Contract is part of an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), Employer or its designated employee(s) shall be the plan administrator and in that capacity hereby delegates to SelectHealth the following discretionary authority:

**Benefits under the Master Group Contract will be paid only if SelectHealth decides in its discretion that the Claimant is entitled to them. SelectHealth also has discretion to determine Eligibility for Benefits and to interpret the terms and conditions of the benefit plan. Determinations made by SelectHealth pursuant to this reservation of discretion do not prohibit or prevent a Claimant from seeking judicial review in federal court of SelectHealth's determinations.**

**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 SelectHealth's determination of Eligibility for Benefits, the payment of Benefits, or interpretation of the terms and conditions applicable to the benefit plan.**

**SelectHealth is an insurance company that provides insurance to this benefit plan and the federal court will determine the level of discretion that it will accord SelectHealth's determinations.**

If this Contract is not part of an employee benefit plan subject to ERISA, this Provision 1.10 does not apply and is not considered part of this Contract.

**1.11 Administrative Provisions.** SelectHealth will from time to time adopt and enforce reasonable rules, regulations, policies, procedures, and protocols to help it in the administration of this Contract and in providing Covered Services to Members. Employer and Members are subject to such rules, regulations, policies, procedures, and protocols in connection with obtaining Covered Services and other matters under this Contract. Such things will not be used to change what are the Covered Services, Exclusions, and Limitations set forth in this Contract.

- 1.12 **Assignments.** The Benefits and the right to receive payments for Benefits available under this Contract are not assignable or transferable by Subscribers or Members. Any attempted assignment or transfer of the right to receive payment from SelectHealth will be invalid unless approved in advance in writing by SelectHealth.
- 1.13 **Choice of Law.** This Contract is governed by, and will be interpreted and enforced according to the laws and regulations of the State of Utah, plus any applicable federal laws and regulations. In case of any inconsistency with the applicable law, this Contract will be construed to include the minimum requirements of the applicable law.
- 1.14 **Compliance Responsibilities.** Each party is responsible for its own compliance with applicable laws, rules, and regulations. SelectHealth is not responsible for Health Plan or Employer compliance with applicable state or federal legal requirements, including, but not limited to, the reporting and disclosure requirements of ERISA and/or any and all requirements under Titles I and II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Employer must immediately notify SelectHealth of all notices it receives regarding Medicare secondary payer information. COBRA continuation of coverage notifications services are not included in this Agreement. In no event is SelectHealth responsible for Employer's selection of any third party COBRA administrator. Further, SelectHealth specifically disclaims responsibility for the performance of any third-party in relation to COBRA services.

## II. **DEFINITIONS.**

Except as specifically provided below, words used in this Contract have their usual meanings in everyday language. For convenience, terms that are defined in this section are capitalized in the text of this Contract and in Exhibit A. The following alphabetical listing of terms and phrases will have the following meanings in this Contract:

- 2.1 **Abortion.** An Abortion is the premature termination of a pregnancy. This may be either spontaneous (occurring from natural causes i.e. miscarriage) or induced (artificial or therapeutic).
- 2.2 **Accidental Injury.** A bodily injury resulting from an unforeseen, unexpected event independent of disease, bodily infirmity, or any other cause. An injury resulting from normal body movement, such as stooping, bending, twisting, lifting, or chewing is not an Accidental Injury under this Contract.
- 2.3 **Activities of Daily Living.** Activities of Daily Living include eating, personal hygiene, and dressing, and include activities that prepare an individual to participate in work or other usual activities, or in the case of students, activities that prepare the student for normal classroom or study activities. Activities of Daily Living do not include school-related, recreational or professional sporting activities.
- 2.4 **Ambulance.** Medically Necessary emergency transportation services are covered when required to transport an acutely sick or injured Member to the nearest available medical facility that can adequately treat the Member's emergency condition. Such emergency transportation must be rendered under the direction of a Physician or a licensed emergency medical technician and supplied by a Provider licensed by the state where services are provided to furnish such transportation. Surface and air modes of transportation are included. Air Ambulance Service is covered only when such Emergency Service is Medically Necessary and where transportation by ground Ambulance is either not available or would cause an unreasonable risk of harm to the Member because of increased travel time.
- 2.5 **Ambulatory Surgical Facility.** A Facility that is 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 care or treatment of patients nor does it house Hospital beds licensed as such by the state.

- 2.6 Ancillary Providers.** Participating Ancillary Providers are credentialed non-Physician clinicians who may provide either primary, secondary, or ancillary care. See Provision 2.81 “Primary Care Physician or Primary Care Provider (PCP)” and Provision 2.87 “Secondary Care Physician or Secondary Care Provider “SCP” for more information.
- 2.7 Annual Open Enrollment Period.** The period of time specified in the Execution Section each year during which Eligible employees are given the opportunity to enroll themselves and their Eligible Dependents in the Employer’s Plan.
- 2.8 Benefit Rider.** Additional coverage provided by SelectHealth that modifies Limitations and/or Exclusions and is incorporated into this Contract by reference on the Member Payment Summary.
- 2.9 Benefits.** The payment by SelectHealth of Eligible Charges for Covered Services provided to Members, subject to maximums, Limitations, Exclusions and all of the other terms and conditions contained in this Contract, including Exhibit A and the other attachments included with this Contract. Benefits are also subject to the payment by Members of applicable Coinsurance, Copays, and Deductible requirements stated on the member Payment Summary.
- 2.10 Certificate of Coverage.** The Certificate of Coverage is the Member Payment Summary, the Membership Guide, and/or other materials prepared by SelectHealth that provide evidence of coverage under this Contract and are provided to Subscribers by SelectHealth. SelectHealth may, at its option, provide a copy of this Contract in lieu of a Certificate. The Benefits, terms, conditions, Limitations and Exclusions are to be determined solely from this Contract and not by the Certificate of Coverage.
- 2.11 COBRA Continuation Coverage.** The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a 1985 federal law that, as amended, requires that an Employer provide continuation of coverage for certain Members under certain conditions. Utah mini-COBRA is a Utah insurance law that requires continuation of coverage under specified conditions. See Section III, “COBRA or Utah mini-COBRA Coverage.”
- 2.12 Coinsurance.** Coinsurance is a percentage of Provider's or Facilities’ Eligible Charges payable by a Member directly to the Provider and/or Facility at the time of service. The Coinsurance amount is stated in the Member Payment Summary. Failure of a Member to pay the amount specified in the Member Payment Summary, or to make payment arrangements that are satisfactory to the Provider or Facility, may result in the denial of Non-Emergency Services and is grounds for termination of coverage for the Member under this Contract.
- 2.13 Continuation Coverage.** See Provision 3.22 “COBRA or Utah mini-COBRA Coverage.”
- 2.14 Contract.** This Master Group Contract, including the Execution Section, Member Payment Summary, and all other documents expressly referred to and incorporated by reference in any of the documents that make up this Contract.
- 2.15 Conversion Coverage.** Health care coverage provided under a separate conversion policy that is made available to a Member whose coverage is terminated. Such coverage is available for the minimum time required by law after that Member has exhausted all Eligibility for coverage under COBRA or Utah mini-COBRA Coverage.
- 2.16 Copayment (or Copay).** A Copay is a fixed amount payable by a Member to a Provider or Facility at the time of service. The Copay amount is stated in the Member Payment Summary. Failure of a Member to pay the amount specified in the Member Payment Summary, or to make

payment arrangements that are satisfactory to the Provider or Facility, may result in the denial of Non-Emergency Services and is grounds for termination of coverage for the Member under this Contract.

- 2.17 Covered Services.** Subject to all the terms, conditions, Limitations, Exclusions, and requirements of this Contract, Covered Services are the Medically Necessary care, services, treatments, drugs, medications, supplies, and equipment used for the treatment and diagnosis of conditions to which Benefits apply. Covered Services generally include Emergency Services, Inpatient Hospital Services, Physician Services, Outpatient Medical Services, and some limited out-of-area coverage for Emergency and Urgent Care. Covered Services include care, services, treatments, drugs, medications, supplies, and equipment for which no payment is actually made by SelectHealth because of the application of Copay, Coinsurance, or Deductible requirements.
- 2.18 Custodial Care, Long Term Care.** Institutional care (including room and board needed to provide that care) provided primarily to maintain rather than improve a patient's condition, or for the purpose of controlling or changing the patient's environment, including but not limited to, care that could be rendered by non-licensed persons for the purpose of meeting personal needs, domiciliary or convalescent care, rest cures, nursing home services, etc. It is care that is provided principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training.
- 2.19 Deductible(s).** An amount that must be paid by the member for Covered Services during a specified period before SelectHealth will make any payment for a particular or all of Covered Services. See Medical Deductible, Mental Health Deductible and/or Pharmacy Deductible.
- 2.21 Diagnostic Test, Major.** A test is determined to be a Major Diagnostic Test based on several different considerations. These considerations include but are not limited to the invasiveness and complexity of performing the test, the level of expertise required to interpret or perform the test, and the place of service where the test is commonly performed. Major Diagnostic Tests include but are not limited to:
- Imaging studies such as MRIs, CT scans PET scans;
  - Neurologic studies such as EMGs and nerve conduction studies;
  - Cardiovascular procedures such as coronary angiograms;
  - Gastrointestinal procedures such as EGDs, ERCPs and colonoscopies; and
  - Gene based testing and genetic testing.
- Tests involving new technologies will be categorized as major if they are similar to these tests in terms of invasiveness, complexity, level of expertise required, or place of service.
- 2.22 Diagnostic Test, Minor.** Tests not meeting the definition of Major Diagnostic Test are by definition considered Minor Diagnostic Tests. Examples of common Minor Diagnostic Tests include routine blood and urine tests, simple X-rays such as chest and long bone X-rays, bone density tests, some EKG's, and echocardiograms.
- 2.23 Durable Medical Equipment (DME).** Medically Necessary equipment that is: (a) prescribed by a Physician; (b) able to withstand repeated use; (c) primarily designated for medical purposes and not for convenience, contentment, personal comfort, or other non-therapeutic purposes; (d) required for activities of daily living; and (e) is generally not useful in the absence of an illness or injury.
- 2.24 Effective Date.** The date on which this Contract goes into effect and coverage begins.
- 2.25 Eligible, Eligibility.** In order to be eligible, an employee of Employer or an Eligible Dependent of a Subscriber must meet the criteria for participation and enrollment specified in the Execution Section and elsewhere in this Contract. A person may only be considered an employee if the

Employer withholds and pays to the government, Social Security and Medicare taxes and income tax withholding on the employee's wages. SelectHealth has the right to audit Employer records to determine employee status.

**2.26 Eligible Charges, Fee Schedule for Providers and Facilities.** The maximum dollar amount allowed by SelectHealth for a specific Covered Service rendered by Providers and Facilities. Deductibles and Coinsurance amounts are calculated based on Eligible Charges and not billed charges. Participating Providers and Facilities accept this allowed amount as payment in full for Covered Services. Non-Participating Providers and Facilities may not accept this amount as payment in full for Covered Services and Members are required to pay the difference. Fees for claims for services outside of SelectHealth's Service Area are determined in one or more of several possible ways determined or negotiated by SelectHealth in its discretion, such as contracting services through a network, discounted fee for service, use of a fee schedule, and possibly other ways. Members are required to pay a share of Eligible Charges as Copays, Coinsurance, and/or Deductible, when otherwise applicable.

**2.27 Eligible Dependent.** A Subscriber's lawful spouse and any child who meets the Eligibility criteria set forth in this Contract according to Part 3.3.1 "Eligible Dependents" of this Contract.

**2.28 Emergency Services/Emergency Care.** Care, services, treatments, drugs, medications, supplies, or equipment that are provided for a condition of recent onset and sufficient severity, including but not limited to severe pain. In an Emergency Care situation, this severe condition would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

- placing the patient's health in serious jeopardy;
- placing the health of a pregnant woman or her unborn child in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Obvious examples of conditions requiring immediate medical attention include, but are not limited to the following:

- sudden, unexplained loss of consciousness;
- breathing stops;
- major bleeding; and
- heart attack (typically a heavy, crushing chest pain).

There are two (2) Benefit levels for Emergency Room Care, Participating and Non-Participating, regardless of Service Area. Refer to the Member Payment Summary.

Emergency Services may be obtained from the closest available Facility, regardless of whether that Facility is under contract with SelectHealth. Once the emergency condition has been stabilized, SelectHealth may request that the Member be transferred and transported, at SelectHealth's expense, to a Participating Facility for the remainder of the required care. If the Member chooses to remain at the Non-Participating Facility after the emergency condition has been stabilized, additional care or services and follow-up care will not be covered. If hospitalized for an emergency in a Non-Participating Facility, the Member or the Member's representative must contact SelectHealth within two (2) working days, or as soon as reasonably possible.

**2.29 Employer.** The party named in the Execution Section of this Contract whose relationship with Eligible employees provides the basis for the enrollment of Members.

- 2.30 Employer Waiting Period.** The time period that a newly hired employee must wait before he/she is Eligible for coverage. Subject to approval by SelectHealth, the Employer specifies in the Execution Section the amount of time for this waiting period.
- 2.31 Employer's Plan.** The group health plan sponsored by the Employer and insured under this Contract with SelectHealth.
- 2.32 Endorsement.** A document that amends the Contract by increasing or decreasing Benefits, waiving a condition of coverage, or in any other way changing the original Contract.
- 2.33 ERISA.** The Employee Retirement Income Security Act (ERISA) is a federal law relating, among other things, to Benefits provided by Employers to employees and their Eligible Dependents. Employer, and not SelectHealth, is responsible for complying with all such laws and with disclosure and reporting requirements related to Employer's health benefit plans, including this Contract.
- 2.34 Excess Charges.** Charges from Providers and Facilities that exceed SelectHealth's Fee Schedule for Covered Services. Members are responsible to pay for Excess Charges from Non-Participating Providers and Facilities. These charges do not apply to Member's Out-of-Pocket Maximum.
- 2.35 Exclusions.** Exclusions are conditions, situations, illnesses, procedures, care, services, treatments, drugs, medications, supplies, or equipment that are not covered by SelectHealth under this Contract. Most Exclusions are set forth in Exhibit A, but other provisions throughout this Contract may have the effect of excluding coverage in particular situations or for particular conditions, situations, illnesses, procedures, Providers, care, services, treatments, drugs, medications, supplies, or equipment.
- 2.36 Execution Section.** A form used by SelectHealth both as an application for coverage by an Employer, and to specify group-specific details of coverage. The Execution Section may contain modifications to the language of this Contract. This form is also used by both parties to manifest their acceptance of this Contract. Other documents, such as Endorsements, may be incorporated by reference into the Execution Section.
- 2.37 Experimental and/or Investigational.** Services, tests, treatments, appliances, drugs, devices, medications, procedures, supplies, equipment (hereafter referred to as "intervention") are considered by SelectHealth to be "experimental" and/or "investigational" if the best available evidence fails to demonstrate direct health benefits that substantially exceed risks, or such evidence fails to validate that the intervention is the "standard of care" within the appropriate medical specialty or are otherwise inconsistent with accepted standards of medical practice, even if approved by the Food and Drug Administration (FDA). This includes, but is not limited to, any service that is research in nature or not generally recognized by the U.S. medical community as conforming to accepted medical practice, and any service for which required government approval has not been granted at the time the service is provided. An intervention is considered Experimental and/or Investigational by SelectHealth in nature if any one or more of the following apply:
- a.** It cannot be lawfully marketed without the approval of the FDA and such approval has not been granted at the time of its use or proposed use; or
  - b.** It is the subject of a current Investigational new drug or new device application on file with the FDA; or
  - 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; or

- d. If thorough review of the peer-reviewed medical literature suggests there is no clear, medical consensus among appropriate experts about the role and value of the intervention; or
- e. It is being delivered or provided 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
- f. The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research or Investigational settings; or
- g. If the predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, effectiveness, or effectiveness compared with conventional alternatives; or
- h. While it is not Experimental or Investigational in itself pursuant to the above, it would not be Medically Necessary but for the provision of a service, test, treatment, appliance, drug, device, medication, procedure, supply, or equipment that is Investigational or Experimental; or
- i. It is being delivered or provided due to psychological events or feelings. This does not exclude Mental Health Benefits that are covered under other provisions within this Contract.

Satisfaction of the above mentioned criteria will be determined exclusively from the following sources:

- a. The Member's medical record;
- b. The protocol(s) pursuant to which the service, test, treatment, appliance, drug, device, medication, procedure, supply, or equipment is to be delivered;
- c. Any consent document the Member has executed or will be asked to execute, in order to undergo or receive the drug, device, treatment, or procedure (or if the Member is a child or incompetent adult, the consent document that the parent or legal guardian has executed or will be asked to execute);
- d. The published peer-reviewed medical literature regarding the services, tests, treatments, appliances, drugs, devices, medications, procedures, supplies, or equipment as applied to similar clinical circumstances; and
- e. Regulations and other official actions and publications issued by the FDA and/or by HHS.

**2.38 Facility.** A health care Facility is an institution that provides certain health care services within specific licensure requirements.

**2.39 Grace Period.** A specified period of time after a Premium is due during which coverage under this Contract continues and the Employer may pay the Premium.

**2.40 Health Benefit Program.** The specific combination of Covered Services, Limitations, Exclusions, and other requirements agreed upon between SelectHealth and Employer as set forth in this Contract including, without limitation, Exhibit A and the Member Payment Summary.

**2.41 Health Care Provider.** See "Provider."

**2.42 Home Bound. Criterion One.** The patient's medical condition restricts his/her ability to leave the home: (1) without the assistance of another individual; or (2) without the assistance of a supportive device; or (3) because absences from the home are medically contraindicated; or

**Criterion Two.** The patient leaves the home: (1) only to receive medical treatment that cannot be provided in the patient's home, i.e., dialysis, chemotherapy, radiation, or other treatments that require equipment that cannot be made available in the patient's home; or (2) infrequently and for short periods of time for non-medical purposes and these absences do not indicate the patient has the capacity to obtain health care provided outside rather than inside the home.

*The patient is not considered Home Bound under either criterion one or criterion two if he/she: (1) leaves the home regularly for social activities; or (2) drives a car; or (3) does regular grocery or other shopping, work, or business.*

**2.43 Home Health Aides/Services.** Services to furnish Personal Care and Additional Care to maintain a Member's health or facilitate treatments.

"Personal Care" is care needed to facilitate treatment or to prevent deterioration of a Member's health, including, but not limited to the following: bathing, dressing, grooming, caring for hair, nail care, oral hygiene, skin care with lotion/powders, changing bed linens for incontinent Member, shaving, deodorant application, foot care, ear care, feeding, assistance with elimination, enemas, routine catheter care, routine colostomy care, assistance with ambulation, changing position in bed, assistance with transfers, simple dressing changes, assistance with medication that are self-administered, assistance with activities directly supportive of skilled therapy, routine maintenance exercises, repetitive speech routines, and routine care of prosthetic and orthotic devices.

"Additional Care" includes but is not limited to the following: administration of oral medications, reading and monitoring oximeters, reading and monitoring apnea and bradycardia monitors, routine oxygen care, chest physiotherapy for chronic respiratory diseases, monitoring routine vital signs, and charting and documentation time.

**2.44 Home Health Care.** Medical care and treatment ordered by a Physician to provide to sick or injured Members at their home by a Nurse or other licensed Health Care Provider who works for an organization that is licensed by the state where services are provided to render such medical care and treatment.

**2.45 Hospice Care.** Palliative and supportive care provided on an inpatient or outpatient basis to terminally ill patients not expected to live more than six (6) months; may also be provided to the patient's immediate family at the family's expense.

**2.46 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.

**2.47 Identification Card.** The card issued by SelectHealth to a Subscriber that provides limited information about the Health Benefit Program in which the Subscriber is enrolled and identifies the Subscriber to Participating Providers and Facilities. The Identification Card is nontransferable and it does not guarantee any coverage or Benefits under this Contract for care, services, treatments, drugs, medications, supplies, or equipment.

**2.48 Ineligible Person.** Any individual who does not meet the Eligibility criteria specified in this Contract.

**2.49 Infertility.** The inability to become pregnant, or impregnate.

- 2.50 Initial Eligibility Period.** The period of time, determined by SelectHealth and Employer, during which Eligible employees may enroll themselves and Eligible Dependents under this Contract.
- 2.51 Lifetime Maximum Benefit Limit.** The maximum accumulated amount that SelectHealth will pay for Covered Services rendered to a Member during that Member's lifetime. The limit includes all amounts paid on behalf of the Member under any prior health benefit plans insured by SelectHealth or any of its affiliated or subsidiary companies. The Lifetime Maximum Benefit Limit amount is specified on the Member Payment Summary. The limit includes the dollar amounts that are applied to the Annual Out-of-Network Maximum.
- 2.52 Limitations.** Care, services, treatments, drugs, medications, supplies, or equipment covered for Members under this Contract only to a limited extent, or only in particular situations or circumstances. Most Limitations are set forth in Exhibit A, but other provisions throughout this Contract may have the effect of limiting coverage of particular care, services, treatments, drugs, medications, supplies, or equipment.
- 2.53 Master Group Contract.** See "Contract"
- 2.54 Medical Deductible.** The fixed, out-of-pocket amount payable each Year directly to Providers at the time of service by a Member that must be paid toward medical Covered Services before medical Benefits are payable by SelectHealth. The Medical Deductible is specified in the Member Payment Summary. Failure of a Member to pay the Medical Deductible amount specified in the Member Payment Summary, or to make payment arrangements that are satisfactory to the Provider, may result in the denial of Non-Emergency Services and is grounds for termination of coverage for the Member under this Contract. Amounts paid for mental health services or pharmacy are not included in determining when this deductible has been satisfied.
- 2.55 Medical Director.** The Physician designated as such by SelectHealth.
- 2.56 Medical Necessity/Medically Necessary.** Care, services, treatments, drugs, medications, supplies, or equipment that a prudent health care 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;
  - c. not primarily for the convenience of the patient, Physician, or other Health Care Provider; and
  - d. covered under this Contract.

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 benefits and harms to the Member, and known to be effective. For interventions not yet in widespread use, the effectiveness shall be based on Scientific Evidence. For established interventions, the effectiveness shall be based on: (1) Scientific Evidence; (2) professional standards; and (3) expert opinion.

Medical Necessity is determined by the treating Physician and by SelectHealth's Medical Director or another Physician designated by SelectHealth. The fact that a Provider or Facility, even a Participating Provider or Facility, may prescribe, order, recommend, or approve care, services, treatments, drugs, medications, supplies, or equipment does not make it Medically Necessary, even if it is not listed as an Exclusion or Limitation.

**2.57 Medical Out-of-Pocket Maximum.** The maximum dollar amount per Year of medical Eligible Charges payable by a Member directly to Providers and/or Facilities as Medical Deductibles, Copays and Coinsurance. The Medical Out-of-Pocket Maximum and charges that do not apply to the Medical Out-of-Pocket Maximum are specified on the Member Payment Summary. Except where noted otherwise on the Member Payment Summary, SelectHealth will pay 100% of medical Eligible Charges during the remainder of the Year once the Medical Out-of-Pocket Maximum is satisfied. Member payments for Non-Covered Services or Excess Charges are not applied to the Out-of-Pocket Maximum. Amounts paid for mental health services or pharmacy are not included in determining when this out-of-pocket maximum has been satisfied.

**2.58 Member.** An Eligible person who enrolled with SelectHealth through Employer's group to receive Benefits and who is recognized by SelectHealth as a Member. To become a Member, a person must be Eligible and must apply to and be accepted by SelectHealth as a Member. Membership is also conditioned upon the timely payment of Premiums by Employer. Unless otherwise indicated in the Execution Section, employees/retirees of Employer who are Eligible to become Members can choose to enroll Eligible Dependents who satisfy dependent Eligibility requirements set forth in this Contract.

In situations requiring consent, payment, or some other action, references to "Member" include the parent or guardian of a minor or disabled Member on behalf of that Member.

**2.59 Member Payment Summary.** The Member Payment Summary is one or more pages incorporated into this Contract that list variable information about the specific Health Benefit Program that Employer has chosen for Members. It lists such things as Copay, Coinsurance, and/or Deductible requirements, Prenotification, Precertification requirements, Limitations on the use of Non-Participating Providers and Facilities, expenses that do not count against the out-of-pocket limits, and similar matters.

**2.60 Mental Health Deductible.** The fixed, out-of-pocket amount payable each Year directly to Providers at the time of service by a Member that must be paid toward Mental Health Covered Services before Mental Health Benefits are payable by SelectHealth. The Mental Health Deductible is specified in the Member Payment Summary. Failure of a Member to pay the Mental Health Deductible amount specified in the Member Payment Summary, or to make payment arrangements that are satisfactory to the Provider, may result in the denial of Non-Emergency Services and is grounds for termination of coverage for the Member under this Contract. This provision only applies if Employer has chosen the "Catastrophic Mental Health and Chemical Dependency" Benefit Rider as specified in the Member Payment Summary.

**2.61 Mental Health Out-of-Pocket Maximum.** The maximum dollar amount per Year of Mental Health Eligible Charges payable by a Member directly to providers as Mental Health Deductibles, Copays and Coinsurance. The Mental Health Out-of-Pocket Maximum and charges that do not apply to the Mental Health Out-of-Pocket Maximum are specified on the Member Payment Summary. Except where noted otherwise on the Member Payment Summary, SelectHealth will pay 100% of Mental Health Eligible Charges during the remainder of the Year once the Mental Health Out-of-Pocket Maximum is satisfied. Member payments for Non-Covered Services or Excess Charges are not applied to the Out-of-Pocket Maximum. This provision only applies if Employer has chosen the "Catastrophic Mental Health and Chemical Dependency" Benefit Rider as specified in the Member Payment Summary.

**2.62 Mental Impairment.** Any mental or psychological disorder, such as mental retardation, emotional or mental illness, and specific learning disabilities as determined by SelectHealth.

**2.63 Miscellaneous Medical Supplies (MMS).** Medically Necessary supplies that are prescribed by a Physician and are: (a) designed for temporary use; (b) not generally reusable; (c) not primarily for convenience, contentment, personal comfort, or other non-therapeutic purposes; and (d) not useful in the absence of an illness or disability.

- 2.64 Month/Monthly.** The period starting with a given day of a calendar month and ending at the end of the day preceding that date in the following calendar month.
- 2.65 Non-Participating Facility.** Health care Facilities that are not under contract with SelectHealth. Except for Emergencies, out-of-area Urgent Conditions, and other exceptions individually approved by SelectHealth, any Covered Services provided by a Non-Participating Facility are not covered.
- 2.66 Non-Participating Provider.** Health Care Providers that are not under contract with SelectHealth. Except for Emergencies, out-of-area Urgent Conditions, and other exceptions individually approved by SelectHealth, services provided by a Non-Participating Provider are not covered.
- 2.67 Nurse.** A graduate Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is licensed by the state where services are provided to provide appropriate nursing care.
- 2.68 Out-of-Pocket Maximum.** A Medical Out-of-Pocket Maximum, Mental Health Out-of-Pocket Maximum and/or Pharmacy Out-of-Pocket Maximum.
- 2.69 Participating Facility.** Facilities under contract with SelectHealth accept Eligible Charges as payment in full for Covered Services provided to Members. These Facilities include Hospitals, Urgent Care centers, Ambulatory Surgical Facilities, laboratory, diagnostic and imaging centers, Skilled Nursing Facilities, and dialysis facilities. The amount or extent of the Benefits provided by SelectHealth generally depends upon whether the care, service, treatment, drug, medication, supply or equipment was obtained from a Participating Facility authorized by SelectHealth to provide care, service, treatment, drug, medication, supply, or equipment.

**Please note:** Unless otherwise expressly authorized by SelectHealth for particular facility services, a professional office or clinic for private practice of a doctor or other professional is not a Participating Facility that is authorized to provide covered imaging (e.g., MRI, CT, and PET Scans), endoscopy laboratory services (e.g., upper GI and colonoscopies), cardiac catheterization laboratory services (e.g., coronary angiography), radiation therapy services, sleep laboratory services, or other services that are otherwise available in Participating Facilities.

- 2.70 Participating Providers.** Health Care Providers under contract with SelectHealth to accept Eligible Charges as payment in full for defined Covered Services provided to Members. These Providers include professionals that deliver health care services such as Primary Care Physicians, Secondary Care Physicians, Ancillary Providers, home health and hospice agencies, and Durable Medical Equipment vendors. The amount or extent of the Benefit provided under this Contract for Covered Services generally depends upon whether the care, service, treatment, drug, medication, supply, or equipment was obtained from a Participating Provider. Unless specifically authorized by SelectHealth, Participating Providers do not have authority to provide services typically provided by Participating Facilities (see Provision 2.69 “Participating Facility”).

**Please note:** Participating Providers that provide Covered Services may in SelectHealth’s discretion be compensated by SelectHealth for its share of Eligible Charges in one or more of several possible ways: discounted fee for service; capitation (fixed payment per Member per month, regardless of level or amount of services rendered); payment of a year end withhold; and possibly other ways. These methods may change from year to year. Some of these payment methods may incentivize Providers to reduce unnecessary health care costs, and efficiently utilize health care resources. However, no payment method is ever used to incentivize any Provider to limit Medically Necessary care to any particular Member or patient. Providers are required and expected, in a cost-effective manner, to directly provide or to assist Members to obtain all Medically Necessary Services that are covered by this Contract. SelectHealth may review

decisions made by Providers for Members, and suggest alternatives that may be more cost effective.

- 2.20 Pervasive Developmental Disorder (PDD/Developmental Delay).** A state in which an individual, usually a child, has not reached certain developmental milestones normal for that individual's age, yet no obvious medical diagnosis or condition has been identified which could explain the cause of this delay. PDD includes but is not limited to five disorders characterized by delays in the development of multiple basic functions including socialization and communication. The most commonly known PDD is (1) Autistic Disorder, with the remaining identified as (2) Rett's Disorder, (3) Childhood Disintegrative Disorder, (4) Asperger's Syndrome, and (5) Pervasive Developmental Disorder Not Otherwise Specified (or PDDNOS).
- 2.71 Pharmacy Deductible.** The amount Members pay each year directly to the pharmacy before SelectHealth will begin to provide any Prescription Drug Benefits. The Pharmacy Deductible, if applicable, is specified on the Member Payment Summary and if applicable, is attached to the Prescription Benefit Rider in this Contract. The Pharmacy Deductible applies only to Prescription Drugs.
- 2.72 Pharmacy Out-of-Pocket Maximum.** The maximum dollar amount per Year of pharmacy Eligible Charges payable by a Member directly to the pharmacy as Pharmacy Deductibles, Copays and Coinsurance. The Pharmacy Out-of-Pocket Maximum, if applicable, is listed on the Member Payment Summary. The Pharmacy Out-of-Pocket Maximum and charges that do not apply to the Out-of-Pocket Maximum are specified on the Member Payment Summary. Except where noted otherwise on the Member Payment Summary, SelectHealth will pay 100% of Eligible pharmacy charges during the remainder of the Year once the Out-of-Pocket Maximum is satisfied. Member payments for Non-Covered Services or Excess Charges are not applied to the Out-of-Pocket Maximum.
- 2.73 Physical Impairment.** Any physiological disorder, or condition, disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory organs, speech organs, cardiovascular, reproductive, digestive, genitor-urinary, hemic and lymphatic, skin, or endocrine.
- 2.74 Physician.** A doctor of medicine or osteopathy who is duly licensed by the state in which he or she provides services and who practices within the scope of his or her license.
- 2.75 Plan Sponsor.** Plan Sponsor is defined in ERISA Section 3(16)(B), 29 U.S.C. 1002(16)(B). In general, a Plan Sponsor is the employer or employers who maintain or establish a plan to provide health care Benefits.
- 2.76 Preauthorization for Certain Drugs.** Providers are required to obtain advance approval for certain drugs before the drug is dispensed to the Member. Providers must Preauthorize these drugs or these drugs will not be covered. A list of these drugs may be obtained by visiting [www.selecthealth.org](http://www.selecthealth.org) or by calling Member Services weekday between 7:00 a.m. and 8:00 p.m. or Saturdays between 9:00 a.m. and 2:00 p.m. at 801-442-5038 in Salt Lake City or 800-538-5038 elsewhere in the Continental U.S.A..
- 2.77 Premiums.** The monetary amount an Employer periodically pays to SelectHealth as consideration for providing Benefits to Members under this Contract. The initial amount of the Premium is specified on the Execution Section. Coverage will be provided according to the terms of this contract when SelectHealth accepts and retains Premiums. However, if Premiums are refunded, coverage will not be provided for the period of time for which the refund applies.
- 2.78 Prenotification or Prenotify.** Prenotification is the process of notifying SelectHealth prior to certain Covered care or Services for which Prenotification is required by SelectHealth's Utilization Management/Quality Improvement Program. Prenotification is the responsibility of Participating

Providers and Facilities, but Members should verify that Providers and/or Facility have Prenotified SelectHealth prior to receiving Covered Services that require Prenotification. Prenotification is not a guarantee that a service is covered under this Contract. Prenotification is not required for Members who reside outside the United States.

**Prenotification does not guarantee coverage by SelectHealth.** For example, a procedure may not be covered, even though a Provider or Facility Prenotified SelectHealth if, at the time the procedure is performed, the Member is no longer covered by SelectHealth; if the Provider or Facility is not authorized by SelectHealth to do the procedure; if the procedure is done in a Facility that is not approved by SelectHealth; or if the procedure differs from the procedure described to SelectHealth during the Prenotification process.

If a previously authorized care, service, treatment, drug, medication, supply, or equipment is not performed within six (6) months, a new authorization is required.

**2.79 Prescription Drugs.** Those medicinal drugs, including insulin that by law must be dispensed by a licensed pharmacist or Physician and that require a Physician's written prescription.

**2.80 Preventive Services.** Examinations, immunizations, certain screening laboratory and x-ray tests, and procedures commonly accepted by clinicians, which when performed periodically can detect disease conditions not known to currently exist in the Member, or which prevent the development of disease conditions in the case of immunizations.

Preventive services include but may not be limited to such tests as screening mammography, colon and prostate cancer screening, flu and pneumonia vaccinations, PAP smears, and routine childhood immunizations. Not every preventive service is appropriate every year. SelectHealth may establish a schedule of yearly or multi-year intervals for the performance of specified Preventive Services.

If a disease state exists for which the treatment of this condition prevents a subsequent condition (e.g. treating high blood pressure preventing a heart attack or stroke) and the purpose of the visit is to evaluate and manage this problem, it is NOT considered a Preventive Services. If management of that condition occurs as part of a visit billed as a yearly preventive health visit it would be covered as Preventive Services.

**2.81 Primary Care Physician or Primary Care Provider (PCP).** A general practitioner who attends to a Member's common medical problems, provides preventive care, and health maintenance. SelectHealth has classified the following types of Physicians and Providers, and their associated physician assistants and nurse practitioners, as PCPs:

- Certified Nurse Midwives;
- Family Practice;
- Geriatrics;
- Internal Medicine;
- Obstetrics and Gynecology (OB/GYN); and
- Pediatrics.

**2.82 Private Duty Nursing.** Medically Necessary Skilled Nursing Services rendered to educate a Member's caregiver on proper procedures for care of the Member during the transition from an acute hospital setting to the home setting.

**2.83 Provider.** A vendor of health care licensed by the state where services are provided to provide care, services, treatments, drugs, medications, supplies, or equipment within the scope of its license. A particular Provider's care, services, treatments, drugs, medications, supplies, or equipment may or may not be either covered by SelectHealth or considered Medically Necessary under this Contract.

**2.84 Qualified Medical Child Support Order.** A court order for the medical support of a child as defined in ERISA Section 609(a)(2)(A) (29 U.S.C. 1169).

**2.85 Respite Care.** Care provided principally for relief, delay, respite, or "rest" from care-taking responsibilities.

**2.86 Scientific Evidence.**

- a. Scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or
- b. Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes.
- c. Scientific Evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company, medical device manufacturer, individuals with apparent vested interest in the results of the study, or a single study without other supportable studies.

**2.87 Secondary Care Physician or Secondary Care Provider (SCP).** Physicians who have specialized in a specific area of care (e.g. orthopedics, cardiology) are classified as Secondary Care Physicians. SelectHealth classifies any Physician who is not identified as a Primary Care Physician (see PCP definition) as an SCP.

In addition, services provided by audiologists, certified registered nurse anesthetists, and optometrists are considered SCP services.

**2.88 Service Area.** The Select Care Service Area is the geographical area defined by the following counties: Beaver, Box Elder, Cache, Davis, Duchesne, Garfield, Iron, Juab, Kane, Millard, Morgan, Piute, Rich, Salt Lake, Sanpete, Sevier, Summit, Tooele, Uintah, Utah, Wasatch, Washington, Wayne, and Weber. However, not all zip codes within these counties are included. As of January 2006, the following zip codes are NOT part of the Select Care Service Area: 84034, 84083, 84313, and 84329. Contact SelectHealth for Service Area information if the U.S. Postal Service changes or adds zip codes after January 2008.

The Select Care Service Area is the area in which SelectHealth arranges for Covered Services for SelectHealth Members from Participating Providers and Facilities. For determination of Urgent Care coverage, the Select Care Service Area is within a forty (40) mile radius of a Select Care Participating Provider or Facility.

**2.89 Skilled Nursing Facility.** A Facility that provides care to improve rather than merely maintain a patient's condition 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 at the patient's expense;
- c. Provides continuous twenty-four (24) hour-a-day nursing service by or under the supervision of a Registered Nurse (RN); and
- d. Maintains a daily medical record of each patient.

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

- 2.90 Skilled Nursing Services.** Services that improve, rather than maintain, a Member's health condition and that require the skills of a licensed Nurse in order to be provided safely and effectively.
- 2.91 Special Enrollment Right.** As required by The Health Insurance Portability and Accountability Act (HIPAA) and HIPAA regulations, means an opportunity to enroll outside the Employer's Annual Open Enrollment Period under the defined circumstances described in Provision 3.8 "Special Enrollment Rights" to become enrolled.
- 2.92 Subscriber.** The individual with employment or another defined relationship to Employer, through whom Eligible Dependents may be enrolled with SelectHealth. Subscribers are also Members.
- 2.93 Urgent Condition/Care.** An Urgent Condition is 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 twenty-four (24) hours (for example: upper or lower respiratory conditions, sore throats, sprains/strains, and headaches). Types of conditions that would never be considered Urgent Care include, but are not limited to: therapy (physical, occupational, speech, chronic pain management), ongoing treatment, preventive care, elective care, extended follow-up care, chemotherapy, radiation, and dialysis. Services are provided for Urgent Conditions through a Participating Provider, Intermountain InstaCare<sup>SM</sup>, or Intermountain KidsCare<sup>SM</sup>. Outside SelectHealth's Service Area, Urgent Care may be obtained from any qualified Health Care Provider or Facility.
- 2.94 Utah mini-COBRA.** Any applicable state law that allows a Member to continue coverage beyond termination. Any continuation of coverage required by state law is separate from COBRA Continuation Coverage but will run concurrently with any required COBRA Continuation Coverage period when applicable. See Provision 3.22 "COBRA or Utah mini-COBRA Coverage."
- 2.95 Utilization Management/Quality Improvement Program.** The procedures that SelectHealth follows to help assure that Medically Necessary Covered Services are provided to Members in high quality, medically appropriate ways, and in cost-effective settings without wasting SelectHealth resources or undue expense.
- 2.96 Year.** Benefits are calculated on a calendar year or plan year basis. Refer to the Member Payment Summary and/or Execution Section to determine whether this Contract is on a calendar year or plan year.
- a.** Each 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. Out-of-pocket maximums and limited benefits start over on January 1.
  - b.** Each plan year begins on the effective date of this Contract at 12:00 a.m. mountain standard time and, unless previously terminated by either party, ends on the last day of the following one (1) year period, at 11:59 p.m. mountain standard time. Out-of-pocket maximums and limited benefits start over each year on the renewal date of this Contract.

### III. ELIGIBILITY, ENROLLMENT, AND TERMINATION.

- 3.1 Employer.** Employer is not the agent of SelectHealth for any purpose, and statements or representations made by Employer or Employer's agents or employees are not binding on SelectHealth. Employer assumes responsibilities under this Contract to help SelectHealth administer the Health Benefit Program for Members enrolled with SelectHealth through Employer. Employer helps with the enrollment process, is required to pay Premiums to SelectHealth, is required to notify SelectHealth of changes in Member status, and agrees to assist SelectHealth in providing notices and distributing information to Members.

To the extent applicable to the Employer group, Employer and not SelectHealth is responsible for all aspects of ERISA compliance for Employer's employee benefit programs. Employer is responsible for all aspects of compliance with COBRA Continuation Coverage and Utah mini-COBRA Coverage requirements (SelectHealth will comply with insurer requirements listed in 31A-22- 722), including but not limited to providing notice to Members of continuation of coverage rights. SelectHealth will not provide COBRA Continuation Coverage or Utah mini-COBRA Coverage in any circumstance in which Employer or a Member fails to strictly adhere to all applicable notice and other requirements and deadlines. SelectHealth will help Employer compile information for reports that relate directly to the health care Benefits available to Members pursuant to this Contract.

- 3.2 Eligibility.** No person may be enrolled who is not Eligible under this Contract to be enrolled, and no care, services, treatments, drugs, medications, supplies or equipment will be covered for any individual who is not enrolled. Only individuals who continuously satisfy the Eligibility criteria of this Contract may be enrolled and continue as Members. Employer, Subscribers, retirees (if allowed), and their Eligible Dependents are responsible for obtaining and submitting to SelectHealth evidence of Eligibility and all other information required by SelectHealth in the enrollment process. SelectHealth will request money back for excess or mistaken payments. For example, if a claim is paid while a person is not Eligible to be a Member, then SelectHealth will request money back. Employer may not change, extend, expand, or waive Eligibility criteria specified in this Contract, including but not limited to the Execution Section, without first obtaining the advance, written approval of an officer of SelectHealth.

**3.2.1 Right to Decline Enrollment.** SelectHealth may decline to enroll individuals or to continue enrollment of Members based on SelectHealth's Contract with Employer and the individual or the group characteristics.

**3.2.2 Coverage Terminated for Cause.** An individual who has been enrolled with SelectHealth and whose coverage was terminated for cause is not Eligible to enroll for twelve (12) months. An individual whose coverage was terminated for cause may appeal this denial of coverage through SelectHealth's appeal process.

**3.2.3 Loss of Eligibility.** Unless an individual's coverage is terminated immediately for cause by SelectHealth, an individual who loses Eligibility to be enrolled will have his/her coverage terminated as of the end of the last day of the month in which the loss of Eligibility occurred; however, if the Eligibility is lost as the result of a termination of employment, the Employer may choose on a uniform and consistent basis to terminate coverage as of the date of termination of employment.

- a. A child ceases to be a Member at the end of the month in which the child no longer meets the Eligibility requirements of an Eligible Dependent.
- b. A Subscriber's spouse ceases to be a Member at the end of the month in which a decree of divorce, in the form of a signed court order (whether or not all property division, support, and other issues are decided), or annulment is granted. Dependent eligibility for a former spouse will not be recognized by SelectHealth

as the result of a court order directing a Subscriber to continue to provide coverage for the former spouse.

- 3.3 Eligibility Criteria.** In consultation with SelectHealth, Employer decides which categories of its employees, retirees and their Eligible Dependents are Eligible to become Members and establishes Eligibility requirements applicable to such individuals. Such individuals must qualify for coverage based on SelectHealth's underwriting criteria. Employer is solely responsible for complying with all state and federal laws and standards relating to Employer's Plans, including coverage for individuals under this Contract.

During the Employer Waiting Period the employee must work the minimum required hours (except for paid time off) specified in the Execution Section, minus hours the employee does not work due to health status, a medical condition, the receipt of health care, or disability. SelectHealth may require payroll reports from Employer to verify the number of hours an employee has worked as well as documentation from employee to verify hours that employee did not work due to health status, a medical condition, the receipt of health care, or disability.

- 3.3.1 Eligible Dependents.** Unless stated otherwise in the Execution Section, a Subscriber may enroll his or her spouse and/or children specified below.

- a. **Spouse.** A Subscriber's lawful spouse may be enrolled as a dependent. A person of the opposite sex who is not formally married to the Subscriber will be enrolled as a lawful spouse only if such person qualifies as a common law spouse under state law at the time of enrollment. Qualification as a common law spouse requires that a court or administrative agency order establishing the marriage be obtained prior to enrollment, with a copy given to SelectHealth at the time of enrollment. A person will not be retroactively enrolled as a spouse as the result of a court or administrative order purporting to establish a common law marriage retroactively. Same sex marriages are not recognized. In cases of court or administrative orders purporting to retroactively either establish or annul/declare void a marriage or divorce, SelectHealth will enroll the Subscriber's lawful spouse on the date the court or administrative order was signed by the court or administrative agency, or the date the order is received by SelectHealth, whichever date is later. Eligibility may not be established retroactively (nunc pro tunc order).
- b. **Children.** The unmarried children (natural, adopted, and children placed for adoption or under legal guardianship through testamentary appointment or court order) of the Subscriber or Subscriber's lawful spouse, who; (i) are under the limiting age specified in the Execution Section; and (ii) rely on the Subscriber for more than half of their support (as described in Section 1.152-1 of the Internal Revenue Code) may be enrolled as Dependents. Unless certified to be disabled under standards prescribed by Utah Code Section 31A-22-611 children lose their Eligibility at age twenty-six (26). If paternity is in question when determining a Dependent child's Eligibility, the Eligible father must provide the Dependent child's birth certificate. If the Eligible father is not listed on the birth certificate, then he must provide a Voluntary Declaration of Paternity that complies with state law. Each of these documents must be notarized.
- c. **Handicapped Children.** In accordance with Utah Code Section 31A-22-611, Dependent children who meet all of the above Eligibility requirements in subsection b "Children" except for age may enroll or remain enrolled as Dependents after reaching the limiting age as long as they: (i) 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 result in death, or which has lasted or can

be expected to last for a continuous period of not less than twelve (12) months; (ii) are chiefly dependent upon the Subscriber or the Subscriber's lawful spouse for support and maintenance since they reached the limiting age; and (iii) have been continuously enrolled in some form of health care coverage, with no break in coverage of more than sixty-three (63) days, under any accident and health insurance since the date they exceeded the limiting age for dependent children. SelectHealth may require proof of the incapacity and dependency be furnished by the Subscriber within thirty (30) days of the effective date or the date the child reaches the limiting age, and annually after the two (2) year period immediately following the child's attainment of the limiting age.

- 3.4 Court Ordered Dependent Coverage.** When the Subscriber or the Subscriber's lawful spouse is required by a court or administrative order to provide health insurance coverage for a child, SelectHealth will enroll the child under the Subscriber's family coverage according to SelectHealth guidelines and only to the minimum extent required by applicable law.

**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 meet the requirements of ERISA Section 609(a) (29 U.S.C. sec. 1169) specifying the following: 1) the name and last known mailing address (if any) of the Subscriber and the name and mailing address of each alternate recipient covered by the order; 2) a reasonable description of the type of coverage to be provided, or the manner in which the coverage will be determined; and 3) the period to which the order applies.

**National Medical Support Notice (NMSN).** An NMSN is a QMCSO issued by a state or local child welfare agency to withhold from an Eligible Employee's income any contributions required under the Contract to provide health insurance coverage for an Eligible child. (See Utah Code sec. 62A-11-326.1.)

- 3.4.1** Employee and, except as provided in Utah Code sec. 31A-22-610.5(4)(a) in the case of a child, the Dependent child must be Eligible in order to be enrolled with SelectHealth. The Eligible employee and/or Eligible Dependent child will be enrolled without regard to enrollment season restrictions and will be subject to applicable waiting period requirements.
- 3.4.2** Coverage will only be provided to a child who is not an otherwise eligible dependent until the age stated in a court or administrative order or age twenty-six (26) if the court or administrative order is silent.
- 3.4.3** Except as provided in Part 3.4.3 c., an Eligible enrolled out-of-area Dependent child who does not reside with the parent who is responsible for providing health insurance coverage required by a court or administrative order and does not reside in SelectHealth's Service Area may receive Covered Services provided by a Non-Participating Provider.
- a.** Such out-of-area Covered Services will be paid according to SelectHealth's Eligible Charges, Fee Schedule for Providers and Facilities and the Subscriber may be balanced billed by the Non-Participating Provider for any amount not paid by SelectHealth.
  - b.** The child, non-custodial parent, or custodial parent must comply with SelectHealth's Prenotification requirements.
  - c.** Coverage set forth in Part 3.4.3 above does not apply if:

- (1) a Dependent child is over the age of 18 and is no longer enrolled in high school; or
- (2) a parent's Employer offers the parent a choice to select health insurance coverage that is not an HMO plan either at the time of the court or administrative order, or at a subsequent Annual Open Enrollment Period.

**Employer Responsibility.** Compliance with all applicable requirements governing the receipt, acknowledgment, determination and administration of QMCSOs is Employer's sole responsibility. In any circumstance in which Employer directs SelectHealth to enroll an alternate recipient on the basis of a QMCSO, SelectHealth reserves the right to review and confirm Employer's determination that the order is qualified. SelectHealth will not enroll an alternate recipient unless it is able to confirm the existence of a QMCSO.

If SelectHealth confirms that the order is qualified, the Effective Date of coverage for the applicable alternate recipient(s) will be the later of:

- the start date indicated in the order;
- the Subscriber's satisfaction of any applicable waiting period; and
- the date the order is received by SelectHealth.

When SelectHealth receives an order for termination of Court Ordered Dependent Coverage, coverage will terminate the end of month in which SelectHealth receives the court order.

### **3.5 Enrollment.**

**3.5.1 Enrollment Responsibility.** Once applicable Premiums have been paid to SelectHealth by Employer, then Benefits are available for Members who are properly and timely enrolled with the Employer's Plan according to this Contract, and who are accepted as Members by SelectHealth. Employer agrees to limit enrollment to Eligible employees and their Eligible Dependents as set forth in this Contract. Employer acknowledges that compliance with any enrollment requirements and standards imposed by state or federal laws or regulations is Employer's exclusive responsibility.

**3.5.2 Enrollment Procedure.** Eligible individuals may enroll themselves and their Eligible Dependents in the Employer's Plan during the Initial Eligibility Period or during an Annual Open Enrollment Period. (Whether there will be Annual Open Enrollment Periods is specified in the Execution Section.) Employer and each Member are responsible for submitting all required enrollment materials required by SelectHealth. An individual is not considered enrolled until:

- a. all enrollment information is provided to SelectHealth;
- b. the Premium has been paid to SelectHealth; and
- c. the individual has been formally accepted, in writing, as a Member by SelectHealth.

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

**3.5.3 Enrollment Forms.** Unless separately agreed to in writing by SelectHealth and Employer, enrollment will be done on forms specified by SelectHealth.

Any act or practice that constitutes fraud in connection with the coverage or application, or an intentional material misrepresentation of material fact in connection with the coverage or application, is grounds for termination. Intentional material

misrepresentation or fraud to questions relating to insurability can serve as the basis for termination or reformation of coverage during the two (2) year period after a Member first enrolls for SelectHealth coverage. Any fraudulent misrepresentation during the enrollment process can serve as the basis for termination at any time.

If SelectHealth should, at its discretion, and at Employer's request, agree to use the Employer's enrollment forms, then Employer agrees to protect, defend, and hold SelectHealth harmless from and against any and all expenses, claims, liability, or damages arising from or reasonably attributable to the failure of Employer's forms to cover and provide all items of consent, disclosure, and needed information that would otherwise have been agreed to by Subscribers and provided to SelectHealth if SelectHealth's usual enrollment forms had been used and properly filled out by Subscribers. Employer also agrees to file or allow SelectHealth to file for use or approval by the appropriate State Insurance Department such enrollment forms prior to use of the forms.

- 3.6 Effective Date of Coverage.** A Member's coverage will take effect as indicated in the following provisions, when applicable, but only if Health Plans: a) timely receives a properly completed enrollment form, b) receives payment of Premium for such coverage, and c) formally approves such person as a Member in writing.
- 3.6.1 Group Effective Date.** Upon the execution of this Contract, coverage will take effect as of the Group Effective Date specified on the first page of this Contract.
- 3.6.2 Annual Open Enrollment.** Coverage elected during Employer's Annual Open Enrollment Period will take effect on the next anniversary of the Group Effective Date.
- 3.6.3 Newly Eligible Members.** Coverage for a newly Eligible employee and his/her Eligible Dependents, if any, will take effect on the date specified in the Execution Section if SelectHealth receives a properly completed enrollment form within thirty-one (31) days of the date the individual becomes Eligible.
- 3.6.4 Special Enrollment Right.** Coverage elected under a Special Enrollment Right will take effect as specified in Provision 3.8 "Special Enrollment Rights."
- 3.7 Eligible Employees Who Waive Coverage.** Eligible employees who do not enroll in coverage for themselves and/or their Eligible Dependents may not enroll themselves and/or Eligible Dependents until the next Annual Open Enrollment Period unless they experience an event that creates a Special Enrollment Right.
- 3.8 Special Enrollment Rights.** SelectHealth provides Special Enrollment Rights in the following four circumstances:
- 3.8.1 Loss of Other Coverage.** Eligible employee and/or their Eligible Dependents who do not initially enroll in coverage may enroll in coverage at a time other than open enrollment if each of the following conditions is met —
- The Eligible employee initially declined to enroll in this coverage due to the existence of other health plan coverage;
  - The Eligible employee stated in writing at the time on the initial enrollment form that the employee declined to enroll in this coverage due to the existence of the other health plan coverage;
  - The loss of the other health plan coverage was involuntary (this Special Enrollment Right will not apply if the other coverage is lost due to an individual's nonpayment of Premiums or cost sharing);

- Exception: there is an exception for Eligible Dependents who voluntarily drop their coverage under another large group health plan (more than 51 Subscribers) during an open enrollment period under the other large group health plan that does not coincide with the Employer's Annual Open Enrollment Period. A special enrollment period will be permitted for such Eligible Dependents in order to avoid a gap in coverage; and
- **The Eligible employee and/or Eligible Dependents who lost the other coverage must enroll in this coverage within thirty-one (31) days after the date the other coverage is lost.**

**Proof of loss of the other coverage (Certificate of Creditable 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 on applicable Members.** In the absence of a Certificate of Creditable Coverage, SelectHealth will accept the following:

- Explanations of Benefits (EOB) claims or other correspondence from a plan or issuer indicating coverage;
- Pay stubs showing a payroll deduction for health coverage;
- A plan ID Card;
- Records from medical care providers indicating health coverage;
- Third party statements verifying periods of coverage;
- Any other relevant documents that evidence periods of health coverage; or
- A telephone call from the other insurer to SelectHealth verifying coverage.

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

### **3.8.2. New Dependents. If:**

- A Subscriber is enrolled in this coverage (or is Eligible to be covered but declined to enroll during a previous enrollment period) and
- Gains an Eligible Dependent through marriage, birth, adoption or placement for adoption with the Subscriber or the Subscriber's lawful spouse, then the Subscriber may enroll the Eligible Dependent (and him/herself, if not otherwise enrolled) under this coverage. In the case of birth or adoption of a child, the Subscriber may also enroll the Subscriber's Eligible spouse, even if he/she is not newly Eligible as a Dependent. However, **this Special Enrollment Right is only available by enrolling within thirty-one (31) days of the marriage, birth, adoption or placement for adoption** (there is an exception for enrolling a newborn, adopted child, or child placed for adoption if enrolling the child does not change the Premium, as explained in Provision 3.9 "Enrolling a Newborn Child, Adopted Child, or Child Placed for Adoption" below).

Coverage of any Members properly enrolled under this Special Enrollment Right will be effective as indicated as the result of the following situations:

- marriage, as of the date of the marriage;
- a Dependent's birth, as of the date of the birth; or
- a Dependent's adoption or placement for adoption if the child is LESS than thirty-one (31) days old, coverage will begin on the date of birth; if the child is MORE than thirty-one (31) days old when adopted or placed for adoption, coverage will begin on the child's date of placement.

**Note:** SelectHealth must receive a copy of the adoption/placement papers before a Dependent who has been adopted/placed for adoption can be enrolled in coverage.

**3.8.3 Legal Guardianship.** Subscribers may enroll as Eligible Dependents the unmarried, financially dependent children who are placed under the legal guardianship (through testamentary appointment or court order) of the Subscriber or Subscriber's lawful spouse and who are under the limiting age.

The Subscriber must enroll any such children within thirty-one (31) days of receiving legal guardianship. Coverage for any Members properly enrolled under this Special Enrollment Right will be effective the later of:

- The date of the court order or testamentary appointment; or
- The date the order is received by SelectHealth.

**Note:** A child is not Eligible to be added as an Eligible Dependent when the Subscriber or the Subscriber's spouse is designated as the child's guardian for school residency purposes. A child is not Eligible to be added as an Eligible Dependent when the Subscriber or the Subscriber's spouse is designated as the child's temporary guardian.

**3.8.4 Annulment of a Dependent Child's Marriage.** Subscribers may enroll as an Eligible Dependent a financially dependent child of the Subscriber or Subscriber's lawful spouse who is under age twenty-six (26) and who becomes financially dependent on the Subscriber or Subscriber's lawful spouse as the result of a divorce or an annulment of the child's marriage. The Subscriber must enroll any such children within thirty-one (31) days after the signing by the court of the order granting the divorce/annulment or must wait until the next Annual Open Enrollment Period. Coverage for any children properly enrolled under this Special Enrollment Right will be effective on the effective date of the divorce/annulment if that date is within six (6) months of date of marriage. If the court signs the order granting the divorce/annulment more than six (6) months from the date of marriage, coverage for any child properly enrolled will be effective on the date the order is received by SelectHealth, without consideration of any retroactive effect stated in the order.

**3.9 Enrolling a Newborn, Adopted Child, or Child Placed for Adoption.** Claims for services for a newborn, adopted child, or child placed for adoption will be denied until the child is properly enrolled. A newborn, adopted child, or child placed for adoption must be enrolled within the time frames listed as follows:

- a. If enrolling such child requires additional Premium, Subscriber must enroll the newborn, adopted child, or child placed for adoption within thirty-one (31) days of the child's birth, adoption, or placement for adoption.
- b. If enrolling such child does **not** change the Premium, Subscriber must enroll the newborn, adopted child, or child placed for adoption within thirty-one (31) days from the date SelectHealth mails notification that a claim for services was received for the child, which claim will not be processed until the child is properly enrolled.

If the newborn, adopted child, or child placed for adoption is not enrolled within the applicable timeframe listed in (a) or (b) above, the child may only be enrolled during Employer's next Annual Open Enrollment Period.

If Subscriber loses Eligibility for coverage before the end of the applicable timeframe listed in (a) or (b) above, Subscriber is still allowed to enroll the newborn, adopted child, or child placed for adoption within the applicable time frame. However, the child will only be covered from the

moment of birth, adoption, or placement for adoption until the date that the Subscriber lost Eligibility for coverage.

- 3.10 Dropping A Spouse from Coverage.** A covered spouse may be removed from coverage during the Annual Open Enrollment Period, when the Subscriber presents proof of legal divorce granted in the form of a signed court order (whether or not all property divisions, support, and other issues are decided) or annulment to SelectHealth, or, if allowed by Employer's Eligibility rules, when the Subscriber and spouse sign SelectHealth's change form and submit the form to SelectHealth. If a Subscriber is dropping a spouse because of divorce, the Subscriber must attach a copy of the divorce decree with the change form. Included with the change form should be the first page of the divorce decree, the signature page, and any other portion(s) of the decree that specifies Subscriber's responsibility for dependent coverage. A Subscriber's spouse ceases to be a Member at the end of the month in which the spouse is voluntarily dropped, or at the end of the month in which the decree of divorce or annulment is granted (whether or not the decree finally decides all property, support, and custody issues).
- 3.11 Incarcerated Dependents.** A person incarcerated in a prison, jail, or other correctional facility may not be added as an Eligible Dependent. The Subscriber may remove a spouse or other Dependent from coverage if the spouse or other Dependent is incarcerated in a prison, jail, or other correctional facility as the result of a criminal conviction.
- 3.12 Other Dependents Not Eligible.** Dependents of the Subscriber and the Subscriber's spouse beyond those specified in this Contract are not Eligible to become Members unless enrollment is otherwise required by state or federal law, or unless an exception is specifically stated in the Execution Section.
- 3.13 Changes in Member Information or Eligibility.** Employers have the obligation to notify SelectHealth within thirty-one (31) days whenever there is a change in a Member's situation that may affect the Member's Eligibility or enrollment, or entitle the Member to Continuation Coverage, or alter the duration of an existing period of Continuation Coverage, including but not limited to the following events;
- Adoption of a child, placement of a child for adoption, birth of a child, or gaining legal guardianship of a child;
  - Child loses Dependent status (e.g., marriage, turning age twenty-six (26), no longer financially dependent);
  - Death;
  - Divorce (granted in the form of a court order, whether or not all property division, support, and other issues are decided);
  - Marriage;
  - Involuntary loss of other coverage;
  - Member called to active military duty;
  - Employer receives a Qualified Medical Child Support Order (QMCSO);
  - Subscriber's reduction in employment hours;
  - Subscriber takes a leave of absence;
  - Subscriber returns from a leave of absence;
  - Subscriber does not return from a leave of absence;
  - Subscriber's termination of employment.

The Subscriber or Member must promptly notify the Employer/Group Sponsor whenever any of these events occur, and then the Employer/Group Sponsor must promptly transmit this information to SelectHealth with the group's eligibility information.

If a Member obtains other health care coverage, the Member must notify SelectHealth within thirty-one (31) days.

**3.13.1 Subscriber and Member Responsibility.** If the Subscriber fails to notify SelectHealth through their Employer within thirty-one (31) days of an event that results in the loss of Eligibility, SelectHealth may recover the amount of any Benefits the Member(s) received after losing Eligibility.

Both the Member receiving Benefits for which he or she is not Eligible, and the Subscriber who failed to remove an Ineligible Dependent from coverage, are jointly and severally responsible to promptly pay SelectHealth upon request the actual expenses incurred by SelectHealth less any Premiums paid for any care, services, treatments, drugs, medications, supplies, or equipment received by such Member during the period following loss of Eligibility until notification is received by SelectHealth.

**3.13.2 Employer Responsibility.** If the Employer fails to notify SelectHealth within thirty-one (31) days of the termination of a Member from employment or other event that results in the loss of a Member's Eligibility, and to the extent SelectHealth has not recovered the following amounts from the Subscriber or Member pursuant to Part 3.13.1, then Employer agrees to promptly pay SelectHealth upon request the actual expenses incurred by SelectHealth for any care, services, treatments, drugs, medications, supplies, or equipment received by such Member during the period following loss of Eligibility until notification is received by SelectHealth.

**3.13.3 Retroactive Termination of Member.** If SelectHealth discovers that a Member has been enrolled when no longer Eligible under Contract guidelines, SelectHealth will terminate the Member, then require payment as detailed in Parts 3.13.1 and 3.13.2 above.

**3.13.4 No Benefits After Loss of Eligibility.** In no event is SelectHealth responsible for health care claims incurred after a Member's loss of Eligibility, even if SelectHealth is properly notified of the loss.

**3.14 Group Termination.** Subject to Continuation Coverage and/or Conversion Coverage mandated by law, as specified in this Contract for individual Members, if applicable, this Contract, and coverage for all Members under this Contract will terminate for reasons listed below.

**3.14.1 Termination by Employer.** Employer may terminate this Contract, with or without cause, by providing SelectHealth with written notice of termination not less than thirty (30) days before the proposed termination. Any such termination pursuant to this Part 3.14.1 will be effective as of the later of the last day for which current monthly Premium has been paid, or thirty (30) days after receipt of written notice by SelectHealth. **Retroactive termination dates will not be accepted by SelectHealth.** Subject to the other terms of this Contract, any Premium paid by Employer after such termination will be returned to Employer.

It is Employer's responsibility as agent of Subscribers after being notified of discontinuance by SelectHealth to provide immediate written notice of not less than thirty (30) days to Subscribers and to provide proof to SelectHealth of having given such notice. In the event that SelectHealth is required to give such notice, Employer will reimburse SelectHealth for the reasonable cost of giving such notice. Notice given to a Subscriber will be sufficient notice to all Members enrolled as Eligible Dependents of that Subscriber.

**3.14.2 Termination of Employer Group by SelectHealth.** SelectHealth may discontinue coverage under this Contract for an Employer group, and all Members enrolled through that group for any one or more of the following reasons:

- a. Nonpayment of Premiums within the thirty (30) day Grace Period following the due date specified in the Execution Section. SelectHealth may discontinue coverage under this Contract at the end of the thirty (30) day Grace Period. Partial payment will be treated as nonpayment, unless SelectHealth, at its sole discretion, indicates otherwise in writing.

During the thirty (30) day Grace Period, SelectHealth will continue to pay Benefits, Employer will remain liable to pay the Premium, including Premium for the Grace Period, and Members will continue to be responsible for paying all Copays, Coinsurance, and Deductibles, as applicable.

- b. Fraud or intentional material misrepresentation to SelectHealth by employer in any matter related to this Contract, or related to SelectHealth's offer to enter into this Contract with Employer, or related to Employer's administration of Employer's Plan as it relates to SelectHealth.
- c. SelectHealth withdraws from the market in which this Contract is sold in accordance with applicable law.
- d. No Members live, reside, or work in the Service Area of the product in which the Members are enrolled, or in a state where SelectHealth is authorized to do business.
- e. The Membership of the Employer in an association, through which the health insurance coverage under this Contract was made available, ceases.
- f. Failure of Employer group to satisfy SelectHealth's minimum group participation and/or Employer contribution requirements.

**3.14.3 Employer Notice of Termination to Subscribers.** In the event of a termination of this Contract for any reason, it is the Employer's responsibility after being notified of discontinuance by SelectHealth to provide immediate written notice of not less than thirty (30) days to Subscribers. Notice given to a Subscriber will be sufficient notice to all Members enrolled as Eligible Dependents of that Subscriber.

**3.14.4 Liability for Services After Termination.** Participating Providers and Facilities will help in transferring financial responsibility for services obtained after the date of termination from coverage to the Member or to the successor carrier or another payer. All care, services, treatments, drugs, medications, supplies, or equipment obtained after the date of termination are the responsibility of the Member or the subsequent carrier or other Provider of coverage or Facility, and not the responsibility of SelectHealth no matter when the condition arose and despite care or treatment anticipated or already in progress. In some circumstances, subsequent coverage from SelectHealth may be available as either Continuation Coverage or through a Conversion policy.

**3.14.5 Subsequent Coverage.** If this Contract is replaced after its termination by other group health coverage, it is the responsibility of Employer, and not SelectHealth, to attempt to require the succeeding carrier to cover, without qualification, any charges for continuing care beyond the date coverage terminates under this Contract. If this Contract is replaced by other group coverage that covers all preexisting conditions that are covered under this Contract (including but not limited to maternity if maternity is covered under this Contract), Members will have no right to either Conversion or Continuation Coverage under this Contract.

**3.15 Termination of Individual Subscribers and/or Members by SelectHealth.** SelectHealth may terminate coverage of individual Members under this Contract, without affecting this Contract as it relates to an Employer group generally or to other Members, for any of the following reasons:

- a. Fraud or intentional material misrepresentation: in connection with enrollment; in connection with obtaining or requesting Covered Services and/or Prescription Drugs; or in the use of Participating Providers or Facilities.
- b. Failure of the Member to satisfy the Eligibility requirements in this Contract.
- c. The Member no longer lives, works or resides in the Service Area of the product in which the Member is enrolled, or in a state where SelectHealth is authorized to do business.
- d. Repeated failure of the Member to make required payroll deductions or pay Copay, Coinsurance, or Deductible payments required to be paid to Providers or Facilities by this Contract.
- e. In connection with the termination of Employer's group.

**3.15.1** The termination of coverage for a Subscriber will also result in the loss of coverage for all Eligible Dependents enrolled as Members because of their relationship to that Subscriber or to that Subscriber's spouse. Subscribers and their Eligible Dependents, who lose coverage as a result of the Subscriber's coverage termination, may be Eligible for COBRA Continuation Coverage, Utah mini-COBRA Coverage, or Conversion Coverage.

**3.15.2** The termination of coverage of an Eligible Dependent for cause does not necessarily affect the Eligibility or enrollment of the Subscriber or the other Eligible Dependents enrolled through that Subscriber. Eligible Dependents who lose coverage may be Eligible for COBRA Continuation Coverage, Utah mini-COBRA Coverage, or Conversion Coverage.

**3.15.3** No Member will be canceled or terminated from coverage after enrollment based on the Member's health. No Member will be terminated from coverage because the Member exercised any right under SelectHealth complaint resolution system. No Member will be terminated for coverage on the basis of race, color, religion, national origin, sex, marital status, or any other basis protected by law.

**3.15.4** If a Member is terminated for fraud or intentional material misrepresentation as specified in "a." above, the Member is allowed to reenroll twelve (12) months after the date of the Member's termination, provided this Contract is still in force. The Member is given notice of this provision at the time of termination.

**3.15.5** Coverage for a Member under the Contract may be canceled, reformed, or rescinded by SelectHealth during the two (2) year period after a Member enrolls or elects to continue coverage with SelectHealth based on enrollment or Eligibility information received that was fraudulent or an intentional material misrepresentation of material fact in connection with the coverage. **Please Note: If a Member's coverage is rescinded as described in this provision, the termination of coverage will relate back to the Effective Date of coverage. SelectHealth will return the amount of Premiums paid to SelectHealth to the Employer, minus an administrative fee, and recover the amount of any claims paid from Providers, Facilities and Members up to the time limits allowed by applicable state and federal law. Therefore, both SelectHealth and the Member are returned to a financial position as if no coverage had ever been in force. This action may be initiated by SelectHealth in the event that there is fraud or an**

**intentional material misrepresentation of material fact in connection with the information that led SelectHealth to provide coverage.**

- 3.16 Leave of Absence.** A Leave of Absence is a change in a Member's status. The Employer has the obligation to notify SelectHealth within thirty-one (31) days whenever a Member takes a Leave of Absence. A Subscriber who is granted a temporary leave of absence by Employer may, with any enrolled Eligible Dependents, continue to be enrolled with SelectHealth for up to the length of time specified in the Execution Section, if the monthly Premiums are paid for such persons to SelectHealth by Employer. Military personnel called into active duty will continue to be covered only to the extent required by law. A Leave of Absence may not be treated retroactively as a termination of employment.
- 3.17 Family Medical Leave Act.** Employer must notify SelectHealth immediately when a Subscriber takes a leave of absence. It is the Employer's responsibility to notify Subscribers of the terms and conditions of continuing coverage under the Family Medical Leave Act. SelectHealth recommends that Employer consult with legal counsel regarding Employer's liability under the Family Medical Leave Act if there is a lapse in coverage for a Subscriber and any enrolled Eligible Dependents. SelectHealth will administer coverage for a Subscriber who is on leave under the Family Medical Leave Act as follows:
- a.** A Subscriber may, with any enrolled Eligible Dependents, continue to be enrolled with SelectHealth if the Premiums for such individuals continue to be paid to SelectHealth by Employer;
  - b.** If Premiums are not paid, coverage will be terminated. Upon the Subscriber's return to work, the Subscriber, with any previously enrolled Eligible Dependents who are still Eligible, will be prospectively reinstated if the applicable Premium for such individuals is paid to SelectHealth by Employer within thirty (30) days. SelectHealth will not be responsible for any claims incurred by the Member during this break in coverage;
  - c.** If Premiums are not paid and coverage is terminated, the Subscriber, with any previously enrolled Eligible Dependents, may be retroactively reinstated with no loss in coverage if all back Premiums are paid within thirty (30) days of the Subscriber's return to work.
- 3.18 Leaves to Run Concurrently.** For any employer who grants leaves of absence for Eligible employees, including long term sick leave, that would fall under the definition of a Family Medical Leave Act (FMLA), the required leave of absence will run concurrently with any required FMLA leave of absence.
- 3.19 Layoffs.** For purposes of termination of coverage, laid-off employees are treated the same as terminated employees.
- 3.20 Member Rights When Group Terminates.** To the minimum extent required by law and while this Contract is in effect, a Member whose coverage was terminated may obtain coverage under the Employer's COBRA Continuation Coverage or Utah mini-COBRA Coverage program or under SelectHealth's Conversion Coverage program in effect at the time of termination, subject to the Member's and Employer's strict compliance with all applicable notice and other requirements and deadlines. The Member whose coverage was terminated must exhaust all Eligibility for coverage under COBRA Continuation Coverage or Utah-mini-COBRA Coverage before Conversion Coverage may be obtained from SelectHealth.
- 3.21 Conversion Coverage.** To the minimum extent required by law, SelectHealth will make available to a Member who has lost coverage the opportunity to obtain coverage under a separate Conversion policy unless otherwise expressly stated in this provision. To obtain

Conversion Coverage, the terminating Member must have been covered under this Contract for at least six (6) consecutive months. Application for Conversion Coverage must be made to SelectHealth within sixty (60) days of the loss of other coverage and must be accompanied by the initial Conversion Coverage Premium. Except to the extent otherwise required by law, Conversion Coverage is not available if:

- a. Termination of the prior group coverage occurred because of failure of the Subscriber to pay any required Prepayment Fee or portion thereof while Eligible under such prior group coverage;
- b. Member acquires other group health coverage that covers all conditions that are covered under this Contract, including maternity (if applicable);
- c. Termination of the prior group coverage occurred because the Subscriber performed an act or practice that constitutes fraud, or made an intentional misrepresentation of material fact under the terms of the prior group coverage.

**3.21.1 Right to limit or refuse to issue Conversion Coverage.** SelectHealth may refuse to issue Conversion Coverage or may limit the extent of the Conversion Coverage if the result of the Conversion Coverage would result in the Member being overinsured under standards established by SelectHealth. SelectHealth will only provide such coverage as required by law in any circumstance in which the Member or Employer fails to strictly comply with all applicable conditions and requirements for Conversion Coverage.

**3.21.2 Availability of Conversion Coverage.** Unless expressly stated below, a Conversion policy will only be available from SelectHealth to any Member whose coverage has been terminated for the minimum time required by law for such a policy to continue, and only after the individual has exhausted all Eligibility for coverage under COBRA or Utah mini-COBRA Coverage. A Member's spouse or dependents may remain on Conversion Coverage for the minimum time required by law for such a policy to continue if Subscriber turns sixty-five (65) and wishes to enroll in Medicare.

**3.21.3 Conversion Policy Available.** The Conversion policy offered will be SelectHealth's contract for such coverage in effect at the time of the Member's termination under this Contract, and may contain otherwise lawful terms and conditions that are different from those under this Contract.

**3.21.4 Coverage May be Different.** The coverage under the Conversion policy may not be the same as or may be less than the coverage provided under this Contract.

**3.21.5 Conversion Coverage for Eligible Dependents.** A Subscriber may elect to obtain Conversion Coverage on behalf of family members who were enrolled with SelectHealth as the result of the Subscriber's relationship with Employer. The spouse of a Subscriber or a legal guardian may elect to obtain otherwise available Conversion Coverage on behalf of Members who are minor children or disabled.

**3.21.6 Premiums.** The Premiums charged for Conversion Coverage will be determined by SelectHealth according to normal insurance considerations but without reference to the Member's health. Such Premiums and coverage will be computed without any Exclusion for pre-existing conditions covered for the Member under this Contract at the time other coverage ends. Premiums for Conversion Coverage must be submitted by the Member whose coverage was terminated directly to SelectHealth and are payable not more often than monthly according to SelectHealth's customary procedures for making such collections. **Failure to make timely Premium payments will result in termination of Conversion Coverage.**

**3.21.7 Effective Date.** Conversion Coverage that is properly and timely obtained is effective as of the date of the Member's termination under this Contract or the date of the termination of Continuation of Benefits Eligibility, if applicable.

**3.22 COBRA or Utah mini-COBRA Coverage.** While this Contract is in effect, SelectHealth will assist Employer in providing COBRA or Utah mini-COBRA Coverage to individuals originally enrolled through Employer's group who become entitled to such coverage by operation of law. If Member or Employer fails to strictly comply with all applicable notice and other requirements and deadlines, then SelectHealth will only provide such coverage as required by law under the circumstances. COBRA or Utah mini-COBRA coverage will only be provided during the term of this Contract, unless otherwise expressly stated in this Contract, and only for the minimum time and only to the minimum extent required by applicable state and federal law, and in strict accordance with all provisions of applicable law. State and federal continuation of coverage periods will run concurrently. All Continuation of Coverage from SelectHealth will end when this Contract ends. Application for Utah mini-COBRA Coverage must be made within sixty (60) days after termination of the group coverage.

Employer is responsible for notifying persons entitled to COBRA or Utah mini-COBRA Coverage under this Contract, to notify SelectHealth of such individuals, and to collect and submit to SelectHealth the maximum Premiums allowed by applicable law for Continuation Coverage. Employer may engage the services of a third party contractor to assist with the administration of Continuation Coverage. If this Contract is terminated, Employer is responsible for obtaining substitute coverage to cover all Members who are then enrolled under this COBRA or Utah mini-COBRA Coverage provision. Such coverage must cover all the then existing conditions and ongoing care and treatment of such Members.

**3.22.1 Administrator.** Employer and not SelectHealth is responsible as the "administrator" of Continuation of Coverage procedures and requirements for itself and its Members.

**3.22.2 Documentation.** Any time Employer notifies SelectHealth that a Member is Eligible for Continuation Coverage, Employer must provide to SelectHealth sufficient written documentation of the initial and continuing satisfaction by the Member, Employer and group health plan of all applicable legal requirements relating to Continuation Coverage. SelectHealth will determine whether the documentation is sufficient under this section.

**3.22.3 Indemnification.** Employer agrees to protect, defend, and indemnify SelectHealth from all costs, expenses, claims, damages, and/or judgments against SelectHealth as the result of any actual or claimed failure of Employer to provide COBRA or Utah mini-COBRA Continuation of Coverage or any notice required in connection with such Continuation of Coverage.

**3.23 Member Receiving Treatment at Termination.** Subject to COBRA Continuation of Coverage, Utah mini-COBRA Coverage, and/or Conversion Coverage rights, all coverage and Benefits under this Contract terminate when this Contract terminates, including but not limited to coverage for Members hospitalized or otherwise within a course of care or treatment.

**3.24 Reinstatement.** Any individual Member terminated from coverage under this Contract will be reinstated only with the advance written approval of both SelectHealth and Employer. Members terminated from coverage for cause will not be reinstated without the written approval of an officer of SelectHealth.

#### **IV. CONDITIONS OF SERVICE.**

- 4.1 Records.** Upon request, every Member, and the parent or legal guardian of minor or incompetent Members, will promptly furnish to SelectHealth and, if requested, will furnish to Providers or Facilities, all information reasonably necessary or appropriate to the rendition of any services sought or received by the Member. Such information includes but is not limited to a Member's medical history and prior medical records. No Provider or Facility will have any obligation to provide Non-Emergency Covered Services before the receipt of such information.
- 4.2 Claims and Reimbursements.** Providers and Facilities will usually send their bills directly to SelectHealth and SelectHealth will make payment directly to the Providers and/or Facilities. A written claim for any Emergency Services or for reimbursement of a Covered Service for which the Member has paid should be submitted to SelectHealth by the Member within sixty (60) days of that service or as soon as reasonably possible. The claim should be sent to SelectHealth at the address listed at the end of this Contract. See Provision 7.8 "Claims and Appeals."
- 4.2.1 Eligible Charges.** Amounts charged for Covered Services that exceed Eligible Charges are not covered. Members are not responsible for Excess Charges for Covered Services from Participating Providers or Facilities but generally will be responsible for such charges from Non-Participating Providers or Facilities. Eligible Charges include both the amounts payable by SelectHealth and any amounts payable by Members as a Copay, Coinsurance, or Deductible. If the Member pays a Participating Provider or Facility amounts in excess of the Member's responsibility under this Contract, then that Member must seek a refund directly from that Participating Provider or Facility. The Member is not entitled to any reimbursement from SelectHealth for any payments made to a Provider or Facility.
- 4.2.2 Disputes on Claim Payments/Coverage.** See Provision 7.8 "Claims and Appeals."
- 4.3 Physical Examinations/Second Opinions.** After enrollment, SelectHealth will have the right to request that a Member be examined by a Physician concerning either a second opinion request, a request for Prenotification, or concerning a claim. SelectHealth will be responsible for paying for any such physical examination requested by SelectHealth. For any second opinion examination requested by a Member, the usual Copay/Coinsurance payment requirements for such a service will apply and be payable by the Member. The extent to which routine, periodic physical examinations are a Covered Service is set forth in Exhibit A.
- 4.4 Health Care Providers.** SelectHealth contracts with a reasonable number of Health Care Providers and Facilities to provide Covered Services to Members within the Service Area in which SelectHealth operates. Not all available Providers and Facilities in a community, and not all categories of Providers and Facilities are invited, allowed, or required to have such a contractual relationship with SelectHealth.
- 4.4.1 Level of Benefits.** The level at which Covered Services are covered by SelectHealth generally depends on whether:
- a. the services are obtained from a Participating Provider and Facility;
  - b. SelectHealth has been Prenotified of the service; and
  - c. the Provider, Facility and the Member have otherwise complied with SelectHealth's Utilization Management/Quality Improvement Program.

Services obtained in a way that does not comply with such requirements are either not covered or coverage will be limited.

**4.4.2 Providers and Facilities not Agents/Employees of SelectHealth.** SelectHealth does not employ any Health Care Providers to provide Covered Services, nor does it own any health care Facilities. Participating Providers and Facilities are not agents or employees of SelectHealth, but are independent contractors who have agreed to provide services to Members under certain conditions. Participating Providers employed by companies affiliated with SelectHealth are not agents or employees of SelectHealth. SelectHealth currently makes a reasonable effort, approved by the National Committee for Quality Assurance (NCQA), to credential Participating Providers and Facilities, but it does not guarantee the quality of services rendered to Members by Providers and Facilities, including Participating Providers and Facilities.

Neither SelectHealth nor any Provider can guarantee any outcome or the result of any medical care or health related service. Providers and Facilities, not SelectHealth, are solely responsible for their own actions, or failures to act, in providing health care services to Members.

Health Care Providers and Facilities, including but not limited to Participating Providers and Facilities, are not authorized to speak on behalf of SelectHealth nor to cause SelectHealth to be legally bound by what they say. A recommendation for care, services, treatments, drugs, medications, supplies, or equipment received from a Participating Provider or Facility or other Health Care Provider or Facility does not guarantee that such care, services, treatments, drugs, medications, supplies, or equipment will be covered by SelectHealth.

Participating Providers and Facilities do not have authority, either intentionally or unintentionally, to modify the terms and conditions of this Contract, to extend or modify the Benefits available under this Contract, or to waive or modify any Exclusion, Limitation, Preauthorization for Certain Drugs, or Prenotification requirement. Benefits under this Contract are determined by and limited to the things stated in this Contract.

**4.4.3 Provider Rules and Regulations.** Providers and Facilities may adopt reasonable rules, regulations, practices, and procedures for their own conduct and the conduct of their delivery of services. Members are required to observe and follow such reasonable rules, regulations, practices, and procedures when obtaining Covered Services.

**4.4.4 Provider/Patient Relationship.** Participating Providers, Participating Facilities, other Health Care Providers and Facilities are responsible for establishing and maintaining appropriate Provider/patient relationships with Members, and SelectHealth is not authorized to interfere with those relationships. Such relationships should be established and health care decisions should be made independent of coverage by SelectHealth or any financial considerations under this Contract. SelectHealth is only involved in decisions about what health care services will be covered and paid for by SelectHealth under this Contract. **Decisions about what health care services a Member needs and obtains must be made between the Member and the Health Care Provider without reference to coverage under this Contract. Members are free to obtain and pay for health care services outside the scope of this Contract.**

**4.5 Termination of Participating Provider or Certified Nurse Midwife/Continuity of Care.** If a Participating Provider is no longer affiliated with SelectHealth, SelectHealth shall provide notice of the change to Members who are receiving ongoing care from such Provider thirty (30) days prior to the termination date of the Provider, or within thirty (30) days upon SelectHealth's receipt of notice that the provider is no longer affiliated with SelectHealth.

If a Participating Provider or Certified Nurse Midwife ceases to participate with SelectHealth while a Member is under the Provider's care, SelectHealth will continue to treat the Provider as a Participating Provider until the completion of the care (not to exceed ninety (90) days), or until the

Member is transferred to another Participating Provider or Certified Nurse Midwife, whichever occurs first. However, a Member receiving maternity care in the second or third trimester may continue such care through the first postpartum visit.

To continue care, the Participating Provider or Certified Nurse Midwife must not have been terminated by SelectHealth for quality reasons, must remain in the Service Area, and agree to all of the following:

- to accept SelectHealth Fee Schedule as payment in full;
- to follow SelectHealth's Utilization Management policies and procedures;
- to continue treating the Member; and
- to share information with SelectHealth regarding the treatment plan.

**4.6 Non-Participating Providers and Facilities.** Except for Emergencies, out-of-area Urgent Conditions, and other exceptions individually approved by SelectHealth, any Covered Services rendered, ordered, or prescribed by a Non-Participating Provider or Facility are not covered. Members may not assign their Benefits under this contract to any Non-Participating Provider or Facility.

**4.7 Utilization Management/Quality Improvement Program.** SelectHealth conducts a Utilization Management/Quality Improvement Program to help assure that Medically Necessary Covered Services are provided to Members in high quality, medically appropriate ways, and in cost-effective settings without undue expense or wasting resources. This program includes but is not limited to the following processes:

- a. requiring the use of Participating Providers and Facilities;
- b. Preauthorization for Certain Drugs;
- c. Prenotification of specified kinds of care;
- d. prospective, concurrent, and retrospective review of care;
- e. requiring that certain kinds of care be provided in certain settings, certain Facilities, or from certain kinds of Providers;
- f. establishing target lengths of stay for inpatient care;
- g. discharge planning; and
- h. establishing, reviewing, and revising treatment plans for particular conditions and circumstances, as determined by SelectHealth.

These processes are part of SelectHealth's efforts to control and manage health care costs, and participation in and cooperation with such matters by Members is a condition to receiving Benefits from SelectHealth pursuant to this Contract. All Benefits available under this Contract are conditioned upon and subject to the Member's compliance and cooperation with SelectHealth's Utilization Management/Quality Improvement Program. Utilization Management makes sure the services Members receive match the medical problem. SelectHealth does not pay employees or doctors for the type of decision made. Also, SelectHealth does not tell employees or doctors to deny care that is needed. SelectHealth Utilization Management/Quality Improvement Program is not available to Members who reside outside the United States.

## **V. PROVISIONS RELATING TO BENEFITS AND COVERED SERVICES.**

**5.1 General.** Subject to all the terms, conditions, Limitations and Exclusions in this Contract, Members are entitled to receive Benefits for Medically Necessary basic health care services in the SelectHealth Service Area while they are enrolled with SelectHealth. Such Medically Necessary health care services are called Covered Services and are set forth in greater detail in Exhibit A.

As a condition to receiving Benefits, Members are required to pay to the Health Care Provider(s), and/or Facilities the Coinsurance, Copay, and/or Deductible amounts set forth in the Member Payment Summary. Benefits are also conditioned upon compliance by Members with all the terms and conditions of this Contract. Employer is also required to make timely payment to SelectHealth of the Premiums set forth in the Execution Section.

**5.1.1 Benefits Limited.** Benefits under this Contract are limited in defined ways. Those limits include:

- a. Exclusions (care, services, treatments, drugs, medications, supplies, or equipment not covered under this Contract);
- b. Limitations (care, services, treatments, drugs, medications, supplies, or equipment covered only to a limited extent or only in certain circumstances). These Limitations include, but are not limited to receiving services from Participating Providers and Participating Facilities authorized to provide the services. This includes also, but is not limited to the following services which, unless otherwise specifically authorized by SelectHealth, must be provided in a Participating Facility:
  - Imaging (e.g., MRI, CT, and PET Scans)
  - Endoscopy Laboratory Services (e.g., upper GI and colonoscopies)
  - Cardiac Catheterization Laboratory Services (e.g., coronary angiography)
  - Radiation Therapy
  - Sleep Laboratory Services

These Exclusions and Limitations on coverage are intended to control costs without unduly limiting the access of Members to basic health care services. While in some circumstances these Exclusions and Limitations will result in a desired health care service either not being covered by SelectHealth, or not being covered through a particular Health Care Provider or Facility, or limited in the extent of coverage, they are necessary to help keep the cost of the HMO's services more affordable to greater numbers of employers and Members. Members should thoroughly familiarize themselves with the requirements, conditions, Limitations, and Exclusions in this Contract, including those contained in Exhibit A.

Covered Services that exceed the Benefit Limits specified on the Member Payment Summary (for example: dollars, days, visits, etc.) are not covered Benefits. The amounts paid or charged for services that exceed the Benefit Limits are not applied to the Out-of-Pocket Maximums specified on the Member Payment Summary.

Amounts exceeding Eligible Charges are not covered Benefits. Eligible Charges are the total dollar amounts allowed by SelectHealth for Covered Services. Eligible Charges include both the amounts payable by SelectHealth and any amounts payable by Members as a Copay, Coinsurance, or Deductible. Members are not responsible for Excess Charges for Covered Services from Participating Providers and Facilities but generally will be responsible for such charges from Non-Participating Providers and Facilities.

**Any care, service, treatment, drug, medication, supply, or equipment that does not qualify as a Covered Service is not covered by SelectHealth under this Contract.**

- 5.1.2 Level of Benefits.** The amount and extent of the Benefits provided under this Contract for Covered Services are dependent on whether the Member's health care is obtained from a Participating Provider and/or Facility. Except for Emergencies and out-of-area Urgent Conditions, health care obtained from Non-Participating Providers and Facilities is not covered.
- 5.1.3 Calendar Year or Plan Year Basis.** Benefits are calculated on a calendar year or plan year basis no matter when enrollment occurred. Refer to the Member Payment Summary to determine whether Benefits are calculated on a calendar year or plan year basis. Annual Out-of-Pocket Maximums, annual limited Benefits and Deductibles that are calculated on a Calendar year basis start over each January 1st. Annual Out-of-Pocket Maximums, annual limited Benefits and Deductibles that are calculated on a plan year basis start over each year on the renewal date of this Contract. Some Health Benefit Programs include lifetime Limitations on particular Benefits and such Benefits are calculated on a lifetime rather than a calendar year or plan year basis.
- 5.2 Notification of Benefits.** SelectHealth will prepare and distribute to Subscribers or to Employer for distribution to Subscribers, an appropriate Certificate of Coverage evidencing enrollment with SelectHealth and setting forth the general features of this Contract.
- 5.2.1** Employer and not SelectHealth is responsible for assuring that the notification of Benefits available to Subscribers satisfies any applicable disclosure requirements for Employer's Plan(s) under Federal law. The completion and filing of any reports regarding Employer's Plan(s) is the sole responsibility of Employer.
- 5.2.2** Notwithstanding anything contained in a Certificate of Coverage, in any application, or in any promotional, advertising, or other document not expressly incorporated into this Contract, the Covered Services available under this Contract and the terms, conditions, and Limitations related thereto, are to be determined solely from this Contract and not by reference to any other such materials.
- 5.3 Benefit Changes.** Upon renewal, as set forth in the Master Group Contract and in the Execution Section, SelectHealth may modify Premium, Benefits, Exclusions, Limitations, and/or services by providing the Employer with thirty (30) days advance notice of the change. During the advance notice period, Employer may cancel this Contract by providing SelectHealth with written notice.
- 5.3.1 Notification of Subscribers.** Except as otherwise expressly stated in this Contract or required by state law, Employer is responsible for providing thirty (30) days advance written notice to Subscribers relating to changes in Benefits or procedures under this Contract, including termination of this Contract. SelectHealth will provide copies of documents to be provided to Subscribers by Employer in case of a termination of the group. Employer agrees to reimburse SelectHealth for all reasonable costs and expenses if Employer fails to provide any required notice immediately upon request of SelectHealth and SelectHealth has to provide such notice.
- 5.3.2 Notification of Members.** Each Subscriber agrees to promptly notify his or her Eligible Dependents of all Benefit and other Contract changes.
- 5.3.3. No Vested Rights.** No Subscriber or Member has a vested right in any care, service, treatment, drug, medication, supply, or equipment as a Covered Service. SelectHealth and Employer may make changes to this Contract without notifying, consulting with, or

obtaining the consent of Member or Subscribers. The rights and interest of Members, at any particular time, depend on the Contract terms in effect at that time.

- 5.4** **Notices.** Any notice required of SelectHealth under this Contract will be sufficient if mailed to the Member, Subscriber, or Employer at the address appearing on the records of SelectHealth. Notice to an Eligible Dependent will be sufficient if given to the Subscriber under whom the Member is enrolled. Any notice to SelectHealth will be sufficient if mailed to the principal office of SelectHealth in Salt Lake City, Utah. All required notices shall be sent by at least first class mail.

## **VI. PROVISIONS RELATING TO LIMITATIONS.**

- 6.1** **General.** The provisions, Limitations, and Exclusions contained in Exhibit A apply to coverage available to Members under this Contract. They are in addition to and not in place of any other Exclusions or Limitations contained in this Contract. Exhibit A and the Member Payment Summary are attached to and made a part of this Contract.
- 6.2** **Limited Coverage.** The Health Benefit Program does not cover all care, services, treatments, drugs, medications, supplies, or equipment that a Member may desire or a Provider or Facility may order or prescribe. The Health Benefit Program does not cover the services of every Health Care Provider or Facility or every category of Health Care Provider or Facility. Some care, services, treatments, drugs, medications, supplies, or equipment is not covered and some is limited in the extent of coverage. Some care, services, treatments, drugs, medications, supplies, or equipment is only covered if it is provided by certain Providers or Facilities, in some specific manner or setting, or following compliance with specified Preauthorization for Certain Drugs, or Prenotification requirements. Some care, services, treatments, drugs, medications, supplies, or equipment is not covered for a specified period of time after initial enrollment with SelectHealth. The care, services, treatments, drugs, medications, supplies, or equipment that is not covered or is limited generally is described in Exhibit A.

The Limitations and Exclusions set forth in Exhibit A are in addition to the terms, conditions, and any other Limitations set forth elsewhere in this Contract. Therefore, to be covered by the Health Benefit Program, care, services, treatments, drugs, medications, supplies, or equipment must be covered under this Contract and not limited or not covered from coverage by the terms of Exhibit A, the Member Payment Summary, or the Execution Section.

Some otherwise covered care, services, treatments, drugs, medications, supplies, or equipment listed in Exhibit A are either not covered or are limited in the extent of coverage during a Member's initial period of coverage as specified in the Execution Section or the Member Payment Summary.

- 6.3** **Non-Covered Services.** When a procedure that is not a Covered Service is performed as part of the same operation or process as a Covered Service (for example: a covered, therapeutic procedure is performed during the same operation as a non-covered cosmetic procedure), only Eligible Charges relating to the Covered Service will be Eligible for Benefits. Eligible Charges may be calculated to exclude any charges related to the Non-Covered Service.
- 6.4** **Management of Care.** On a case by case basis, and if not prohibited by law, SelectHealth may in its sole discretion extend or add Benefits to cover care, services, treatments, drugs, medications, supplies, or equipment that are not otherwise expressly covered under this Contract or limited under this Contract. In making such a decision to extend or add a Benefit, SelectHealth may consider such things as whether such service/method of treatment is medically appropriate, whether such service/method of treatment is more cost-effective than alternative care to which the Member may otherwise be entitled, the possibility of preventing foreseeable future medical problems, and Member and provider preferences. SelectHealth reserves the right to specify the providers and circumstances in which such additional care will be provided and/or to limit

payment for additional services described in this paragraph to those amounts that would have been paid by SelectHealth had they been provided in the Service Area by Participating Providers. Benefits paid under this provision are subject to all other Member payment obligations of this Contract (such as Copays, Coinsurance, and Deductibles), as specified on the Member Payment Summary. This paragraph will not be used to deprive a Member of any care, services, treatments, drugs, medications, supplies, or equipment to which the Member is otherwise entitled under this Contract, unless the Member consents in advance and in writing.

**6.5 Out-of-Area Benefits and Services.** The only services covered outside the Service Area are Emergency Services, (out-of-area Emergency Services are covered under the Non-Participating Emergency Room Benefit as specified on the Member Payment Summary) and Urgent Care Services. In very limited circumstances approved in advance and in writing by SelectHealth, otherwise Covered Services that are not available from any Participating Provider or Facility and are not available in the Service Area may be approved for coverage from an out-of-Service Area Provider or Facility.

**6.6 Subrogation/Restitution.** As a result of this Contract and as a condition to receiving Covered Services or Benefits under this Contract, Members agree that SelectHealth is automatically subrogated to, and has a right to receive equitable restitution from, any right of recovery a Member may have against any third party as the result of an accident, illness, injury, or other condition involving the third party that causes the Member to obtain Covered Services of any type that are paid for or provided by SelectHealth. To the extent of all payments, costs, and expenses paid by SelectHealth because of any such accident, illness, injury, or other condition, SelectHealth is entitled to receive as equitable restitution the proceeds of any judgment, settlement, or other payment paid or payable in satisfaction of any such claim or potential claim that the Member has or could assert against the third party. Any funds recovered by a Member by way of settlement, judgment, or other award from a third party or from Member's own insurance due to an accident, illness, injury, or other condition involving a third party as described in this Provision 6.6 shall be held by Member (or Member's agent or attorney) in a constructive trust for the benefit of SelectHealth until SelectHealth's equitable restitution interest has been satisfied. SelectHealth shall have the right to intervene in any lawsuit, threatened lawsuit, or settlement negotiation involving a third party for purposes of asserting and collecting its equitable restitution interest as described in this Provision 6.6. SelectHealth shall have the right to bring a lawsuit against, or assert a counterclaim or cross-claim against, Member or Member's agent or attorney for purposes of collecting SelectHealth equitable restitution interest or to enforce the constructive trust required by this Provision 6.6. **Except for proceeds obtained from uninsured or underinsured motorist coverage, this contractual right of subrogation/restitution applies whether or not the Member believes that he or she has been made whole or otherwise fully compensated by any recovery or potential recovery from the third party.** The obligation of Members and the corresponding right of SelectHealth described in this provision applies and extends to that portion not specified as compensation for damages other than medical expenses. Any settlement that does not fairly allocate a reasonable amount to medical expenses (as compared to the total amount of the settlement and the other damages), shall be subject to this subrogation/restitution interest to the same extent as if it had allocated to medical expenses an amount equal to the payments made on behalf of the member by SelectHealth as the result of the event giving rise to the settlement.

Members are required to:

- a. promptly notify SelectHealth of all possible subrogation/restitution situations;
- b. help SelectHealth or its designated agent to assert its subrogation/restitution interest;
- c. not settle any dispute with a third party without protecting SelectHealth's subrogation/restitution interest; and

- d. sign any papers required to enable SelectHealth to assert its subrogation/restitution interest.

SelectHealth's right of subrogation/restitution exists to the full extent of any payments made, services provided, or expenses incurred on behalf of the Member because of or reasonably related to the situation involving the third party.

Member or Member's personal representative will be personally liable for the equitable restitution amount to the extent that SelectHealth does not recover that amount through the process described above.

In addition to SelectHealth's subrogation/restitution right described in this part, if a Member fails to fully cooperate with SelectHealth or its designated agent in asserting SelectHealth's subrogation/restitution right, then SelectHealth may deny coverage under this Contract for any claims arising from the accident, illness, injury, or other condition involving the third party, including but not limited to any complications or extended or follow-up care or treatment. Further, SelectHealth may compromise with a Member on any issue involving subrogation/restitution in a way that includes the Member surrendering the right to receive further care, service, treatment, drug, medication, supply, or equipment under this Contract for the illness, injury, or other condition from which the subrogation/restitution claim arose.

**6.7 Non-Duplication of Coverage.** Unless otherwise expressly required by law, this Contract does not provide coverage for any care, service, treatment, drug, medication, supply, or equipment that is covered by or would have been covered, if the Member (and the Member's parent or spouse or other relative in the case of minor or Dependent Members) had enrolled and maintained coverage in, any one or more of the following:

- a. Automobile insurance, including but not limited to no-fault type coverage up to the minimum amount required of not less than \$3,000 per person. In the event of a claim, the Member should provide a copy of the Personal Injury Protection (PIP) documentation from the automobile insurance carrier. This PIP is a letter, summary, or itemized statement that details which providers have been paid for services rendered due to the accident. If the driver of the vehicle is not related to the Member, then coverage is not available under this contract to the extent that coverage is available under either the driver's or any other driver's PIP;
- b. Workers' Compensation. Coverage under this Contract will be reduced to the extent that Benefits are provided, or would have been provided, had the Member been enrolled, applied, maintained Eligibility, paid any required Premium, and made claim for such Benefits, under Worker's Compensation laws and programs.

SelectHealth does not cover any care, service, treatment, drug, medication, supply or equipment for which the Member or the Member's parent or guardian on behalf of the member has obtained a payment, settlement, judgment, or other recovery or arrangement for future payment intended to compensate the Member, either in whole or in part, for future medical expenses of the kind in issue in connection with the payment, settlement, judgment, or other recovery.

This Contract does not provide coverage for any care, service, treatment, drug, medication, supply, or equipment for a Member incarcerated in a prison, jail, or other correctional facility as the result of an arrest, court order, or a criminal conviction at the time services are provided, including but not limited to any such care provided outside of a correctional facility to a person who has been arrested or is under a court order of incarceration.

**6.8 Coordination of Benefits.** This Coordination of Benefits (COB) provision applies when a Subscriber or the Subscriber's covered Eligible Dependents have health care coverage under more than one health benefit plan. When this COB provision applies, these Coordination of

Benefits rules should be looked at first. The rules determine whether the Benefits of this Contract are primary or secondary to the Benefits of the other coverage.

**6.8.1 Coordination of Benefit Rules.** When this Contract is the primary plan, its Benefits are paid before those of the other health benefit plan and without considering the other health benefit plan's Benefits. When this Contract is the secondary plan, its Benefits are determined after those of the other health benefit plan and may be reduced to prevent duplication of Benefits. When secondary, SelectHealth must calculate the amount of Benefits it would normally pay in the absence of coordination, including the application of credits to any policy maximums, and apply the payable amount to unpaid covered charges owed by the Member after Benefits have been paid by the primary plan. This amount must include Deductibles; Coinsurance and Copays left owing by the Member. SelectHealth can use its own Deductibles, Coinsurance, and Copays to figure the amount it would have paid in the absence of coordination. SelectHealth is not required to pay a higher amount than what it would have paid in the absence of coordination. SelectHealth shall only apply its own Deductibles, Coinsurance, and Copays to the total allowable expenses, not to the amount left owing after payment by any primary plans.

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

When a Benefit has been coordinated incorrectly on the grounds that a claim was timely submitted to one or more secondary plans, SelectHealth will not deny a submitted claim if the claim is submitted to SelectHealth within thirty-six (36) months of the date of service. When a payment between SelectHealth and Provider/Facility has been coordinated incorrectly, SelectHealth will make proper payment adjustment if the request is submitted to SelectHealth within thirty-six (36) months from the date of the payment.

SelectHealth determines whether it has primary or secondary responsibility for Benefit payments using the first of the Coordination of Benefit Rules outlined below, which applies.

- A. Employee, Member, or Subscriber.** The Benefits of the plan, which covers the person as an employee, Member, or Subscriber, that is, other than as a dependent, are determined before those of the plan which covers the person as a dependent.
- B. Dependent Child/Parents Married or Living Together.** The rules for the order of Benefits for a dependent child when the parents are married or living together are as follows:
  - a.** The Benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in the year. ("Birthday" refers only to month and day in a calendar year, not the year in which the person was born.)
  - b.** If both parents have the same birthday, the Benefits of the plan, which covered the parent longer, are determined before those of the plan which covered the other parent for a shorter period of time.

If the other health benefit plan does not have this rule, but instead has a rule based upon another order, and if, as a result the coordinating plans do not agree on the order of Benefits, the rule of the other plan will determine the order of Benefits.

- C. Dependent Child/Parents Separated, Divorced, or Not Living Together.** If two or more health benefit plans cover a child of parents divorced, separated, or not living together, Benefits for the child are payable in this order:
- (1) first, the plan of the custodial parent of the child;
  - (2) then, the plan of the spouse of the custodial parent of the child;
  - (3) the plan of the noncustodial parent; and
  - (4) finally, the plan of the spouse of the noncustodial parent.
- a. **Court Decree.** If the specific terms of a court decree state that one (1) of the parents is responsible for the child's health care expenses, or health insurance coverage, and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no coverage for the child's health care services or expenses, but the parent's spouse does, the spouse's plan is primary.
- b. **Joint Custody.** If the specific terms of a court decree state that the parents have joint custody, without stating that one (1) of the parents is responsible for the health care expenses or health insurance coverage of the child and the child's residency is split between the parents, then the Benefits are determined as outlined above under part B, "Dependent Child/Parents Married or Living Together.
- c. **No Court Decree.** If there is no court decree allocating responsibility for the child's health care services or expenses, the order of Benefit Determination among the plans of the parents and the parent's spouse, if any, is:
- (1) the plan of the custodial parent;
  - (2) the plan of the spouse of the custodial parent;
  - (3) the plan of the noncustodial parent; and then
  - (4) the plan of the spouse of the noncustodial parent.
- D. Active/Inactive Employee, Member, or Subscriber.** The Benefits of a health benefit plan which covers a person as an active employee, Member, or Subscriber are payable before those of a health benefit plan which covers that person as an inactive employee, Member, or Subscriber. If the other health benefit plan does not have this rule, and if, as a result the plans do not agree on the order of Benefits, then this provision is ignored.
- E. Longer/Shorter Length of Coverage.** If none of the above Coordination of Benefit Rules set forth above apply, then the Benefits of the plan which has covered the Member for the longest period of time will be payable first.
- a. To determine the length of time a person has been covered under a plan, two (2) plans shall be treated as one (1) if the Claimant was Eligible under the second within twenty-four (24) hours after the first ended.
- b. The start of a new plan does not include:
- (1) a change in the amount or scope of a plan's Benefits;
  - (2) a change in the entity which pays, provides, or administers the plan's Benefits; or
  - (3) a change from one type of plan to another, such as, from a single employer plan to that of a multiple employer plan.

- c. The Claimant's length of time covered under a plan is measured from the Claimant's first date of coverage under that plan. If that date is not readily available, the date the Claimant first became a Member of the group shall be used as the date from which to determine the length of time the Claimant's coverage under the present plan has been in force.

**6.8.2 Other Health Benefit Plans.** The types of health benefit plans, contracts and programs with which SelectHealth coordinates Benefits include but are not limited to individual, group, and HMO health insurance policies, employee benefit plans, programs that provide hospital, medical-surgical, and other health care related Benefits. Such plans, contracts, and programs include but are not limited to group, group-type and individual automobile "no-fault" medical payment contracts and, to the extent permitted by law, to Medicare and other government Benefits, excluding Medicaid, but will not include hospital indemnity coverage with Benefits not related to expenses incurred, disability income protection coverage, accident only coverage, specific disease or specific accident coverage, nursing home or Long Term care coverage, or Medicare supplement policies.

**6.8.3 Required Information.** Members are required to cooperate with SelectHealth in administering Coordination of Benefits. Such cooperation includes providing notice of other health benefit coverage, divorce decrees, supplying copies of bills and payment notices from other payers, signing documents required by SelectHealth to administer Coordination of Benefits, and other, related matters at the request of SelectHealth.

**6.8.4 Right of Recovery.** If the amount of the payments made by SelectHealth is more than it should have paid, SelectHealth may recover the excess from one or more of the following:

- (1) The insured it has paid. However, reversals of payments made due to issues related to Coordination of Benefits are limited to a time period of eighteen (18) months from the date a payment is made unless the reversal is due to fraudulent acts, fraudulent statements, or intentional material misrepresentation by the Member. It is SelectHealth's responsibility to see that the proper adjustments between insurers and Providers/Facilities are made;
- (2) The Provider or Facility (Participating and Non-Participating) it has paid. It is SelectHealth's responsibility to see that the proper adjustments are made. However, reversals of payments made due to issues related to Coordination of Benefits are limited to a time period of thirty-six (36) months from the date a payment is made unless the reversal is due to fraudulent acts, fraudulent statements, or intentional material misrepresentation by the Member.
- (3) SelectHealth may recover from insurance companies; or
- (4) SelectHealth may recover from other organizations.

**6.8.5 Payments Made.** SelectHealth may make a direct payment to another health benefit plan which paid an amount which should have been paid under the Health Benefit Program. That amount will be treated as though it were a Benefit paid under the Health Benefit Program and SelectHealth will not have to pay that amount again. Any Benefit provided as care, services, treatments, drugs, medications, supplies, or equipment will be treated as a Benefit paid at the reasonable value of such care, services, treatments, drugs, medications, supplies, or equipment.

**6.9 Responses by SelectHealth's Employees.** Certain employees of SelectHealth are engaged in the process of responding to Subscriber, Member, Employer, Participating Provider, and

Participating Facility inquiries about the coverage provided by SelectHealth or about the Limitations or conditions on such coverage. It is agreed that such employees of SelectHealth do not have the authority to extend or modify the coverage or Benefits provided by this Contract as the result of such responses.

- 6.9.1** In the event of any discrepancy between any such information and the written terms of this Contract, the terms of this Contract will control, and the Subscriber, Member, Employer, Participating Provider, or Participating Facility shall not be justified in relying solely on any such employee response.
- 6.9.2** A Subscriber, Member, Employer, Provider, or Facility shall not be justified in relying solely on any such SelectHealth employee response that is contrary to this Contract, taken as a whole, unless such response from SelectHealth is provided in writing and signed by the President, Vice President, or Medical Director of SelectHealth.
- 6.9.3** Clerical or administrative errors will not invalidate coverage otherwise in force or give rise to rights or coverage not otherwise provided for in this Contract.
- 6.9.4** Participating Providers, Participating Facilities, SelectHealth, Employer, Subscribers, and Members will make appropriate adjustments in Premium and charges and payments to correct administrative or payment errors.
- 6.9.5** In the event that SelectHealth chooses to or is required by law to honor any coverage mistakenly authorized or provided, such coverage will be limited to a maximum period of not more than thirty (30) days and SelectHealth will have the right, in its discretion, to change the group's Premium after giving thirty (30) days advance written notice to Employer.

## **VII. GENERAL PROVISIONS.**

- 7.1** **SelectHealth.** SelectHealth is an HMO licensed by the State of Utah that arranges to provide and pay for specified health care services for Members enrolled with SelectHealth as a result of the Members having some relationship with Employer or an employee or retiree of Employer. SelectHealth's obligations to Employer and to Members are determined by and are subject to the terms and conditions of this Contract.

SelectHealth provides managed health care coverage. Such management necessarily limits some choices of Providers and Facilities that might otherwise be available to persons insured under more traditional health insurance programs. Those management procedures and requirements as well as the Limitations and Exclusions contained in Exhibit A, are a part of the arrangement described by this Contract. SelectHealth establishes a Health Benefit Program for Members that is intended to meet basic health care needs, but not necessarily to satisfy Member's every health care need or every desire Members may have for health care services.

SelectHealth is affiliated with Intermountain Healthcare and the affiliated Intermountain companies but is a separate, licensed HMO. Employer and Members agree that this Contract does not involve Intermountain Healthcare or any of the other affiliated Intermountain companies, or their officers or employees, and that such companies are not responsible to Employer, Subscribers, or Members for SelectHealth's obligations, duties, actions, inactions, or responsibilities under this Contract.

SelectHealth establishes reasonable administrative, claims processing, Member Service, Utilization Management, and other functions to aid it in administering Benefits for Members. Members and Participating Providers or Facilities are required to cooperate with such functions when obtaining and providing Covered Services.

**7.2 Entire Contract.** This Contract, including but not limited to Exhibit A, the Execution Section, the Member Payment Summary and any Endorsements constitute the entire Contract between parties. Except as otherwise stated in this Contract, this Contract may only be modified by a written document signed by an officer of SelectHealth and an Authorized Representative of Employer.

**7.3 Distribution of Surplus.** In the discretion of and at the direction of its Board of Directors, SelectHealth may distribute a portion of excess surplus to current policyholders if such policyholders maintain coverage in good standing at the time of distribution. Distribution may be contingent upon the renewal of the policy and timely payment of premium payments to SelectHealth.

**7.4 Premiums.** The fees the Employer pays to SelectHealth as consideration for SelectHealth providing Covered Services to Members under this Contract are known as Premiums.

Employer is responsible for making timely payment of all Premiums to the address provided by SelectHealth to Employer. The amount of Premium or a formula for computing the Premium and the date the Premium is due at SelectHealth office each month is set forth in the Execution Section. The obligation of the Employer to make payments to SelectHealth is not contingent upon Employer's ability to collect the employee's contribution to the Premium, if any.

**7.4.1 Premium Rates.** The rates used for computing the Premium as set forth in the Execution Section will remain the same until the end of the term specified in the Execution Section. However, should federal or state laws or regulations mandate that SelectHealth modify Benefits under this Contract, then SelectHealth may reasonably modify the Premium.

**7.4.2 Modify Premium.** SelectHealth may unilaterally modify the amount of the Premium upon renewal by providing Employer with thirty (30) days advance written notice of the change. During the advance notice period, Employer may cancel this Contract by providing SelectHealth with written notice during the thirty (30) day notice period furnished by SelectHealth. If Employer does not provide such notice, then the change becomes effective upon renewal as specified in the Master Group Contract and Execution Section.

**7.4.3 Right to Audit Employer Records.** Employer agrees to allow SelectHealth to audit Employer's personnel and/or payroll records to verify the status and Eligibility of Members.

**7.5 Grace Period.** A Grace Period of thirty (30) days will be granted for the payment of Premium, during which time the policy will continue in force. In no event will the Grace Period extend beyond the date this Contract terminates.

**7.6 Excess or Mistaken Payments.** SelectHealth will have the right at any time to recover any payment made in excess of SelectHealth's obligations under this Contract, whether such payment was made in error or otherwise. Such recoveries are limited to a time period of eighteen (18) months (or thirty-six (36) months for a coordination of benefits error) from the date a payment is made unless the recovery is due to fraudulent acts, fraudulent statements, or intentional material misrepresentation by the Member. Such right will apply to payments made to Employer, Members, 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 payment against any excess or mistaken payment already made to a Member or for a Member to a Provider or Facility. The making of a payment in error or under a mistaken understanding of the relevant facts is not a recognition by SelectHealth that the service in question is covered under this Contract.

**7.7 Term and Renewal.** The term of this Contract is specified in the Execution Section. Unless terminated by either party, providing not less than thirty (30) days written notice to the other party, this Contract will continue from month to month following the term of this Contract. Subject to any conversion rights under state law, Members whose coverage has not been terminated by SelectHealth can only continue coverage while this Contract is in effect between SelectHealth and Employer. Any renewal of the Contract requires the express, written consent of both SelectHealth and Employer, and does not involve any participation or approval by Subscribers or Members.

**7.8 Claims and Appeals.** This provision contains the claims and appeals procedures and requirements, applicable for new claims and appeals filed on or after January 1, 2008. 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 Membership Guide and Master Group Contract and that, where appropriate, their provisions have been applied consistently with respect to similarly situated Claimants. This provision uses the following additional (capitalized) defined terms:

**Adverse Benefit Determination.** The term Adverse Benefit Determination means any of the following: 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 Utilization Management program, and determinations that particular care or treatment is Experimental and/or Investigational or not Medically Necessary or appropriate.

**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 Care Claim is involved, a health care professional with knowledge of the medical condition will be permitted to act as your Authorized Representative without a prior written authorization.

**Benefit Determination.** A Benefit Determination is the decision by SelectHealth regarding the acceptance or denial of a claim for Benefits under the Master Group Contract.

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

**Concurrent Care Decisions.** Concurrent Care Decisions are decisions by SelectHealth regarding coverage of an ongoing course of treatment that has been approved in advance.

**Pre-Service Appeal.** A Pre-Service Appeal is a request to change an Adverse Benefit Determination for care or services that must be approved, in whole or in part, in advance of the Member obtaining medical care or treatment, for the claimant to receive full benefits under the Master Group Contract.

**Post-Service Appeal.** A Post-Service Appeal is a request to change an Adverse Benefit Determination for care or treatment that has already been received by the Member.

**Post-Service Claim.** A Post-Service Claim is a written request for reimbursement of care or treatment received by the Member.

**Pre-Service Claim.** A Pre-Service Claim is any claim that requires approval prior to obtaining medical care or treatment for the Claimant to receive full Benefits under the Master Group Contract. For example, a request for Precertification under the Utilization Management program is a Pre-Service Claim.

**Pre-Service Inquiry.** A Pre-Service Inquiry is a Member's oral or written inquiry to SelectHealth regarding the existence of coverage under the Master Group Contract for proposed care or treatment that does not involve a Pre-Service Claim, i.e., does not require prior approval for the Claimant to receive full Benefits under the Master Group Contract. Pre-Service Inquiries are not claims and are not treated as Adverse Benefit Determinations.

**Urgent Care Claim.** An Urgent Care Claim is any Pre-Service 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 care or treatment. Whether a claim is an Urgent Care 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 Care Claim will be treated as an Urgent Care Claim.

**7.8.1 How to Make a Pre-Service Inquiry.** Pre-Service Inquiries should be directed to Member Services at **801-442-5038** in Salt Lake City or **800-538-5038** elsewhere in the Continental U.S.A. An Inquiry is not a claim for Benefits.

**7.8.2 How to File a Claim for Benefits.**

**Pre-Service Claims.** The procedures for filing most Pre-Service Claims — Prenotifications and Precertifications — are set forth in the Utilization Management section of this document. If there is any other plan Benefit that would be subject to a Pre-Service Claim, you or your Authorized Representative may file a claim for that Benefit by contacting Member Services at **801-442-5038** in Salt Lake City or **800-538-5038** elsewhere in the Continental U.S.A. Under certain circumstances provided by federal law, if you or your Authorized Representative fail to follow the proper procedures for filing a Pre-Service 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 not later than five (5) days after receipt of the claim and may be oral unless you specifically request it in writing.

**Urgent Care Claims.** In order to file an Urgent Care Claim, you or your Authorized Representative must provide SelectHealth: 1) information sufficient to determine whether, or to what extent, Benefits are covered under the Master Group Contract and 2) a description of the medical circumstances that give rise to the need for expedited review. Under certain circumstances provided by federal law, if you or your Authorized Representative fails to follow the proper procedures for filing an Urgent Care Claim, SelectHealth will notify you of the failure and the proper procedures to be followed. This notification will be provided as soon as reasonably possible, but not later than twenty-four (24) hours after receipt of the claim and may be oral unless you specifically request it in writing.

**Post-Service Claims.** Participating Providers and Facilities directly file all Post-Service Claims with SelectHealth. If you receive a bill from a Participating Provider or Facility, please contact them and ask if SelectHealth has been billed before you make any payment. However, if you need to file a Post-Service Claim from a Non- Participating Provider or Facility, you or your Authorized Representative must submit the Claim in writing in a form pre-approved by SelectHealth. Contact Member Services or your Employer to find out what information is needed to submit a Claim. All Claims must be

received by SelectHealth within a twelve (12) month period from the date of the expense or as soon as reasonably possible.

**7.8.3 Timing of Benefit Determinations.** SelectHealth will make and notify you or your Authorized Representative of Benefit Determinations as follows:

**Urgent Care Claims.** Notice of a Benefit Determination will be provided as soon as possible, taking into account the medical circumstances, but not later than seventy-two (72) hours after receipt of the claim. However, if SelectHealth gives you notice of an incomplete claim, the notice will include a time period of not less than forty-eight (48) hours for you to respond with the requested specified information. SelectHealth will then provide you with the notice of Benefit Determination within forty-eight (48) hours after the earlier of: receipt of the specified information, or the end of the period of time given you to provide the information. If the Benefit Determination is provided orally, it will be followed in writing no later than three (3) days after the oral notice.

If the Urgent Care Claim involves a Concurrent Care Decision, notice of the Benefit Determination will be provided as soon as possible, but not later than twenty-four (24) hours after receipt of your claim for extension of treatment or care, as long as the claim is made at least twenty-four (24) hours before the prescribed period of time expires or the prescribed number of treatments ends.

**Other Pre-Service Claims.** Notice of a Benefit Determination will be provided in writing within a reasonable period appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim. However, this period may be extended one (1) time by SelectHealth for up to an additional fifteen (15) days if SelectHealth both determines that such an extension is necessary due to matters beyond its control and provides you written notice, prior to the end of the original fifteen (15) day period, of the circumstances requiring the extension and the date by which SelectHealth expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least forty-five (45) days from your receipt of the notice to provide the specified 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.

**Post-Service Claims.** Notice of Adverse Benefit Determinations will be provided in writing within a reasonable period of time, but not later than thirty (30) days after receipt of the Claim. However, this period may be extended one (1) time by SelectHealth for up to an additional fifteen (15) days if SelectHealth both determines that such an extension is necessary due to matters beyond its control and provides you written notice, prior to the end of the original thirty (30) 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 specifically describe the required information, and you will be given at least forty-five (45) days from your receipt of the notice to provide the specified information.

The applicable time period for the Benefit Determination begins when your Claim is filed in accordance with the reasonable procedures of SelectHealth, even if you haven't submitted all the information necessary to make a Benefit Determination. However, if the time period for the Benefit Determination is extended due to your failure to submit information necessary to decide a claim, the time period for making the Benefit Determination will be suspended until the earlier of: 1) the date on which you respond to

the request for additional information, or 2) the date established by SelectHealth for the furnishing of the requested information (at least forty-five (45) days).

**7.8.4 Notice of Adverse Benefit Determinations.** If your Claim is subject to an Adverse Benefit Determination, you will receive a notification that includes:

- The specific reason(s) for the Adverse Benefit Determination;
- Reference to the specific provisions on which the Adverse Benefit Determination was based;
- A description of any additional information or material needed from you to complete the Claim and an explanation of why it is necessary;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline protocol, or other similar criterion was relied upon in the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
- If the Adverse Benefit Determination was based on a Medical Necessity, Experimental and/or Investigational or similar Exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Master Group Contract to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
- A description of SelectHealth review or appeal procedures, including applicable time limits, and a statement of your right to bring suit under ERISA Section 502(a) with respect to any Claim denied after an appeal.

**7.8.5 Problem Solving.** SelectHealth is committed to making sure that all of your concerns or problems are investigated and resolved as soon as possible. Most situations can be resolved informally by contacting SelectHealth's Member Services. A Member Services Representative will attempt to resolve the matter informally, usually within seven (7) days.

Call Member Services at **801-442-5038** in Salt Lake City or **800-538-5038** elsewhere in the Continental U.S.A.

**7.8.6 Formal Appeals.** If you are not satisfied with the result of working with Member Services, you and/or your Authorized Representative may file a written formal appeal of any Adverse Benefit Determination or the negative outcome of a Pre-Service Inquiry. 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 under the Master Group Contract.

**General Rules and Procedures.** You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your claim for Benefits. You will also 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.

At each level in the appeal process, no deference will be afforded to the Adverse Benefit Determination, and decisions will be made by appropriately named 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 care, services, treatments, drugs, medications, supplies, or equipment is Experimental and/or Investigational or not Medically Necessary, the fiduciaries at each applicable level 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.

**Form and Timing.** All requests for a formal appeal of an Adverse Benefit Determination (other than those involving an Urgent Care Claim) must be in writing and should include a copy of the Adverse Benefit Determination and any other pertinent information that you wish SelectHealth to review in conjunction with your appeal. Send all information to the SelectHealth Appeals Department at:

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

You may appeal an Adverse Benefit Determination of an Urgent Care Claim on an expedited basis, either orally or in writing. You may appeal orally by calling the SelectHealth Appeals Department at **801-442-4684** in Salt Lake City or **800-538-5038 extension 4684** elsewhere in the Continental U.S.A. If the request is made orally, the SelectHealth Appeals will within twenty-four (24) hours send written confirmation acknowledging the receipt of your request. All necessary information, including SelectHealth determination on review, will be transmitted between SelectHealth and you by telephone, facsimile, or other available similarly expeditious method.

You may also formally appeal the negative outcome of a Pre-Service Inquiry by writing to the SelectHealth Appeals Department at the address set forth above. You should include any information that you wish SelectHealth to review in conjunction with your appeal.

You or your Authorized Representative must file a formal appeal within one hundred eighty (180) days from the date you received notification of the Adverse Benefit Determination or made the Inquiry, as applicable.

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

**Mandatory and Voluntary Appeal Levels.** As described below, the formal appeals process differs for Pre-Service Claims and Post-Service Claims. In each case, there are both mandatory and voluntary levels of review. For purpose of the formal appeals process only, Pre-Service Inquiries will be treated like Pre-Service Claims.

You must exhaust all mandatory levels of review before you may pursue civil action under Section 502(a) of ERISA. It is your choice, however, whether or not to seek voluntary levels of review, and you are not required to do so before pursuing civil action under Section 502(a) of ERISA. SelectHealth agrees that any statute of limitations or other legal defense based on timeliness is suspended during the time that any voluntary appeal level is pending. Your decision whether or not to seek voluntary levels of review will have no effect on your rights to any other Benefits under the Master Group Contract.

SelectHealth will provide you, upon request, sufficient information to enable you to make an informed judgment about whether or not to engage in a voluntary level of review.

- A. **Pre-Service Appeals.** The formal process for Pre-Service Appeals and appealing the negative outcome of a Pre-Service Inquiry provides one mandatory review level, two possible voluntary review levels and the right to pursue civil action under ERISA Section 502(a).

**Step 1–Mandatory Review**

Upon receipt, your appeal will be investigated by the Appeals Department. All relevant, available information will be reviewed by the Appeals Department, the Customer Complaint Review Committee, or an appropriate health care practitioner. The Customer Complaint Review Committee consists of at least three supervisors or managers of SelectHealth and at least one consumer representative, who will be present at every meeting. The Appeals Department will notify you in writing of the appeal decision within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after the receipt of your appeal.

If your appeal involves an Urgent Care 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 not later than seventy-two (72) hours after the receipt of your appeal. A decision communicated orally will be followed-up in writing.

**Step 2–First Level Voluntary Review**

If you are dissatisfied with the decision made under Step 1, mandatory review, you or your Authorized Representative may voluntarily request a review of your appeal by the SelectHealth Grievance Committee. If you are appealing an Adverse Benefit Determination regarding Medical Necessity, you may request a review of your appeal by either the Grievance Committee or an Independent Review Organization (IRO). The Grievance Committee consists of SelectHealth managers, directors and a Physician consultant (when medical issues are involved), and a consumer representative, who will be present at every meeting. You and/or your Authorized Representative may appear in person or by telephone before the Grievance Committee to present any arguments or evidence you feel is relevant to the matter; however, participation is not a requirement. An IRO is an independent external review organization that is not connected in any way with SelectHealth. The IRO engages health care professionals with the appropriate level and type of clinical knowledge and experience to properly judge an appeal. There is no cost to you for the Grievance Committee or IRO appeal. Such a request for this voluntary review must be made in writing to the Appeals Department within sixty (60) days for Grievance Committee review, and one hundred eighty (180) days for an IRO review, from the date the Appeals Department notifies you of its appeal decision. If you are appealing an Adverse Benefit Determination of Medical Necessity, your request must specify whether the appeal is to the Grievance Committee or to an IRO. SelectHealth will notify you of the result of the Grievance Committee or IRO review in writing within thirty (30) days of the date you requested the review.

If your appeal involves an Urgent Care Claim, you may orally 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 not later than seventy-two (72) hours after the receipt of your appeal. A decision communicated orally will be followed-up in writing.

### **Step 3-Second Level Voluntary Review**

If you are dissatisfied with the result of Step 2, first level voluntary review (Grievance Committee or IRO) and you do not require an expedited review, you or your Authorized Representative may voluntarily request to have your appeal reviewed by the SelectHealth Appeals Committee. Such a request must be made in writing to the Appeals Department within sixty (60) days of the date of SelectHealth's response to the first level voluntary review. The Appeals Committee is generally comprised of the Chief Executive Officer (CEO) of SelectHealth, a practicing Physician in the community, legal counsel, an employer from the community who also serves as a Member of the SelectHealth Board of Trustees, and a consumer representative, who will be present at every meeting. You and/or your Authorized Representative may appear in person or by telephone before the Appeals Committee to present any arguments or evidence you feel is relevant to the matter; however, participation is not a requirement. SelectHealth will notify you of the result of the Appeals Committee review in writing within sixty (60) days of the date you requested the review.

**Note:** This second level voluntary review is not available on an expedited basis. There is only one level of voluntary review (Step 2) for Urgent Care Claims that require expedited review.

The Appeals Committee may, in its sole discretion and at no cost to you, seek an assessment from an Independent Review Organization (IRO) in conjunction with its decision if no such review has previously been conducted.

**Civil Action --** At any point after the mandatory review process (Step 1), you may choose to pursue civil action under ERISA Section 502(a). Failure to properly pursue the mandatory appeals process may result in a waiver of the right to challenge SelectHealth original decision.

- B. Post-Service Appeals.** The formal process for Post-Service Appeals provides two mandatory review levels, one voluntary review level, and the right to pursue civil action under ERISA Section 502(a).

### **Step 1-First Level Mandatory Review**

Upon receipt, your appeal will be investigated by the SelectHealth Appeals Department. All relevant information will be reviewed by the Appeals Department, the Customer Complaint Review Committee, or an appropriate health care practitioner. The Appeals Committee consists of at least three supervisors and/or managers of SelectHealth and a consumer representative, who will be present at every meeting. The Customer Relations Department will notify you in writing of the appeal decision within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after the receipt of your appeal.

### **Step 2-Second Level Mandatory Review**

If you are dissatisfied with the decision made under Step 1, first level mandatory review, you or your Authorized Representative may request further consideration by the SelectHealth Grievance Committee. Such a request must be made in writing to the Appeals Department within sixty (60) days of the date the Appeals Department notifies you of its appeal decision. The Grievance Committee is comprised of at least two administrative officers of SelectHealth, a Physician consultant (when medical issues are involved), and a consumer representative, who will be present at every meeting. You and/or your Authorized Representative may appear in person or by telephone before the Grievance Committee to present any arguments or evidence you feel are relevant to the matter; however, participation is not a requirement. SelectHealth will notify you of the result of the Grievance Committee review, in writing, within thirty (30) days of the date you requested the review.

The Grievance Committee may, in its sole discretion and at no cost to you, seek an assessment from an Independent Review Organization (IRO) in conjunction with its decision if no such review has previously been conducted.

### **Step 3—Voluntary Appeals Committee Review**

If you are dissatisfied with the result of Step 2, second level mandatory review (Grievance Committee), you or your Authorized Representative may voluntarily request a review of your appeal by the SelectHealth Appeals Committee. If you are appealing an Adverse Benefit Determination regarding Medical Necessity, you may request a review of your appeal by either the Appeals Committee or an Independent Review Organization. The Appeals Committee is generally comprised of the Chief Executive Officer (CEO) of SelectHealth, a practicing Physician in the community, legal counsel, an employer from the community who also serves as a Member of the SelectHealth Board of Trustees, and a consumer representative, who will be present at every meeting. You and/or your Authorized Representative may appear in person or by telephone before the Appeals Committee to present any arguments or evidence you feel is relevant to the matter; however, participation is not a requirement. An IRO is an independent external review organization that is not connected in any way with SelectHealth. The IRO engages health care professionals with the appropriate level and type of clinical knowledge and experience to properly judge an appeal. There is no cost to you for the Appeals Committee or IRO review. Your request for voluntary review must be made in writing to the Appeals Department within sixty (60) days for Appeals Committee review, and for an IRO review within one hundred eighty (180) days, from the date of SelectHealth response to the second level mandatory review. If you are appealing an Adverse Benefit Determination of Medical Necessity, your request must specify whether the appeal is to the Appeals Committee or to an IRO. SelectHealth will notify you of the result of the Appeals Committee or IRO review in writing within sixty (60) days of the date you requested the review.

The Appeals Committee may, in its sole discretion and at no cost to you, seek an assessment from an IRO in conjunction with its decision if no such review has previously been conducted.

**Civil Action** -- At any point after SelectHealth mandatory review process (Steps 1 and 2), you may choose to pursue civil action under ERISA Section 502(a). Failure to properly pursue the mandatory appeals process may result in a waiver of the right to challenge SelectHealth original decision.

#### **7.8.7 Notification of Appeal Decisions.**

At each applicable level of the appeals process described above, if your appeal is denied, SelectHealth written notification will include the following information:

- A statement of SelectHealth's understanding of the pertinent facts of the appeal;
- The specific reason(s) for the adverse determination, in easily understandable language;
- Reference to the specific provisions on which the adverse determination was based;
- A statement regarding your right, upon request and free of charge, to access and receive copies of documents, records and other information that are relevant to the claim;

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline protocol, or other similar criterion was relied upon in denying the appeal and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
- If the denied appeal was based on a Medical Necessity, Experimental and/or Investigational or similar Exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Master Group Contract to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
- A list of titles and qualifications of the individuals participating in the review; and
- A statement describing any additional mandatory or voluntary appeal levels either required or offered by SelectHealth, including the opportunity for IRO assessment, if applicable, and your right to obtain information about such procedures, and a statement of your right to bring suit under ERISA Section 502(a).

Notification of the decision on an Urgent Care Claim may be provided orally, but a follow-up written notification will be provided no later than three days after the oral notice.

**7.9 Indemnification.** SelectHealth agrees to protect, defend, and indemnify Employer from and against any claims for liability based upon SelectHealth's failure to do its duties and responsibilities under this Contract.

Employer agrees to protect, defend, and indemnify SelectHealth from and against any claims for liability based upon Employer's failure to do its duties and responsibilities under this Contract. Such indemnification by Employer specifically includes, but is not limited to, Employer's duties to:

- a. comply with federal and state laws (for example: ERISA and HIPAA);
- b. provide continuation of coverage (COBRA) and all associated notices to its employees; and
- c. promptly provide SelectHealth with current information about Member employment status and Eligibility for enrollment.

**7.10 Identification Cards.** SelectHealth will provide Identification Cards to Subscribers. Such cards will provide limited information about the Health Benefit Program in which the Subscriber is enrolled. Providers and Facilities may require the presentation of the Identification Card plus one other reliable form of identification as a condition to providing services. The Identification Card does not guarantee any coverage or Benefits.

If any Member permits the use of the Member's Identification Card by any other person not covered by the Card, the Card will be confiscated by SelectHealth or by a Provider or Facility and all rights of such Member under this Contract will be immediately terminated. If a Member uses an Identification Card to obtain care, services, treatments, drugs, medications, supplies, or equipment for which he or she is not Eligible under this Contract, then such person will be responsible to pay or reimburse SelectHealth and/or the Provider or Facility, as appropriate, for the Provider's or Facility's usual and customary charges for such care, services, treatments, drugs, medications, supplies, or equipment.

**7.11 Information.** Information about this Contract or the Benefits and Covered Services available to Members under this Contract or the Exclusions and Limitations or other conditions on coverage can be obtained by contacting SelectHealth as follows:

SelectHealth, Inc.  
4646 W. Lake Park Blvd., P.O. Box 30192  
Salt Lake City, Utah 84130-0192  
Phone: **801-442-5038** in Salt Lake City or  
**800-538-5038** elsewhere in the Continental U.S.A.

- 7.12 Circumstances Beyond SelectHealth's Control.** In the event of circumstances reasonably beyond the control of SelectHealth, such as earthquake, disaster, epidemic, destruction of Provider Facilities, disability of a significant portion of Provider or Facility capability, riot, war, civil insurrection, an act of terrorism, nuclear release or similar situation that cause a delay or Limitation in the ability of SelectHealth to provide Covered Services hereunder, neither SelectHealth nor any Provider or Facility will have any liability or obligation on account of such delay or failure, provided only that in such circumstances SelectHealth will use its best efforts to provide for such Covered Services through available Providers and Facilities.
- 7.13 Unfair Discrimination.** Unless another, independent cause for termination exists, SelectHealth will not terminate or refuse to re-enroll any Member during the term of this Contract solely because of the health status or the health care needs of the Member.
- SelectHealth will not discriminate against any Member based on race, sex, religion, national origin, or any other basis forbidden by law.
- 7.14 Workers' Compensation Insurance.** This Contract does not replace and is not in lieu of workers' compensation coverage for the employees of Employer. Employer agrees to carry adequate workers' compensation coverage. Employment-related accidents, injuries, and conditions are not covered under this Contract.
- 7.15 No Waiver.** Failure of SelectHealth to insist upon strict compliance with any part of this 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.
- 7.16 Enforcement.** The parties agree that it shall not be a breach of the covenants of good faith and/or fair dealing, or a breach of this Contract, or a violation of any statutory or common law right or interest, for SelectHealth to insist upon the strict enforcement of this agreement and/or to deny, limit, or restrict payments for Covered Services strictly in accordance with the terms, conditions, Limitations, and Exclusions contained in this Contract.
- 7.17 Administration of Contract.** SelectHealth may adopt reasonable policies, rules, and procedures to help in the administration of this Contract. Employer, Subscribers, and Members agree to abide by all such reasonable policies, rules, and procedures that are not inconsistent with the Contract.

## Exhibit A

### HEALTH BENEFIT PROGRAM

The Benefits that are covered for Members while they are enrolled with SelectHealth and while this Contract is in effect are described in this Exhibit. This Exhibit also describes the Exclusions and Limitations that reduce the extent of coverage available under this Contract. To be covered, care, services, treatments, drugs, medications, supplies, or equipment must not be limited, excluded or precluded by anything that is contained in this Exhibit, the Member Payment Summary, the Execution Section, or in the Contract to which this Exhibit is attached.

Whenever there are inconsistencies between a general description and a more specific description that could apply to the same situation, then the more specific description shall be the one that applies to resolve the inconsistencies. If two (2) such descriptions are not inconsistent, then both should be applied.

**Benefits are limited, and there is no presumption of coverage. Care, services, treatments, drugs, medications, supplies, or equipment must satisfy the requirements of this entire Contract to be covered by SelectHealth.**

#### **I. GENERAL COVERED SERVICES.**

Care, services, treatments, drugs, medications, supplies, or equipment is a Covered Service if and only if it is described as being covered in this Exhibit, and if it satisfies all of the conditions of this Contract, including but not limited to the Execution Section, the Member Payment Summary, and the following:

- A. The care, services, treatments, drugs, medications, supplies, or equipment is obtained or provided in connection with the treatment of a covered condition, illness, or injury;
- B. The care, services, treatments, drugs, medications, supplies, or equipment is Medically Necessary for the treatment of that covered condition, illness, or injury and is expected to improve the Member's condition or prevent a foreseeable deterioration in the Member's condition;
- C. The care, services, treatments, drugs, medications, supplies, or equipment is not excluded from coverage;
- D. The care, services treatments, drugs, medications, supplies, or equipment is covered only in a manner and to the extent consistent with any Limitation that applies to the extent of coverage;
- E. The care, services, treatments, drugs, medications, supplies, or equipment is obtained in a time and in a manner consistent with coverage, given any Waiting Period Limitation;
- F. The care, services, treatments, drugs, medications, supplies, or equipment is obtained in a manner consistent with the requirements of SelectHealth's Utilization Management/Quality Improvement Program, including but not limited to the requirements relating to Prenotification, use of Participating Providers and Facilities, and length of stay Limitations;
- G. No care, services, treatments, drugs, medications, supplies, or equipment is covered either before a Member's Effective Date with SelectHealth or after termination from SelectHealth, regardless of the reason; and
- H. Charges in excess of SelectHealth's Eligible Charges, Fee Schedule for Providers and Facilities are not covered.

## II. FACILITY SERVICES.

The following Facility Services are covered when ordered by the Member's attending Physician under circumstances that completely satisfy Section I of this Exhibit and the conditions outlined in the Contract to which this Exhibit is attached.

### A. Emergency Room (ER).

- (1) Medically Necessary Emergency Room Services are covered for Emergencies.
- (2) SelectHealth reserves the right to review all emergency claims arising in the Service Area to determine whether such claims satisfy the requirements for Emergency Services/Emergency Care in this Agreement.
- (3) Although payment of the Emergency Room Copay/Coinsurance amount is not required before service may be provided in the Emergency Room, it is the Member's responsibility to pay the ER Copay/Coinsurance listed on the Member Payment Summary directly to the providing Facility.

If the Member is admitted directly to the Hospital as an inpatient because of the condition for which Emergency Room Services were sought then the Emergency Room Copay/Coinsurance will be waived. The usual Copay/Coinsurance amounts normally applied to such a hospitalization will be required.

### B. Hospice and Outpatient Private Duty Nurse.

- (1) **Hospice.** If provided pursuant to the direction of the Member's Physician, Hospice Care is covered if provided on an inpatient or outpatient basis.
- (2) **Private Duty Nurse.** Medically Necessary Private Duty Nursing Services provided on an outpatient basis is covered when ordered by a Physician. Private Duty Nursing is not available for Respite Care or Long Term Care in lieu of placement in a Long Term Care Facility.

### C. Inpatient Hospital Services.

- (1) Semiprivate room accommodations and other Hospital-related services ordinarily furnished and billed by the Hospital are covered.
- (2) Private room accommodations are covered only if Medically Necessary in connection with a medical condition requiring isolation. A Member choosing a private room accommodation is responsible for paying the difference in the Hospital's semiprivate room rate and the private room rate. No additional charge will be made to the Member if the Facility only provides private room accommodations for patients.
- (3) Intensive care unit, including cardiac care unit accommodations are covered.
- (4) Medically Necessary pre-admission testing prior to Inpatient Hospital Services is covered.
- (5) Short-term inpatient detoxification provided by a SelectHealth approved treatment Facility is covered for alcohol/drug dependency.
- (6) Inpatient maternity/obstetrical Services resulting in childbirth or miscarriage are covered at a Hospital, or women's center subject to the day Limitations stated in the Member Payment Summary. Extensions of inpatient stays beyond the day Limitations indicated in the Member Payment Summary must be Prenotified for reasons of Medical Necessity.

**Note:** Inpatient Maternity Services for a Member Dependent child of the Subscriber or Subscriber's spouse are covered. However, services for the newborn child of the Dependent child Member are not covered unless the newborn child satisfies the definition of Eligible Dependent or the Execution Section indicates otherwise.

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

*Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the plan, or issuer may pay for a shorter stay if the attending Provider (e.g., your Physician, Nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.*

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

*In addition, a plan or issuer may not, under federal law, require that a Physician or other Health Care Provider obtain authorization for prescribing a length of stay of up to forty-eight (48) hours (or ninety-six (96) hours). However, to use certain Providers or Facilities, or to reduce your out-of-pocket costs, you may be required to obtain Precertification. For information on Precertification, contact your plan administrator.*

- (7)** The following inpatient Facility care, services, treatments, drugs, medications, supplies, or equipment is covered in connection with otherwise covered Inpatient Hospital Services:
- a.** Operating, recovery, delivery, labor, treatment rooms and related equipment.
  - b.** Anesthesia and related anesthesia supplies.
  - c.** Diagnostic and therapeutic radiologic and other imaging services and related supplies.
  - d.** Electronic diagnostic and monitoring services and supplies such as electrocardiograms and electroencephalograms.
  - e.** Prescribed drugs and medications that are FDA approved.
  - f.** Dressings, splints, casts, and other supplies for medical treatment supplied by the Facility from its supply department.
  - g.** FDA approved devices and appliances surgically inserted into the body.
  - h.** Oxygen and its administration.
  - i.** Non-replaced blood, blood products and their administration.
  - j.** Intravenous injections and solutions.

- D. **Intermountain InstaCare.** Medically Necessary Intermountain InstaCare Services are covered. The Intermountain InstaCare Copay/Coinsurance listed on the Member Payment Summary is payable to the Intermountain InstaCare providing the services.
- E. **Outpatient Facility and Ambulatory Surgical Facility.** Medically Necessary Outpatient Surgical and Medical Services including supplies, blood, and blood derivatives are covered if provided under the direction of a Physician to treat an otherwise covered condition at a licensed Participating Facility.
- F. **Skilled Nursing Facility Services.** Medically Necessary Skilled Nursing Facility Services are only covered if provided instead of continued Hospital confinement that is supplying Medically Necessary Skilled Nursing and Medical Services that cannot be provided adequately through a home health program. Such services are subject to and limited by the annual day Limitations listed on the Member Payment Summary, and are covered at the Facility's semiprivate room rate. Otherwise, Skilled Nursing Facility Services are not covered.

### **III. PHYSICIAN AND OTHER PROVIDER SERVICES.**

The following Physician and other Provider Services are covered under circumstances that completely satisfy Section I of this Exhibit and the conditions outlined in the Contract to which this Exhibit is attached.

- A. **After Hours Visits.** Medically Necessary office visits and minor surgery provided after the Physician's regular business hours are covered.
- B. **Anesthesia.** Medically Necessary anesthesia is covered if administered in connection with otherwise Covered Services and if it is administered by a Physician certified as an anesthesiologist or by a Certified Registered Nurse Anesthetist (CRNA) under the direct supervision of a Physician certified as an anesthesiologist. General anesthesia rendered in a Physician's office is not covered.
- C. **General Medical-Surgical.** Medically Necessary Physician or other Professional Services provided in connection with covered general medical-surgical or Emergency Services in an inpatient, outpatient, or Ambulatory Surgical Facility are covered.
- D. **Home Visits.** Medically Necessary home visits by a Physician are covered only if the Member is physically incapable of traveling to the Physician's office.
- E. **Infertility Diagnosis and Treatment.** Infertility counseling, diagnostic testing, and limited treatment are covered only when rendered by Participating Providers and/or Facilities and only to the extent stated on the Member Payment Summary. The Infertility Benefit may not be used for any Infertility related service that is listed as being not covered. The Infertility Services that are not covered by the Health Benefit Program are stated in Section VI "General Limitations and Exclusions" of this Exhibit.
- F. **Intermountain KidsCare.** Medically Necessary Intermountain KidsCare Services are covered. The Intermountain KidsCare Copay/Coinsurance is the same as an office visit listed on the Member Payment Summary and is payable to the Intermountain KidsCare providing the services. Participating Providers must coordinate all follow-up care.
- G. **Mastectomy/Reconstructive Services.** In accordance with the Women's Health and Cancer Rights Act (WHCRA), SelectHealth covers mastectomies for the treatment of breast cancer and reconstructive surgery after a mastectomy for the treatment of breast cancer. If a Member is receiving Benefits in connection with a mastectomy, coverage will be provided according to SelectHealth's Utilization Management criteria and in a manner determined in consultation with the attending Physician and the Member, for:

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

Under WHCRA, coverage of mastectomies and breast reconstruction Benefits are subject to Deductibles, Copays, and Coinsurance Limitations consistent with those established for other Benefits under SelectHealth. Following the initial reconstruction, any additional modification or revision is covered only to the extent that it is not otherwise limited or not covered from coverage by this Contract. Refer to, for example, “Cosmetic, Reconstructive, and Corrective Procedures” in Section VI “General Limitations and Exclusions” of this Exhibit. For example, revisions requested as the result of the normal aging process would not be covered.

- H. Office Surgery, Major.** Medically Necessary major surgical procedures provided in a Physician's office to treat covered conditions, illnesses or injuries, are covered. General anesthesia rendered in a Physician's office is not covered. Major surgery is defined as Surgical and Endoscopic Services for which SelectHealth's Eligible Charges, Fee Schedule for Providers and Facilities is more than \$350.
- I. Physician Office Visits and Minor Surgery.** Medically Necessary office visits for consultation, diagnosis, and treatment of covered conditions, illnesses, and injuries, including minor surgery as defined by SelectHealth, are covered.
- J. Postnatal Care.** For the Subscriber and his/her Eligible Dependents, Medically Necessary maternal postnatal care, including complications of delivery, are covered. **Note: Postnatal Care is covered for Members only.** This includes a Member dependent child of the Subscriber or Subscriber's spouse. However, postnatal care for the newborn child of the dependent child Member is not covered unless the newborn child satisfies the definition of Eligible Dependent.
- K. Prenatal Care; Labor and Delivery.** Prenatal care, labor and delivery are covered. Prenatal and childbirth education classes are not covered.
- L. Preventive Care.** The following Preventive Services are covered when supplied by a Participating Provider and/or Facility and when supplied according to SelectHealth's Preventive Care Examination Schedule. These Preventive Services are covered only to the extent stated on the Member Payment Summary.
- (1) Well-baby care and the related screening tests necessary for the prevention and detection of disease during the first twenty-four (24) months of life.
  - (2) One routine physical examination per year and the related screening tests necessary for the prevention and detection of disease after the first twenty-four (24) months of life if your Physician bills this as a preventive visit.
  - (3) Annual routine hearing and visual evaluation.
  - (4) Immunizations and vaccinations when ordered or approved by a Participating Provider are covered. Immunizations for employment or travel, or for typhoid, yellow fever, cholera, plague, and BCG are not covered. For covered, limited, and not covered injectable drugs see “Drugs, Medications, and Injections” in Section VI “General Limitations and Exclusions” of this Exhibit.
  - (5) Prostate cancer screening.

- M. Second Opinions.** When SelectHealth requests a Second Opinion, then the charges associated with that Second Opinion are covered with no additional cost to the Member. If the Member requests a Second Opinion, then the Copay/Coinsurance/Deductibles that apply for a regular office visit are required.

#### **IV. MISCELLANEOUS SERVICES.**

The following Miscellaneous Services are covered when ordered by the Member's attending Physician under circumstances that completely satisfy Section I of this Exhibit and the conditions outlined in the Contract to which this Exhibit is attached.

- A. Allergy Tests, Treatment, or Serum.** Allergy testing, treatment and serum are covered except those tests and treatments specifically listed as not covered. Covered allergy tests, treatments, and serum must be received from a Participating board certified allergist, immunologist, or otolaryngologist, or Participating Facility. Oral food challenge testing is only covered when provided by a Provider who is board certified in allergy/immunology and when this services is performed in a Participating Facility. See Section VI "General Limitations and Exclusions" of this Exhibit.
- B. Ambulance.** Ambulance transportation is covered when Medically Necessary to transport a Member to the nearest Facility expected to have appropriate services for the treatment of the covered emergency injury or illness involved. Ambulance transportation is covered only for Emergencies; it is not covered when the Member could safely be transported by other means. Air Ambulance transportation is covered only for Emergencies; it is not covered when the Member could safely be transported by ground Ambulance or other means.
- C. Attention Deficit Disorder/ADD/ADHD.** Medical management for the adjustment of medication and to assess the efficacy and/or safety of medical therapy for these disorders is covered.
- D. Chiropractic Services.** Chiropractic Services are not covered unless listed as a Benefit Rider in the Member Payment Summary, and then coverage will only apply to the extent provided for in the Benefit Rider, when attached to this Contract. Members must receive care from Participating Providers or Facilities. Refer to the Chiropractic Benefit Rider for Covered Services, Definitions, Limitations, and Exclusions.
- E. Durable Medical Equipment (DME).** Medically Necessary Durable Medical Equipment (DME) is covered only when it is used to treat an otherwise covered condition. DME is covered when prescribed by a Participating Provider and obtained from a Participating DME Provider or Facility. To be covered, the Durable Medical Equipment must also satisfy the following conditions: (1) be able to withstand repeated use; (2) be primarily used for medical purposes and not for convenience, contentment, personal comfort, or other non-therapeutic purposes; (3) required for activities of daily living; and (4) is generally not useful in the absence of an illness or injury. **Note:** Some DME and related services are not covered. See Section VI "General Limitations and Exclusions" of this Exhibit.
- F. Home Health Care.** Home Health Care services provided by a Participating Health Care Provider are covered in the home when the Member: (1) has a condition that requires the services of a licensed Health Care Provider; (2) is Home Bound for medical reasons; (3) is physically unable to obtain necessary medical care on an outpatient basis; and (4) is under the care of a physician.

Home Health Care services requested for the convenience of the patient or family that do not require the training and technical skills of a licensed Nurse or other licensed Provider, or provided by a Non-Participating Provider are not covered.

- G. Miscellaneous Medical Supplies (MMS).** Medically Necessary Miscellaneous Medical Supplies (MMS) are covered only when used to treat an otherwise covered condition. **Note:** Some MMS and related services are not covered. See Section VI “General Limitations and Exclusions” of this Exhibit.
- H. Other Diagnostic Services.** Medically Necessary Diagnostic Tests for covered conditions are covered.
- I. Other Therapeutic Services.** Medically Necessary chemotherapy, radiation therapy, and radioactive isotope therapy are all covered. Medically Necessary dialysis is also covered.
- J. Rehabilitation Therapy.** Subject to and limited by the Year limitations listed in the Member Payment Summary, physical, occupational, and speech rehabilitative therapy are covered.

Coverage of therapy is limited to treatments that are reasonably expected to result in a significant improvement of the Member's condition within the Year limitations specified in the Member Payment Summary.

Subject to and limited by the per Year limitations listed in the Member Payment Summary, occupational therapy, physical therapy, or speech rehabilitative therapy will be covered for an impairment that is caused by a covered accident or illness. Occupational therapy, physical therapy, or speech rehabilitative therapy will not be covered for an impairment that is caused by a functional nervous disorder or PDD. Rehabilitation services are not covered when used to assist a member in establishing skills not previously possessed regardless of the etiology or age of the individual. This is considered habilitation therapy and is not covered.

Speech therapy services are not covered for PDD associated with chronic recurrent otitis media not associated with hearing loss.

Aural rehabilitation related to an approved cochlear implantation is subject to the speech therapy benefit limitations.

## **V. ADDITIONAL BENEFITS.**

**Adoption Indemnity Benefit.** If a Member adopts a child while the Member is covered under this Contract, SelectHealth will provide an indemnity Benefit payable to the Member, as required under Utah Code Section 31A-22-610.1, if the child is placed for adoption with the Member within ninety (90) days of the child's birth. Members have one (1) year from the date of placement to submit a claim for this Benefit or as soon as reasonably possible. SelectHealth will pay its pro rata share of the adoption indemnity Benefit if each adoptive parent has coverage for maternity Benefits with a different insurer, and each adoptive parent makes a claim for the adoption indemnity Benefit described in this provision. The Adoption Indemnity Benefit is subject to Coinsurance, Copays, and Deductibles applicable to the Maternity Benefit as indicated on the Member Payment Summary. Only one (1) Adoption Indemnity Benefit is payable to the Member for adopting more than one (1) child from the same birth (adopting twins, triplets, etc.).

**Smoking Cessation.** Nicotine and smoking cessation medications may be covered depending upon the Member's particular Prescription Drug Benefits and participation in a SelectHealth-sponsored smoking cessation program.

## **VI. GENERAL LIMITATIONS AND EXCLUSIONS.**

Unless noted otherwise in the Member Payment Summary, the following Limitations and Exclusions apply to limit coverage. Care, services, treatments, drugs, medications, supplies, or equipment that are not covered are not considered Benefits under this Contract and are not covered under this Contract. Things that are limited are not Benefits and are not covered to the extent of the Limitations. These Limitations and Exclusions apply regardless of whether a Provider or Facility, including but not limited to a Participating Provider or Facility, may order or recommend the care, service, treatment, drug, medication, supply, or equipment and regardless of whether a Provider or Facility may consider the care, service, treatment, drug, medication, supply, or equipment to be Medically Necessary under the circumstances.

**Please note:** Not all desired, care, services, treatments, drugs, medications, supplies, or equipment is covered. SelectHealth strictly enforces the limits on payments and coverage available to Members from SelectHealth; this is done according to the terms, conditions, Limitations, and Exclusions contained herein. Members should not expect that any care, services, treatments, drugs, medications, supplies, or equipment will be covered or otherwise provided or paid for by SelectHealth in excess of the types and amounts specified in this Contract. Members may personally obtain and pay for health care outside of the coverage provided by SelectHealth, and Members are encouraged to obtain and pay for care, services, treatments, drugs, medications, supplies, or equipment not covered by SelectHealth, if they feel it is necessary for their own well-being.

When required by federal law, Exclusions will not apply to injuries that are otherwise covered by SelectHealth if the injury is the direct result of either an act of domestic violence or a medical condition (including both physical and Mental Health conditions).

1. **Abortions/Termination of Pregnancy.** Abortions are not covered except:
  - a. When determined by SelectHealth to be Medically Necessary to save the life or good health of the mother; or
  - b. Where the pregnancy was caused by a rape or by 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; or
  - c. When there is evidence of grave fetal defects that are inconsistent with sustaining life.Medical complications resulting from an Abortion are covered.  
Treatment of a miscarriage/spontaneous Abortion (occurring from natural causes) is covered.

2. **Accepted Medical Practice.** Care, services, treatments, drugs, medications, supplies, or equipment determined by SelectHealth to be inconsistent with accepted medical practice or illegal are not covered. This includes any care, service, treatment, drug, medication, supply, or equipment that is not generally recognized by the U.S. medical community as conforming to accepted medical practice, and any care, service, treatment, drug, medication, supply, or equipment for which required government approval has not been granted at the time the care, service, treatment, drug, medication, supply, or equipment is provided. This Exclusion includes care, services, treatment, drugs, medications, supplies, or equipment that are Investigational, Experimental, or research in nature. Procedures, devices, drugs, or "biologics" for which there is insufficient evidence to determine their likely effects on patients' health outcomes are also not covered.
3. **Acupuncture/Acupressure.** Acupuncture, acupressure services, and dry needling procedures are not covered.

4. **Administrative Charges.** Provider and Facility charges are not covered for completing insurance forms, duplication services, interest (except where required by UAC Rule R590-192), finance charges, late fees, missed appointments, and other administrative charges.
5. **Administrative Exams and Services.** Examinations and services are not covered when SelectHealth determines that they are not Medically Necessary or when obtained for administrative purposes, whether or not illness or injury is involved. Such administrative purposes include, but are not limited to, immunizations, supplies, accommodations, treatment, care, reports, or appearances obtained for or pursuant to legal proceedings, court orders, employment, continuing or obtaining insurance coverage, governmental licensure, home health recertification, travel, military service, school, or institutional requirements.
6. **Allergy Tests.** The following allergy tests are not covered:
  - Cytotoxic Test (Bryan's Test)
  - Leukocyte Histamine Release Test
  - Passive Cutaneous Transfer Test (P-K Test)
  - Provocative Conjunctival Test
  - Provocative Nasal Test
  - Rebeck Skin Window Test
  - Rinkel Test
  - Subcutaneous Provocative Food and Chemical Test
  - Sublingual Provocative Food and Chemical Test
7. **Allergy Treatments.** The following allergy treatments and services are not covered:
  - Allergoids
  - Autogenous Urine Immunization
  - Medical Devices (filtering air cleaner, electrostatic air cleaner, air conditioners etc.)
  - Neutralization Therapy
  - Photoinactivated Extracts
  - Polymerized Extracts
  - Oral desensitization therapy
8. **Ambulance.** See Provision 74 "Transportation Services."
9. **Appointments Not Kept.** Provider and Facility charges for appointments scheduled and not kept are not covered.
10. **Attention Deficit Disorder/ADD/ADHD.** Cognitive or behavioral therapies for the treatment of these disorders are not covered. Medical management for the adjustment of medication and to assess the efficacy and/or safety of medical therapy is covered.
11. **Axillary Hyperhidrosis.** The medical, surgical or psychological treatment of axillary hyperhidrosis is not covered.
12. **Bariatric Surgery.** Gastric or intestinal bypass services including lap banding, gastric stapling, and other similar procedures to facilitate weight loss; the reversal, or revision of such procedures; and services required for the treatment of complications from such procedures are all not covered. See also the Obesity exclusion.
13. **Biofeedback/Neurofeedback.** Biofeedback/Neurofeedback for the treatment of medical conditions is not covered.

14. **Birth Centers and Home Childbirth.** Childbirth in the home or a stand-alone birthing center is not a Covered Service. This includes all Provider and/or Facility charges related to the delivery.

15. **Cancer Therapy.** The evaluation and treatment of cancer is a Covered Benefit unless the Diagnostic Test or the treatment meets the definition of Investigational/Experimental as outlined in Section II "Definitions" of the Master Group Contract.

In addition, certain Non-Investigational therapies will not be covered and are specifically not covered as they have been found to have no better therapeutic outcomes for the disease being treated and are less cost effective than other therapies offered by the Health Benefit Program. These treatments that are not covered include but are not limited to the following:

- High dose brachytherapy for prostate cancer;
- Neutron beam therapy; and
- Proton beam therapy.

16. **Certain Illegal Activities.**

Care, services, treatments, drugs, medications, supplies, or equipment for an illness, condition, accident, or injury are not covered if the illness, condition, accident, or injury occurred:

- (1) While the Member was engaged in the commission of a felony; or
- (2) While the Member was engaged in disorderly conduct, riot, or other breach of the peace; or
- (3) While the Member was engaged in any conduct involving the illegal use or misuse of a firearm or other deadly weapon, except for a peace officer in the lawful performance of his or her official duties; or
- (4) While the Member, was driving or otherwise in physical control of a car, truck, motorcycle, scooter, off-road vehicle, boat, or other motor driven vehicle if the Member either:
  - a. Had sufficient alcohol in the Member's body that a subsequent test shows that the Member has either a blood or breath alcohol concentration of .08 grams or greater at the time of the test; or
  - b. Had any illegal drug, or other illegal substance in the Member's body to a degree that it affected the Member's ability to drive or operate the vehicle safely; or
- (5) While the Member was driving or otherwise in physical control of a car, truck, motorcycle, scooter, off-road vehicle, boat, or other motor driven vehicle either without a valid drivers permit or license, if required under the circumstances, or without the permission of the owner of the vehicle; or
- (6) As a complication of, or as the result of, or as follow-up care for any illness, condition, accident, or injury that is not covered as the result of this exclusion.

The presence of drugs or alcohol may be determined by tests performed by or for law enforcement, test performed during diagnosis or treatment, or by other reliable means.

17. **Chiropractic.** Unless stated otherwise on the Member Payment Summary, chiropractic Services are not covered.

18. **Claims After One Year.** Claims submitted directly to SelectHealth for payment from a Provider, Facility or Member are denied if submitted more than one (1) year after the care, services, treatments, drugs, medications, supplies, or equipment were provided unless the Member, Provider, or Facility can show that 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 to SelectHealth within one (1) year after the claim was first processed by SelectHealth unless the Member shows that the additional information relating to the claim was filed as soon as reasonably possible. Coordination of Benefits payments, when SelectHealth is the secondary payer, will be made only if the information supporting the payment is submitted to SelectHealth within one (1) year after the claim was processed by the primary plan unless the Member shows that the information was given or proof of loss was filed as soon as reasonably possible. When a Benefit has been coordinated incorrectly on the grounds that a claim was timely submitted to one or more of the coordinating plans, SelectHealth will not deny a submitted claim if the claim is submitted to SelectHealth within thirty-six (36) months of the date of service. When a payment between SelectHealth and Provider/Facility has been coordinated incorrectly, SelectHealth will make proper payment adjustment if the request is submitted to SelectHealth within thirty-six (36) months from the date of the payment.

19. **Cochlear Implants and Similar Devices.** Unilateral cochlear implantation for prelingual deafness in children or postlingual deafness in adults is covered only in limited circumstances set forth in SelectHealth's Utilization Management guidelines in effect at the time services are rendered.

- Such cochlear implantation must be pre-approved by SelectHealth in writing.
- Such cochlear implantation must be provided by a Participating Provider in an Intermountain facility.
- Bilateral cochlear implantation is not a covered Benefit.
- Auditory Brain Implantation or similar devices are not a covered Benefit.
- Batteries for cochlear implants are not a covered DME item.

Aural rehabilitation related to an approved cochlear implantation is subject to the speech therapy Benefit limitations. See Provision 63 "Rehabilitation Therapy Services."

20. **Complementary and Alternative Medicine (CAM).** Complementary and Alternative Medicine, or similar non-traditional services, are not covered. Such services may include, but are not limited to, acupuncture (as stated in Section VI "General Limitations and Exclusions" of this Exhibit), homeopathy, homeopathic drugs, massage therapies, aromatherapies, yoga, hypnosis, rolfing, thermography, etc.

21. **Complications.** All care, services, treatments, drugs, medications, supplies, or equipment provided or ordered to treat complications of a non-covered illness, injury, condition, situation, procedure, or treatment are not covered unless stated otherwise in this Contract. This includes but is not limited to complications resulting from any illness, injury, condition, situation, procedure, or treatment occurring prior to coverage under this Contract if such earlier illness, injury, condition, situation, procedure, or treatment would not have been covered under this Contract.

22. **Cosmetic, Reconstructive, and Corrective Procedures.** Any care, treatment, or procedure performed primarily for cosmetic purposes is not covered. Any care, treatment, or procedure is considered cosmetic when it is primarily intended to improve appearance or correct a deformity, whether congenital or acquired, without restoring physical bodily function. Reconstruction or corrective procedures done primarily for purposes of restoring "normal" body form or appearance are not covered. (This restriction includes reconstructive or corrective procedures to restore or correct non-function-impairing congenital anomalies; it does not apply when reconstructive or corrective procedures are to improve or correct an impairment or loss of bodily function.)

Psychological factors, such as but not limited to, poor self-image or difficult peer or social relations, are not relevant to this Exclusion, even though a Physician may indicate that such factors constitute "Medical Necessity."

Cosmetic surgery and other care or procedures required as the result of an Accidental Injury, illness, or therapeutic intervention are not covered unless the services are rendered (or a planned, staged series of services – as specifically documented in the Member's medical record – are initiated) within twelve (12) months of the cause or onset of the injury, illness or therapeutic intervention.

Surgery to revise a scar whether acquired through injury or surgery is not a covered Benefit except when the primary purpose of the surgery is to improve or correct a functional impairment. The reversal, revision, repair, or treatment for a non-covered Cosmetic, Reconstructive, or Corrective Procedure is not covered. The treatment of complications resulting directly or indirectly from a non-covered Cosmetic, Reconstructive, or Corrective Procedure is not covered.

The following procedures and the treatment for the following conditions are not covered unless otherwise indicated below:

- Abdominoplasty;
- Acne (except routine office visits and drug therapy. Laser, dermabrasion, and chemical peels are not covered.);
- Alopecia;
- Breast augmentation (except when related to reconstructive surgery following treatment for breast cancer);
- Body piercing, including ear piercing, including any immediate or remote complications of the procedure;
- Breast reduction (except according to SelectHealth criteria);
- Congenital cleft lip except for treatment rendered (or a planned, staged, series of services – as specifically documented in the Member's medical record – are initiated) within twelve (12) months of birth, or when congenital cleft lip surgery is performed as part of a cleft palate repair;
- Face lift;
- Genioplasty;
- Helmet therapy for positional plagiocephaly is not covered for members less than twelve (12) months of age;
- Idiopathic short stature;
- Implantation of a breast implant (except following a mastectomy for breast cancer);
- Liposuction of the face, neck, chest, abdomen, flanks, buttocks, arms, legs (except covered breast surgery or surgery related to the treatment of breast cancer);
- Otoplasty;
- Port wine stain treatment (except according to SelectHealth criteria);
- Rhinoplasty;
- Scar revision (except to correct a functional problem);
- Sclerotherapy of superficial varicose veins (spider veins);
- Tattoos or their removal – (except when related to reconstructive surgery following treatment for breast cancer); and
- Vitiligo.

The above list is not intended to be a complete listing of all procedures and treatments that are not covered as the result of this section.

- 23. Custodial Care, Long Term Care.** Custodial Care and Long Term Care are not covered Benefits.

24. **Dental, Mouth, and Jaw.** Tooth related Dental Services, and Mouth and Jaw Services provided by a dentist or oral surgeon are not a covered Benefit, except as specified elsewhere in this Contract. Dental Services are defined as care rendered to the teeth, the tooth pulp, the gums, or the bony structure supporting the teeth. This includes all diagnostic procedures, care, treatment, therapy or surgery for treatment of tooth related dental, mouth, and jaw. This includes, but is not limited to the following:

- Appliances, bite guards, space maintainers, splints
- Bone resection, bone screws, implants
- Crowns, dentures, bridges
- Dental restorative procedures for any reason, restoring of occlusion
- Endodontic procedures, apicoectomies, and retrofills
- Extractions
- Full mouth rehabilitation therapy
- Genioplasty;
- Injection of joints, joint surgery, joint therapy
- Orthodontic procedures
- Periodontal procedures
- Treatment for teeth, including Nursing Bottle-Mouth Syndrome, caries, etc.
- X-rays associated with dental, mouth, and jaw diagnosis or treatment

Except where noted in the list above, diagnostic procedures, care, treatment, therapy or surgery necessary to treat medical complications of a dental procedure are covered only if administered under the direction of a medical provider.

Dental and/or Medical Services for the diagnosis or treatment of any condition, disorder, syndrome, disease, or other problem of the temporomandibular joint (TMJ) are not covered, including but not limited to arthritis, and dislocation of the TMJ.

Maxillary and/or mandibular osteotomy and orthognathic procedures, upper/lower jaw augmentation or reduction procedures, including developmental corrections or altering of vertical dimensions may be covered if SelectHealth determines such treatment(s) to be Medically Necessary.

Repairs are covered for physical damage to natural teeth, crowns, and the supporting structures surrounding the teeth when such damage is a direct result of an accident that is independent of disease or bodily infirmity or any other cause. Such repairs are only covered if medical advice, diagnosis, care or treatment was recommended or received for the injury at the time of the accident and if the repair is initiated within one (1) year of the date of the accident. Please notify SelectHealth to determine coverage of repairs related to dental accidents. Dental implants, orthodontia, and the replacement/repair of artificial/manufactured dental appliances are not covered even after an accident. Repairs for physical damage resulting from biting or chewing are not covered.

Bleaching of teeth to restore the cosmetic pre-injury appearance of the injured tooth/teeth is covered to a maximum allowed cost established by SelectHealth.

The removal of **cysts involving mandible** when distant from the teeth or supporting structures of the teeth is covered when found to be Medically Necessary to treat other medical conditions or to avoid further injury or illness to the Member.

Dental Anesthesia Services including, but not limited to, local, regional, general, and/or intravenous sedation anesthesia, will only be covered for Members who meet all of the following criteria:

- The patient is under five (5) years of age;
- Proposed dental work involves three (3) or more teeth;
- Diagnosis is Nursing Bottle-Mouth Syndrome or Extreme Enamel Hypoplasia;
- Proposed procedures are restoration or extraction for rampant decay; and
- The anesthesia is administered at a participating Hospital or participating surgical center.

Additionally, consideration of coverage will be given to patients with congenital cardiac or neurological conditions who provide documentation that the need for dental anesthesia is due to their underlying medical condition and the need to closely monitor this condition.

Dental anesthesia necessary only for conditions such as ADHD, situational anxiety, fear of dentists, are not covered

- 25. Dietary Products.** Dietary products (a medical food or low protein modified food product) are only covered when:

In cases of hereditary metabolic disorders:

- The member has an error of amino acid or urea cycle metabolism;
- The product is specifically formulated and used for the treatment of errors of amino acid or urea cycle metabolism; and
- The product is used under the direction of a doctor, and its use remains under the supervision of the doctor.

In all other situations:

- Standard, over-the-counter formulas that are used as a replacement for breast milk or normal breastfeeding (e.g. Enfamil, Similac, or other store brand preparations) are not covered.
- Formulas used under the direction of a physician that can only be obtained by prescription and through a pharmacy are covered.
- Other formulas are covered only if they are the member's primary source of nutrition and are primarily given through a form of feeding tube; or
- The member has gastrointestinal dysfunction (such as malabsorption) and the product is specifically designed to be used in the management of the condition that prevents their ability to maintain adequate weight.

Dietary products or formula are not covered as a replacement for or supplement to normal breastfeeding except as outlined above.

- 26. Dietetic Consultation.** Dietetic consultation is only covered in limited circumstances for specific diagnoses as specified by SelectHealth. Currently, consultations are only covered as part of the treatment of patients with the diagnosis of anorexia nervosa, bulimia and obesity/morbid obesity. To qualify for coverage, an individual must meet the following criteria:

- The consultation must be prescribed by a Participating Provider as part of a structured program to treat a specific condition.
- In the case of bulimia and anorexia nervosa, the Participating behavioral health Provider must obtain a Prenotification.
- The services must be provided by a registered dietitian working at an Intermountain Facility.

This Benefit is limited to a maximum of \$300 per Member per Year.

- 27. Drugs, Medications, and Injections.** Prescription Drugs, medications, and injections are only covered to the extent indicated in the Member Payment Summary. Generic medications are generally covered at a different level than name brand medications. Medications may also be

grouped into payment tiers with different levels of coverage. Even when there is a Prescription Drug Benefit, the following types of Drugs, Medications, and Injections are never covered or coverage is limited as indicated below:

- Appetite suppressants and weight loss medications.
- Cosmetic, health and beauty aids and Prescription Drugs used for cosmetic purposes such as but not limited to, retinoids (Retin-A) when used for non-acne therapy.
- Drug use that is not Medically Necessary.
- Certain off-label drug usage, either alone or in combination with other FDA approved drugs, unless the use has been approved by either a SelectHealth Medical Director or by a SelectHealth Pharmacologist.
- Drugs purchased from Non-Participating Providers over the Internet.
- Drugs that may be FDA approved, but have not shown to be better than other standard therapies in medical literature.
- Experimental drugs, medications labeled "Caution, Limited by Federal Law to Investigational Use," drugs not approved by the FDA, or FDA approved drugs used for treatment(s) not recognized by SelectHealth. See Provision 2.37 "Experimental and/or Investigational" of the Master Group Contract.
- Flu symptom medications (e.g., Tamiflu<sup>®</sup>, Relenza<sup>®</sup>).
- Foreign Medications—Drugs and medications purchased through a foreign pharmacy. However, please call Pharmacy Services if you have a special need (for example, an emergency while traveling out of the country), for medications from a foreign pharmacy.
- Human growth hormone for the treatment of idiopathic short stature.
- Infertility medications.
- Medications for non-covered medical condition medications (e.g., topical minoxidil, Nystatin powder, etc.).
- Minerals, fluoride, vitamins other than prenatal. Vitamins are covered only when determined to be Medically Necessary to treat a specifically diagnosed disease. Naturopathic vitamins, minerals, and similar medications are not covered.
- Nicotine and smoking cessation medications. Exception: These may be covered depending upon the Member's particular Prescription Drug Benefits and participation in a SelectHealth-sponsored smoking cessation program.
- Over-the-counter (OTC) medications are not covered by SelectHealth except when all of the following conditions are met:
  - 1) The OTC medication is listed on the SelectHealth formulary as a covered medication.
  - 2) The SelectHealth Pharmacy & Therapeutics Committee has approved the OTC medication as a medically appropriate substitution of a Prescription Drug or medication.
  - 3) The OTC medication is Medically Necessary to treat a condition that is covered by SelectHealth.
  - 4) The Member has obtained a prescription for the OTC medication from a participating licensed Provider, and filled the prescription at a participating pharmacy.
- Prescriptions for conditions covered under Workers' Compensation or any other local, state, or federal health coverage or other insurance coverage.
- Prescriptions written by a licensed dentist, unless for the prevention of infection or pain in conjunction with a dental procedure.
- Progesterone suppositories, except when used in pregnancy or other FDA-approved use.
- Replacements of lost, stolen, or damaged drugs and medications.
- Sexual dysfunction medications unless the Sexual Dysfunction Rider is listed as a Benefit Rider on the Member Payment Summary.
- Travel-related medications, including preventive medication for the purpose of travel to other countries.

- Vitamin injections are covered only when determined by SelectHealth to be Medically Necessary for Members with specifically diagnosed diseases.
28. **Drug Testing.** Urine or blood testing for illegal drugs when performed for administrative purposes related to work or recreational activities, to monitor an individual's compliance with a legal order, or other work-related testing or for personal screening when there are no clinical conditions present establishing the medical necessity of this testing is not covered.
29. **Durable Medical Equipment (DME).** DME Services are not covered if determined by SelectHealth to not be required for activities of daily living or to be primarily for convenience, contentment, personal comfort, other non-therapeutic purposes, or that may be of use or benefit to persons in the absence of illness or disability. DME is not covered when obtained through a Non-Participating DME Provider or Facility. In addition, the following DME products and services are not covered:
- Accessories, controls, or related appurtenances or modifications of DME supplies, power supplies (including any charges for utilities such as light, power, and water), batteries, structures, and vehicles, however, batteries are covered when they are used to power a wheelchair or an infusion pump for the treatment of diabetes;
  - Any DME with a purchase price of more than \$750 without approval from SelectHealth;
  - Any equipment that is not considered by SelectHealth to be a standard of care or Medically Necessary;
  - Automated home blood pressure monitoring equipment;
  - Bath and shower fixtures;
  - Computerized, microprocessor controlled lower extremity prostheses (e.g., the Otto-Block C-leg) are not covered;
  - Continuous Passive Motion (CPM) Therapy for any indication is limited to twenty-one (21) days of continuous coverage from the first day applied;
  - Duplication, replacement of lost, damaged, stolen DME, or replacement more often than SelectHealth considers Medically Necessary;
  - Helmet therapy for positional plagiocephaly is only covered for Members less than twelve (12) months of age if determined to be medically necessary following a 3 month trial of more conservative therapy;
  - Home fitness equipment, spas, hot tubs, or similar equipment;
  - Interferential/Neuromuscular Stimulators for the treatment of chronic pain or musculoskeletal conditions are not covered for home use;
  - Items that are attached to a home or a car;
  - Oxygen therapy services for travel not considered necessary to complete Activities of Daily Living as defined by SelectHealth is not covered; however, oxygen therapy provided by airlines when used to complete Activities of Daily Living is covered;
  - Pediatric/infant scales;
  - Products or services obtained without a Physician's order;
  - Rental costs exceeding the purchase price (**Note:** For covered rental DME that is subsequently purchased, cumulative rental costs are deducted from the purchase price).
30. **Educational and Nutritional Training.** Educational and nutritional training is only covered in the following circumstances:
- Diabetic and asthma education is only covered in connection with the treatment of diabetes or asthma, and only when referred to by a Participating Provider to a certified educator or registered dietitian provided at a Participating Facility.
  - Educational and nutritional training for bulimia, anorexia nervosa, obesity, and morbid obesity is only covered when referred by a Participating Provider to a certified educator or registered dietitian affiliated with an Intermountain Facility, and is limited to a maximum of \$300 per Member per Year.

31. **Excess Charges.** Charges from Non-Participating Providers and Facilities that exceed SelectHealth's Fee Schedule for Covered Services are not covered even under circumstances when SelectHealth may otherwise pay for such services. SelectHealth Members are responsible for charges from Non-Participating Providers and Facilities that exceed SelectHealth's Fee Schedule for Covered Services.
32. **Experimental and/or Investigational Services.** Care, services, treatments, drugs, medications, supplies, or equipment is considered to be Experimental and/or Investigational is not covered. See Section II "Definitions" of the Master Group Contract.
33. **Eye Surgery, Refractive.** Radial Keratotomy and Lasik or other eye surgeries performed primarily to correct refractive errors are not covered. Accommodating or multifocal intraocular lenses to correct refractive problems are not covered, including when used in cataract surgery.
34. **Felony, Riot, or Insurrection.** Care or treatment of an illness or injury, or connected disability, is not covered if the Member engaged in, caused, or contributed to a felony, riot, insurrection, rebellion, or similar acts.
35. **Fitness Training.** Fitness training or conditioning is not covered when conducted as a preventive measure. Exercise equipment as well as membership fees to a spa or health club are also not covered.
36. **Food Supplements.** Food supplements, food substitutes, medical foods, and formulas are not covered (except when related to treatment of inborn errors of amino acid or urea cycle metabolism, refer to "Dietary Products" in this section).
37. **Gene Therapy.** Gene therapy or gene-based therapies are not covered. These are any treatments that try to replace a portion of a person's DNA code with material from an external source with the purpose of correcting a genetic defect related to a specific disease or to treat a specific condition. The external DNA may be in the form of intact genes, portions of genes or the building blocks of genes-nucleic acids.
38. **Genetic Testing.** Genetic testing is only covered in the following circumstances:
- a. As prenatal testing when performed as part of an amniocentesis to assess specific chromosomal abnormalities in women at high risk for conditions such as Down's Syndrome or other inheritable conditions that can lead to significant immediate and/or long term health consequences to the child after birth.
  - b. As neonatal testing to look for specific inheritable metabolic conditions such as PKU.
  - c. In select cases, when the patient being tested has a more than five percent probability of having an inheritable genetic condition **and** has presenting signs or symptoms suggestive of a specific condition or has a strong family history of the condition (defined as two or more first degree relatives with the condition) **and** results of the testing will directly affect the patient's treatment.
- Genetic testing is not covered when done as part of in vitro fertilization or as part of pre-implantation genetic testing.
- This coverage is only for individuals who are currently Members of SelectHealth. Genetic testing is not covered for Member's relatives who are not covered by SelectHealth.
39. **Habilitation Therapy Services.** Habilitation Therapy Services designed to create or establish function that was not previously present are not covered.

40. **Hearing Aids.** The purchase, fitting, or ongoing evaluation of hearing aids, appliances, or related procedures are not covered, including but not limited to hearing aids, auditory brain stem implants and similar devices to achieve a similar function, other hearing appliances, and any other procedure or device intended to establish or improve hearing or sound recognition.
41. **Home Health Aides/Services.** Home Health Aides/Services are not a covered Benefit.
42. **Infertility Services.** The following Infertility Services are not covered:
- Artificial insemination, sperm washings, sperm banking and/or storage
  - Donor costs
  - Experimental or Investigational treatment (See Section II “Definitions” of the Master Group Contract for a complete definition of “Experimental and/or Investigational”)
  - Gamete Intrafallopian Transfer (GIFT)
  - Hamster egg penetration tests
  - In-Vitro Fertilization (IVF)
  - In-vitro genetic testing
  - Medications for Infertility, and ultrasounds associated with Infertility medication therapy
  - Non-Participating Provider or Facility Services for Infertility
  - Pre-implantation genetic testing
  - Sterilization reversal, including tuboplasty except in cases of ectopic pregnancies, tubotubal anastomosis, vasovasotomy, vasovasorrhaphy, etc.
  - Zygote Intrafallopian Transfer (ZIFT)

For a description of Infertility Services that are covered, please see “Infertility Diagnosis and Treatment” in Section III “Physician and Other Provider Services” of this Exhibit.

43. **Immunizations.** The following immunizations are not covered: typhoid, yellow fever, cholera, plague, and BCG.
44. **Long Term Care.** See “Custodial Care, Long Term Care.”
45. **Medical Necessity.** Care, services, treatments, drugs, medications, supplies, or equipment that are not Medically Necessary are not covered. See Section II “Definitions” of the Master Group Contract.
46. **Mental Health.** Inpatient Mental Health and Chemical Dependency Rehabilitation Services and outpatient Mental Health and Chemical Dependency Rehabilitation Services are not covered. If the group covered hereunder purchases the “Catastrophic Mental Health and Chemical Dependency” Benefit Rider, broader Mental Health and Chemical Dependency rehabilitation coverage will be provided, but only to the extent specified in the Benefit Rider, when attached to this Contract. The existence of such coverage can be determined by reference to the Execution Section or Member Payment Summary.
47. **Methadone Clinics.** Methadone maintenance/therapy clinics or services are not covered.
48. **Miscellaneous Medical Supplies (MMS).** Miscellaneous Medical Supplies (MMS) are not covered unless determined by SelectHealth to be Medically Necessary, therapeutic, not generally usable in the absence of an illness or injury, and prescribed by a licensed Physician.
49. **Neuropsychological Testing.** Neuropsychological testing provided by behavioral health specialists is covered under the mental health benefit except in specific circumstances. When performed for any indication other than those listed below coverage for testing is limited to once in a patient’s lifetime.

The only conditions for which neuropsychological testing will be covered as a **medical benefit** are as follows:

- Testing performed as part of the pre-operative evaluation patients undergoing:
  - seizure surgery
  - solid organ transplantation
  - CNS malignancy
- Patients being evaluated for dementia/Alzheimer's Disease
- Post-stroke patients undergoing formal rehabilitation
- Post traumatic Brain Injury Patients

All other conditions are considered under the mental health benefit

Neuropsychological testing for any of the following reason is not covered under either the medical or mental health benefit.

- Autism spectrum disorder/pervasive developmental disorder
- Chronic fatigue syndrome
- Attention-deficit/hyperactivity disorder (ADHD)
- When performed primarily for educational purposes
- When performed in association with vocational counseling or training
- Learning disability
- Mental retardation
- Tourette's syndrome

Neuropsychological testing that is ordered strictly as a result of court-ordered services is not covered unless medical necessity criteria are met (see medical necessity criteria above).

50. **Non-Covered Services and Complications.** All care, services, treatments, drugs, medications, supplies, or equipment related to Non-Covered Services are not covered, including complications resulting directly from a Non-Covered Service, unless stated otherwise in this Contract. When a non-covered procedure is performed as part of the same operation or process as a Covered Service, then only Eligible Charges relating to the Covered Service will be Eligible for Benefits. Eligible Charges may be calculated and fairly apportioned to exclude any charges related to the Non-Covered Service.
51. **Non-Participating Providers.** Except for Emergencies, out-of-area Urgent Care Services and exceptions approved in advance and in writing by SelectHealth, Covered Services rendered, ordered or prescribed by Non-Participating Providers and Facilities are not covered.
52. **Norplant Removal.** Norplant is limited to Norplant insertion and removal. You are required to pay a \$150.00 Copay for Norplant insertion and removal. The \$150.00 Copay will be required regardless of SelectHealth's Coinsurance and Copay requirements for other services. Norplant removal is only covered five (5) years after the insertion date or if earlier removal is Medically Necessary. For Norplant removal, office surgery Benefits apply. (Refer to the Member Payment Summary for specific office surgery Benefits.) To be Eligible for Benefits, Norplant Services must be rendered by a Participating Provider and/or Facility.
53. **Obesity.** The medical management of obesity is covered only for Medical nutrition therapy; however, such therapy is limited to a maximum of \$300 per Member per Year when referred by a Participating Provider to a dietitian employed by an Intermountain facility.

All other medical therapies including, but not limited to, spa/health club membership, behavioral/cognitive therapy specifically intended to treat overweight/obese conditions, acupuncture, hypnotherapy, the rent or purchase of home exercise equipment, and medications specifically intended to treat overweight/obese conditions are not covered.

Complications related to the medical treatments for obesity not listed as covered, including but not limited to medical or surgical conditions arising out of the use of "fen-phen" therapy, are not covered.

Surgical treatment or other management of all types of obesity regardless of the nature of the surgery is not covered except when a Bariatric Surgery Rider is listed as a Benefit Rider on the Member Payment Summary. The reversal of any operations whose intent is to treat overweight/obese conditions and any complications from such operations or treatments are also not covered.

Medical or Surgical Complications which can be reasonably attributed to a surgical treatment for obesity are not covered if they arise within 10 years of the time of the procedure. Complications arising after 10 years from the date of the procedure are covered if determined to be medically necessary by SelectHealth. If the surgery was originally covered by SelectHealth pursuant to a Bariatric Surgery Rider, then complications arising from that surgery are not subject to this exclusion.

**54. Organ Transplants/Implants.** Except as expressly stated herein, all organ transplants and/or implants are not covered and all related services (such as, but not limited to, cross-matching and harvesting of organs from donors) are also not covered. Transplant/implant services may be covered if:

- a. approved in advance in writing by SelectHealth's Medical Director; and
- b. provided by Participating Providers in a Participating Hospital unless otherwise approved in writing in advance by SelectHealth's Medical Director.

For the transplant/implant services listed below that are covered, Medically Necessary cross-matching services and organ harvesting from donors are covered for purposes of an otherwise covered transplant/implant to a Member, but are not covered when a Member is the donor. Services for both the donor and the recipient are only covered under the recipient's coverage, even if both are Members of SelectHealth. Donor related services are limited to \$40,000 per transplant.

Unless specified as not covered under this Contract and provided that all other conditions of the Contract are satisfied, the only organ transplant/implant services that are covered are the following:

- Cornea
- Kidney (but only to the extent not covered by any government program);
- Heart
- Combined Heart/Lung
- Liver
- Combined Pancreas/Kidney
- Bone marrow whether from a donor or from the Member but only as treatment for conditions listed in SelectHealth's "Bone Marrow Transplant Criteria" in effect at the time authorization for the Transplant is sought.

55. **Orthotics and Other Corrective Appliances.** Orthotics and other corrective appliances are 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.

56. **Osteoporosis Screening.** Osteoporosis screening for patients at high risk for having or developing osteoporosis is covered. Screening of low risk individuals or mass screening groups are not covered. The only evaluation technology covered is central bone density testing (DEXA) scan. Peripheral bone density studies, ultrasound studies, and quantitative CT scans (QCT) are not covered.

57. **Pain Management Services.** In general, services for the treatment of acute and chronic pain are a covered Benefit. However, some therapies/services are not covered. These non-covered therapies and services include, but are not limited to the following:

- Prolotherapy
- Radiofrequency Ablation of dorsal root ganglion
- Acupuncture
- IV Pamidronate therapy for the treatment of reflex sympathetic dystrophy

Additionally, the following pain management services are only covered when approved in advance, and in writing, by SelectHealth:

- Radiofrequency Ablation of facet joints
- Spinal cord stimulators
- Intrathecal pain pumps
- Sacral Nerve Stimulation

58. **Pervasive Developmental Disorder.** Diagnostic tests, evaluations, services, medications or treatments with the intent of diagnosing, testing, or correcting Pervasive Developmental Disorder are not covered.

59. **Prescription Drugs and Medications.** See “Drugs, Medications, and Injections.”

60. **Preventive Care.** The following Preventive Care Services are not ever covered:

- Non-Participating Provider/Non-Participating Facility Services for preventive care;
- More than one (1) preventive examination and related screening tests per year (except for well-baby visits during the first twenty-four (24) months of life); and
- Injections, immunizations, and medications related to employment or travel, and typhoid, yellow fever, cholera, plague, and BCG immunizations.

61. **Psychiatric.** See “Mental Health.”

62. **Rehabilitation Therapy Services.** Physical, speech, and occupational rehabilitation therapy services are not covered unless 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. See the Member Payment Summary for Year Benefit Limitations imposed on Therapy Services.

The use of Continuous Passive Motion (CPM) devices as part of a rehabilitative program is limited to twenty-one (21) days of continuous coverage.

Aural rehabilitation related to an approved cochlear implantation is subject to the speech therapy Benefit limitations.

Additionally, rehabilitation therapy services in some specific clinical circumstances are not covered, as the benefit of rehabilitation therapy in these circumstances is unproven. These clinical circumstances include but are not limited to the following:

- Functional nervous disorders, Pervasive Developmental Disorder, or problems of similar nature, or impairment otherwise not attributable to a specific accident or illness, are not covered.
  - Vision rehabilitation therapy services.
  - Speech therapy for developmental speech delay associated with chronic otitis media/effusions without hearing loss.
  - Physical/occupational therapy specifically intended for the individual to participate or resume recreational, curricular/extracurricular or professional sports-related activities.
63. **Related Provider Services.** Care, services, treatments, drugs, medications, supplies, or equipment is not covered when provided to a Member by a Health Care Provider who ordinarily resides in the same household as the Member.
64. **Research.** See “Accepted Medical Practice.”
65. **Respite Care.** Respite Care is not a covered Benefit.
66. **Sexual Dysfunction.** Unless the Sexual Dysfunction Rider is listed as a Benefit Rider on the Member Payment Summary, all services, Durable Medical Equipment, and medications related to erectile dysfunction or other sexual dysfunction, including but not limited to surgical procedures, appliances, drugs and medical office visits, and whether or not required as the result of any Covered Service, are not covered.
67. **Shipping and Handling.** All finance, interest, postage, shipping and handling fees charged by a Provider or Facility are not covered.
68. **Specialty Services.** In the interest of providing high quality care for Members, coverage for specific specialty services may be restricted to only those Providers who document expertise through board certification or other formal training documentation that is considered a standard part of their training experience.
69. **Sterilization Procedures.** Sterilization procedures are not covered unless provided by a Participating Provider.
70. **Supplemental Accident Benefit Rider.** If the Supplemental Accident Benefit Rider is listed as a Benefit Rider on the Member Payment Summary and attached to this Contract, supplemental accident Benefits only apply to unintentional, non-self-inflicted physical injury to the body resulting from an unforeseen, unexpected event independent of disease, bodily infirmity, or any other cause. Once the supplemental accident Benefit is reached, normal medical-surgical Benefits apply for Covered Services. Supplemental accident Benefits do not apply to injuries resulting from normal body movement, such as stooping, bending, twisting, lifting, or chewing. The Supplemental Accident Benefit Rider does not apply to Chiropractic Services if the group covered hereunder purchases the Chiropractic Rider.
71. **Telephone/E-mail Consultations.** Charges for Provider telephone, E-mail, or other electronic consultations are not covered.
72. **Terrorism or Nuclear Release.** Care or treatment of an illness or injury, or connected disability, is 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.

73. **Transportation Services.** Emergency transportation services (Ambulance) are not covered beyond the nearest Facility expected to have appropriate services for the treatment of the emergency injury or illness involved, or when the Member could be safely transported by other means. Air Ambulance transportation is not covered when ground Ambulance transportation is available or when in the opinion of responding medical professionals, the delay would not jeopardize patient safety. Costs associated with travel to a local or distant medical provider, including accommodation and meal costs, are not covered. Any requests for coverage of transportation services in Non-emergency situations must be approved in advance by SelectHealth.

The costs related to transportation of a Member to the location of a covered organ transplant are not covered when such services can be provided by a commercial carrier in a timely fashion. However, if transportation to a transplant site cannot be accomplished within four (4) hours by commercial carrier, the costs of a chartered service will be covered.

74. **Unproven Interventions and Therapies.** Unproven care, services, treatments, drugs, medications, supplies, or equipment or devices are not covered. Generally, these do not provide better outcomes than covered procedures, have not demonstrated an improvement in the health outcomes and may lack strong evidence of their efficacy, especially compared to available, less-expensive alternatives. SelectHealth's review of these treatments includes the benefits and risks, quality of the evidence supporting the outcomes, availability of alternative treatments, and costs. These treatments that are not covered include, but are not limited to, the following:

- Anodyne Infrared Device for any indication
- Balloon Kyphoplasty
- Chronic Intermittent Insulin IV Therapy
- Coblation therapy of the soft tissues of the mouth, nose, throat, or tongue
- Computer-assisted interpretation of X-Rays (except mammograms)
- Extracorporeal Shock Wave Therapy for musculoskeletal indications
- Cryoablation therapy for plantar fasciitis and Morton's neuroma
- Free-standing/home cervical traction
- The Glucowatch, continuous glucose monitoring system
- Home anticoagulation or hemoglobin A1c testing
- Intimal Media Thickness (IMT) testing to assess risk of coronary disease
- Lovass therapy
- Magnetic Source Imaging (MSI)
- Microprocessor controlled, computerized lower extremity limb prostheses
- Mole mapping
- Nonsurgical spinal decompression therapy (e.g. VAX-D or DRS therapy)
- Nucleoplasty or other forms of percutaneous disc decompression
- Pressure Specified Sensory Device (PSSD) for neuropathy testing
- Prolotherapy
- Radiofrequency Ablation for lateral epicondylitis
- Radiofrequency Ablation of the dorsal root ganglion
- Robotic Surgery
- Secretin infusion therapy for the treatment of Autism
- Virtual Colonoscopy
- Whole body scanning

75. **Urgent Conditions.** Covered Services provided for an Urgent Condition by a Non-Participating Provider/Facility if a Participating Provider/Facility is within forty (40) miles of the Member are not covered.

76. **Utilization Management Requirements.** Care, services, treatments, drugs, medications, supplies, or equipment obtained in a manner that does not comply with SelectHealth's Utilization Management requirements are not covered or are limited in the extent of coverage in the manner stated on the Member Payment Summary. Utilization Management requirements include but are not limited to Preauthorization for Certain Drugs, Prenotification, Precertification and length of stay limits. See Provision 4.7 "Utilization Management/Quality Improvement Program."
77. **Vertebral Column Manipulations.** See "Chiropractic."
78. **Vision Aids.** The purchase, fitting, or ongoing evaluation of vision aids, appliances, or procedures is not covered, including but not limited to, contact lenses and eyeglasses. Prescribed eyeglasses are covered for Members following covered cataract surgery. In such cases, coverage is limited to a one-time Benefit up to \$100.00. Contacts are covered for Members diagnosed with Keratoconus.
- Monofocal intraocular lenses after cataract surgery are covered. However, accommodating or multifocal intraocular lenses to correct vision after cataract surgery are not covered.
79. **War.** Care or treatment of an illness or injury, or connected disability, is 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.

**SelectHealth, Inc.**  
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Domicile state: Utah

## **PRESCRIPTION DRUG BENEFITS RIDER**

### **USING YOUR PRESCRIPTION DRUG BENEFITS**

This section includes important information about how to use your prescription drug benefits, including certain requirements and limitations that you should know. You will also find more information about prescription drugs, injectable drugs, immunizations, etc. in the "General Limitations and Exclusions" section of the contract.

### **ONLINE PHARMACY TOOLS**

MySelectHealth.org gives you 24-hour online access to your personal prescription drug information. You can find information about the following topics:

- Potential lower-cost alternatives for drugs you currently take
- Tier statuses of prescription drugs
- Your prescription copays and benefits
- Maintenance drug (90-day) medications
- Your prescription history
- Explanation of Benefits (EOBs) for your drug claims
- Participating pharmacies
- Drugs requiring preauthorization and step therapy
- Items that prescription drug benefits do not cover
- Drugs with dispensing limits
- Drug indications and interactions

### **USE PARTICIPATING PHARMACIES**

To get the most from your prescription drug benefit, you must use a participating pharmacy and always present your ID Card when filing a prescription. SelectHealth contracts with pharmacy chains on a national basis, and with independent pharmacies in the state of Utah. If you are on the Select Value network, you must use participating pharmacies, or your drugs will not be covered.

If you are on the Select Med, Select Care or Select Choice network, you may use a nonparticipating pharmacy. When you do, you must pay full price for the drug, and then submit a Prescription Reimbursement Form with your pharmacy receipt to SelectHealth. Please be sure to send the itemized pharmacy receipt and not the receipt from the cash register. If covered, you will be reimbursed the discounted amount that SelectHealth would have paid to a participating pharmacy for the drug, minus your copay/coinsurance and/or deductible. Please be sure to send the pharmacy receipt and not the receipt from the grocery store. There are three (3) ways to find out which pharmacies participate with SelectHealth both nationally and within the state of Utah:

- Refer to your Provider & Facility Directory;
- Call Member Services; or
- Visit MySelectHealth.org

### **DRUGS WITH SPECIAL REQUIREMENTS**

Certain drugs require preauthorization or step therapy before they are covered. Please note that these drugs may change due to new drugs, new therapies, or other factors. As a result, there may be other drugs not on the Prescription Drug List that may require preauthorization or step therapy. For the most current list of drugs that have special requirements, visit [www.selecthealth.org](http://www.selecthealth.org) or call Member Services.

**PREAUTHORIZATION OF PRESCRIPTION DRUGS** - There are certain drugs that require your doctor to call SelectHealth before you purchase your medication. This is called "preauthorization." Preauthorization is not required when SelectHealth is the secondary insurance, unless Medicare is your primary insurance carrier. Prescription drugs that require preauthorization are identified on the Prescription Drug List included in the Membership Guide. The letters (PA) appear next to each drug that requires preauthorization. Preauthorization is also required if the medication is in excess of the plan limits (quantity, duration of use, maximum dose, etc.). Your doctor must preauthorize these drugs, or SelectHealth will not cover them.

To get preauthorization for these drugs, please have your doctor call the SelectHealth Pharmacy Services Help Desk at 801-442-4912 (Salt Lake area) or 800-442-3129, weekdays from 7:00 a.m. to 8:00 p.m. or Saturdays from 9:00 a.m. to 3:00 p.m.

If your doctor 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.

### **DRUGS THAT REQUIRE STEP THERAPY –**

Drugs that require step therapy are covered by SelectHealth only after you have tried a required preferred drug therapy, and it didn't work (the therapy failed).

If your doctor believes that your condition requires an exception to step therapy, your doctor can request preauthorization for the medication by calling SelectHealth Pharmacy Services at the number listed above.

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

### **LIMITATIONS**

The following limitations apply to your pharmacy benefits:

- Eligibility: If you are not eligible for coverage at the time your prescription is filled, then your prescription will not be covered, even if the prescription was written while you were eligible
- Copay/coinsurance: You will be charged one copay/coinsurance per covered prescription up to a 30-day supply at participating retail pharmacies
- Day Supply and Quantity Limitations: Prescriptions are subject to SelectHealth quantity and day supply limitations. For example, Schedule II drugs are limited to a 30-day supply per prescription. Schedule II drugs include, but are not limited to, controlled substances such as pain medications and stimulants. For certain drugs, a 90-day supply may be obtained, see the Maintenance Drug Benefit section below
- Dose limit: If your physician prescribes a dose of a medication that is not available, you will be charged a copay for each strength of the medication
- Refills: Refills are allowed after 80 percent of the last refill has been used. Some exceptions may apply; contact Member Services for more information.

### **EXCLUDED DRUGS**

Some drugs are excluded from coverage such as flu symptom medication, over the counter drugs, and cosmetics. Please see the General Limitations and Exclusions Section of your membership guide or contract for a list of excluded drugs.

### **COORDINATION OF BENEFITS**

If you have other health insurance that is your primary coverage, claims must be submitted to your primary insurance carrier first 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 claim to SelectHealth as the secondary carrier, a Prescription Reimbursement Form and the pharmacy receipt must be included in order to process your claim. In some circumstances, an Explanation of Benefits (EOB) from your primary carrier may also be required.

### **INAPPROPRIATE PRESCRIPTION PRACTICES**

In the interest of safety for our members, SelectHealth reserves the right to not cover certain prescription medications. These medications include, but are not limited to the following:

- Narcotic analgesics;
- Other addictive or potentially addictive medications; and
- Medications or drugs prescribed in quantities, dosages, or usages that are far outside the usual standard of care for the medication in question.

These medications are not covered when they are prescribed:

- Outside the usual standard of care for the practitioner prescribing the medication,
- In a manner inconsistent with accepted medical practice,
- For unproven indications as defined by the experimental/investigational definition in the "Definitions" section of the Master Group Contract.

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

**IF YOU ABUSE THE DRUG BENEFIT** - SelectHealth may limit the availability and filling of any prescription for a controlled substance or other prescription drug, which is susceptible to abuse. A care manager may administer these requirements in any of the following ways:

- Require you to obtain drugs only in medically necessary dosages and supplies;
- Require you to obtain prescriptions only from a specified participating doctor;
- Require prescriptions be filled only at a specified pharmacy;
- Require you to participate in specified treatment for any underlying medical problem (such as, but not limited to, a pain management program);
- Require that you complete a drug treatment program; or
- Require you to adhere to any other specified limitation or program designed to reduce or eliminate drug abuse or dependence.

If you abuse the healthcare delivery system to obtain drugs in amounts in excess of what is medically necessary, such as making repeated emergency room visits to obtain drugs for non-emergent conditions, SelectHealth may deny coverage of any medication susceptible of abuse. SelectHealth may also deny coverage for any particular medication susceptible of abuse beyond the amount considered medically necessary according to accepted medical practice and may deny amounts requested or needed to support any drug dependence, addiction, or abuse.

SelectHealth may terminate you from coverage if you make an intentional misrepresentation of material fact in connection with obtaining or attempting to obtain prescription drugs, medications, or hospital-dispensed drugs or medications, such as by intentionally misrepresenting a condition, other medications, healthcare encounters, or medically relevant information. At SelectHealth's discretion, you may be permitted to remain a member if you agree in writing to specified conditions and then faithfully comply with that agreement.

### **INJECTABLE DRUGS AND SPECIALTY MEDICATIONS**

Injectable drugs and specialty medications are a class of drugs that may be administered orally, as a single injection or "shot," intravenous infusion or in an inhaled/nebulized solution. They are generally used to treat an ongoing chronic illness and can be given by a medical professional or through self-administration. Characteristics of these medications may include but are not limited to the following:

- Products of a living organism or produced by a living organism through genetic manipulation of the organisms natural function
- Require special training to administer
- Have special storage and handling requirements
- Are typically limited in their supply and distribution to patients or providers
- Often have additional monitoring requirements

Certain drugs used routinely in a provider's office to treat common acute and common medical conditions (such as intramuscular penicillin) are not considered injectable drugs or specialty medications, because they are widely available, distributed without limitation and are not the product of "bio-engineering."

Injectable drugs and specialty medications are covered under your medical benefits. This benefit can be found by locating the "Injectable Drug and Specialty Medications" line on your Member Payment Summary. You will pay a coinsurance for these drugs after your medical deductible, if applicable. You can receive up to a thirty (30) day supply on injectable drugs, though exceptions can be made for travel purposes. Contact Member Services for more information. Some injectable drugs and specialty

medications are not covered. Please refer to the “General Limitations and Exclusions” section of this contract for more details.

Coverage of injectable drugs and specialty medications may change periodically because of new drugs, new therapies, or other factors. For the most current list of covered drugs and requirements, call Member Services at **801-442-5038** (Salt Lake area) or **800-538-5038**, weekdays from 7:00 a.m. to 8:00 p.m. or Saturdays from 9:00 a.m. to 2:00 p.m. or visit [www.selecthealth.org](http://www.selecthealth.org).

### **OBTAINING INJECTABLE DRUGS AND SPECIALTY MEDICATIONS**

In general, your doctor will coordinate the process for obtaining these drugs. You may be required to receive the drug or medication in your doctor’s office. Some injectable drugs and specialty medications may only be obtained from certain drug distributors. If this is the case, contact Member Services to obtain information on participating drug vendors.

### **PREAUTHORIZATION OF INJECTABLE DRUGS AND SPECIALTY MEDICATIONS**

Injectable drugs and specialty medications that require preauthorization are listed on the Injectable Drugs and Specialty Medications List with the letters (PA).

Preauthorization is also required if the medication is in excess of the plan limits (quantity, duration of use, maximum dose, etc.).

To request preauthorization for these drugs, please have your doctor call SelectHealth Pharmacy Services at 801-442-4912 (Salt Lake area) or **800-442-3129**, weekdays from 7:00 a.m. to 8:00 p.m. or Saturdays from 9:00 a.m. to 3:00 p.m.

Documentation supporting the medical necessity of the drug will be requested from your provider. To request preauthorization of a drug not listed, your provider can call SelectHealth Pharmacy Services at the number referenced above.

Participating providers will initiate the request for drugs requiring preauthorization on your behalf by calling SelectHealth.

Nonparticipating providers will not initiate the preauthorization process. When you receive injectable drugs and specialty medications from a nonparticipating provider or facility, you (not the provider) must obtain preauthorization. Call Member Services in advance to begin the preauthorization process. If you do not obtain preauthorization for the nonparticipating service, your benefits will be reduced, and your payments will not apply to your out-of-pocket maximum. However, once an approved preauthorization is obtained for services later on, your benefits will be paid at the nonparticipating level and will begin to apply to your out-of-pocket maximum.

### **PHARMACY INJECTABLE DRUGS AND SPECIALTY MEDICATIONS**

While injectable drugs apply to your medical benefits, the following injectable drugs may also be covered under your prescription drug benefits:

- Heparin
- Low Molecular Weight Heparin (Lovenox®)
- Glucagon
- Insulins
- Epinephrine (Epipen®)
- Sumatriptan (Imitrex®)

### **MAINTENANCE DRUG BENEFIT**

This benefit is available for prescriptions you use on an ongoing basis. These are called maintenance drugs. Eligible drug categories are listed below. Maintenance drugs are identified by the letter (M) on the online pharmacy tools and on the Prescription Drug List. The maintenance drug Benefit is only available for drugs that you have been taking for two or more months and expect to continue using for the next year. Call Member Services to verify if your medication is considered a maintenance drug and is eligible for the maintenance drug Benefit.

Eligible drugs are available on this program for a ninety (90) day or three (3) month supply for each prescription/refill. Eligibility and Benefits for maintenance drug medications are based on the date the prescription is filled. The following drug classifications may be eligible for the maintenance drug benefit:

- Alzheimer's
- Antidepressants
- Anti-gout medications
- Asthma medications
- Cardiovascular (ACE inhibitors, alpha II blockers, angiotensin II receptor blockers, antiadrenergic agents, beta blockers, blood modifiers, calcium channel blockers, cardiac glycosides, diuretics, etc.)
- Contraception
- Diabetic (insulin, oral, and test strips)
- Eye Drops (ophthalmic beta blocker, prostaglandins, and antihistamines)
- Hormone replacement therapy
- Inflammatory bowel disease medications
- Nasal preparations
- NSAIDs
- Osteoporosis treatments
- Potassium replacements
- Prenatal vitamins
- Prostate treatments
- Seizure disorder
- Thyroid medications
- Ulcer treatments (PP1 and H2 blockers)
- Urinary incontinence

### **OPTIONS WHEN FILLING MAINTENANCE MEDICATIONS**

You now have two (2) options when filling prescriptions under the maintenance drug benefit.

|                   | <b>Retail90<sup>SM</sup></b>  | <b>Medco By Mail</b>  |
|-------------------|---|---|
| Description       | 90-day supply available through participating retail pharmacies.  | 90-day supply available through mail order.   |
| New Prescriptions | <p>You must have filled one month's supply of the medication using your SelectHealth prescription drug benefit in one of the following ways:</p> <ul style="list-style-type: none"> <li>• at least once at any participating retail pharmacy within the previous 120 days; or</li> <li>• at least once through Medco by Mail within the previous 180 days.</li> </ul> <p>Please give the pharmacy two</p> | <p>Ask your doctor for two prescriptions. The first prescription should be for a one month supply to be filled at a participating retail pharmacy. The second prescription must be for a 90-day or three-month supply (refills up to a year) to be filled through Medco By Mail. Submit the second prescription either by mail or fax together with the Medco Order Form.</p> |

|                        |   |   |
|------------------------|---|---|
|                        | to three days notice before you pick up your new Retail90 prescription.   |   |
| Refills                | Refills are picked up at the pharmacy where you will pay a new copay. Please order your refill two to three days before you plan to pick it up. | Your medication will include instructions for refills, if applicable.                           |
| Delivery of Medication | You will pick up your medication at the pharmacy.   | Medications are usually sent to you by U.S. mail or UPS. Please allow two weeks for processing. |
| Paying for Medication  | You will pay the applicable copay at the pharmacy before you pick up your medication.   | You may pay by check, money order, or most major credit cards.                                  |

Note: If you have been using Medco by Mail and would like to switch to Retail90, you will need to obtain a new prescription. Medco by Mail is unable to transfer prescriptions.

## **GENERIC SUBSTITUTION REQUIRED**

You are required to use generic drugs whenever available. A generic drug will be substituted for a brand-name drug except when a doctor states on the prescription that, based on medical reasons, a generic drug may not be substituted. If you (not your doctor) request a brand-name drug instead of a generic drug, then you must pay the difference between the amount SelectHealth would have paid to a participating pharmacy for a generic drug, and the amount SelectHealth would have paid to a participating pharmacy for the brand-name drug, plus the copay/coinsurance. The difference in cost between the generic and brand-name drug will not apply to your pharmacy deductible and out-of-pocket maximum. If, for medical reasons, your doctor requests a brand name drug when a generic is available, this penalty will not apply.

## PRESCRIPTION DRUG BENEFIT

SelectHealth offers a tiered prescription drug benefit. There are three benefit levels (or tiers) for covered prescription medications. The three tiers are:

### **Tier 1 - Lowest Copay/Coinsurance**

### **Tier 2 - Middle Copay/Coinsurance**

### **Tier 3 - Highest Copay/Coinsurance**

These tiers listed on your ID Card and Member Payment Summary tell you how much you pay when you go to the pharmacy.

Drugs on each tier are selected by an expert panel of physicians and pharmacists who serve on a Pharmacy and Therapeutics (P&T) Committee. The drugs included on the lower tiers are chosen to provide quality, cost-effective prescription therapy and may change periodically because of new drugs, new therapies, or other factors.

SelectHealth's three-tier prescription drug benefit allows you to choose the drugs that best meet your medical needs while encouraging you and your provider to discuss pharmaceutical treatment options and choose lower tier drugs that are therapeutically appropriate. If your doctor prescribes a Tier 2 or Tier 3 drug, you can discuss with him or her to determine if there is an appropriate Tier 1 drug available.

#### **TIER 1 - LOWEST COPAY/COINSURANCE**

- You will pay the lowest copay/coinsurance for Tier 1 drugs.
- Tier 1 drugs include most generic drugs and select brand-name drugs. A generic drug is a medication whose active ingredients, safety, dosage, quality, and strength are identical to that of its brand-name counterpart. Both the brand-name drug and the generic drug must get approval from the Food and Drug Administration (FDA) before they can be sold.

#### **TIER 2 - MIDDLE COPAY/COINSURANCE**

- You will pay a middle copay/coinsurance for Tier 2 drugs.
- Tier 2 drugs include select brand-name drugs and select generic drugs.

#### **TIER 3 - HIGHEST COPAY/COINSURANCE**

- You will pay the highest copay/coinsurance for Tier 3 drugs.
- Tier 3 drugs are generally brand-name medications that have an alternate drug in a lower tier.
- Your doctor can determine whether a lower tier drug is right for you.
- Any covered medication not listed in Tier 1 or Tier 2 is considered a Tier 3 drug.

To determine which tier applies to each prescription drug, refer to the Prescription Drug List included in the Membership Guide. The Prescription Drug List includes the most commonly prescribed drugs and is not a complete list of covered medications. If a prescription drug is not listed, information for that drug is available by calling Member Services at **1-801-442-5038** (Salt Lake area) or **1-800-538-5038**, weekdays from 7:00 a.m. to 8:00 p.m. or Saturdays from 9:00 a.m. to 2:00 p.m. or by visiting [www.selecthealth.org](http://www.selecthealth.org).

## MENTAL HEALTH BENEFITS RIDER

### Using Your Mental Health Benefits

The Catastrophic Mental Health and Chemical Dependency benefit provides access to high quality mental health care with professionalism and confidentiality. The benefit serves you through an assessment and referral service that directs you to mental health providers that are best qualified to meet your needs.

Your Catastrophic Mental Health and Chemical Dependency benefits are subject to all the provisions, limitations, and exclusions of your medical benefit that are listed in this document and the Master Group Contract.

If you have any questions regarding any aspect of the benefits described in this Rider, please call the Behavioral Health Advocates weekdays between 8:00 a.m. and 6:00 p.m. at **801-442-1989** (Salt Lake area) or **800-876-1989**.

When you need assistance from a mental health provider, you must call the Behavioral Health Advocates at one of the numbers listed above. A Behavioral Health Advocate will evaluate your needs and determine the most appropriate plan of action for you to obtain quality care.

### USE PARTICIPATING MANAGED MENTAL HEALTH PROVIDERS

Mental health services will be covered only when rendered by a managed mental health provider unless otherwise noted on the MPS.

### DEFINITION OF TERMS

The following are in addition to the "Definitions" section of the Master Group Contract.

**Gateway:** An initial referral service provided to you when contact is made to access your mental health benefits. Specific Gateway information is provided on the Member Payment Summary.

**Managed Mental Health Panel:** The group of participating managed mental health providers who have been accepted by SelectHealth to provide mental health services as defined in this section. See also "Participating Managed Mental Health Provider" subsection of this section.

**Mental Health Deductible:** The portion of eligible mental health charges payable by you each year directly to providers for covered mental health services before SelectHealth provides mental health benefits. If the mental health deductible applies to your plan it will be specified on the Member Payment Summary.

**Mental Health Disorder or Alcohol/Chemical Dependency:** An emotional condition or chemical dependency listed as a mental disorder in the *Diagnostic and Statistical Manual*, as periodically revised, and which requires professional intervention for as long as mental health services are considered medically necessary.

**Mental Health Out-of-Pocket Maximum:** The maximum dollar amount per year of eligible mental health charges payable by you directly to providers as deductibles, copays, and coinsurance. If the mental health out-of-pocket maximum applies to your plan, the amount will be listed on your Member Payment Summary. Except where noted otherwise on the Member Payment Summary, SelectHealth will pay 100 percent of eligible mental health charges during the remainder of the year once the mental health out-of-pocket maximum is satisfied. This does not apply to changes that are not "eligible." Member payments for noncovered services or excess charges are not applied to the out-of-pocket maximum.

**Mental Health Provider:** A licensed and qualified mental health provider.

**Mental Health Service:** A treatment for a mental health disorder or alcohol/chemical dependency.

**Nonparticipating Mental Health Provider:** A mental health provider who has not been accepted on the managed mental health panel.

**Participating Managed Mental Health Provider:** A licensed and qualified mental health provider who has been accepted to participate on the managed mental health panel and who has signed a written provider agreement with SelectHealth that is in effect at the time the services is rendered. Refer to your Provider & Facility Directory to find out which mental health providers participate on the managed mental health panel. Participating managed mental health providers are identified by the “p” symbol in the provider directory.

## **EXCLUSIONS**

The mental health services that are covered are limited in scope and extent. Mental health services are not covered unless SelectHealth determines that evaluation and intervention on a crisis or short-term basis will improve the condition. The following are not covered: long term care and care for excluded conditions, treatments, and situations.

The following psychiatric procedures and diagnoses are not covered:

### **Psychiatric Procedures**

- Behavior modification;
- Biofeedback;
- 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;
- Education or training;
- Electrosleep or electronarcosis therapy;
- Family counseling and/or therapy;
- Marriage counseling and/or therapy;
- Methadone maintenance/therapy clinics or services;
- Milieu therapy;
- Psychotherapy or psychoanalysis credited toward earning a degree or furthering your education or training;
- Residential treatment, day treatment, partial hospitalization, and intensive outpatient treatment when rendered by non-participating providers;
- Rest cures;
- Self-care or self-help training (non-medical);
- Sensitivity training;
- Surgical procedures to remedy a condition diagnosed as psychological, emotional, or mental, including but not limited to transsexual or sex change treatment; and
- Psychological or neuropsychological testing by non-participating providers or facilities, and any testing or mental examinations in the absence of symptoms of mental illness.

### **Psychiatric Diagnoses (except where secondary to a covered primary diagnosis)**

- Adjustment disorder;
- Chronic organic brain syndrome;
- Conduct disorder;
- Diagnosis that refer to someone else’s illness, such as family history of psychiatric condition, family history of mental retardation, family disruption, and/or alcoholism in the family;
- Difficult life circumstance not part of treatment for a recognized mental illness;
- Marital or family problems;
- Mental retardation;
- Personality disorder;
- Psychosexual disorder such as, but not limited to transsexualism, psychosexual identity disorder, psychosexual dysfunction, or gender dysphoria;
- Problems with gambling, theft, or fire setting;
- Screening exams;

- Separation anxiety;
- Social, occupational, religious, or other social maladjustment; and
- Specific developmental disorder or learning disabilities such as, but not limited to autism, Attention Deficit Disorder (ADD)/hyperactivity, and pervasive developmental disorder.
- Social, occupational, religious, or other social maladjustment.

## **SUPPLEMENTAL ACCIDENT BENEFITS RIDER**

Supplemental accident benefits only apply to unintentional, non-self-inflicted physical injury to the body resulting from an unforeseen, unexpected event independent of disease, bodily infirmity, or any other cause. Once the supplemental accident benefit limit is reached, normal medical-surgical benefits apply for Covered Services. Supplemental accident benefits do not apply to injuries resulting from normal body movement, such as stooping, bending, twisting, lifting, or chewing. The Supplemental Accident Benefit Rider does not apply to chiropractic services if the group covered hereunder purchases the Chiropractic Rider.

The benefit amount specified on the Member Payment Summary is a per person per calendar year benefit and starts over every January (as long as the Rider is identified as covered on the Member Payment Summary). This benefit does not increase if multiple accidents occur within a given calendar year. Any claims for a specific accident under this benefit must be incurred within twelve (12) months of the accident.

**EXECUTION SECTION  
(AND APPLICATION)**

**Master Group Contract reference number:** **LG-HMO**

**Plan:** **SelectHealth, Inc.**, a Utah nonprofit corporation doing business as: **Select Care**, 4646 West Lake Park Boulevard, Salt Lake City, Utah 84120, telephone number (801) 538-5038.

**Employer:** Farm Credit Foundations  
**Key Contact:** Cindy Burkel  
**Employer Address:** 375 Jackson Street  
St. Paul, Minnesota 55101  
**Employer Phone:** (651) 282-8347

**Affiliated Businesses/Subsidiaries Covered by this Application:**

Employer applies to Plan for group health coverage. When countersigned by Plan and attached to a signed Master Group Contract, this document and its attachments become the Execution Section referred to in the Master Group Contract. Once fully executed, Plan and Employer agree to the terms set forth in the attached Master Group Contract and this Execution Section.

Employer acknowledges that the Contract is entered into by Plan in reliance upon the Employer supplying complete and accurate information, including but not limited to this document, and in connection with any proposals which have preceded this document, all of which shall be considered to be material representations of fact by Employer to Plan. Plan and Employer thus agree upon the following:

**A. MONTHLY PREPAYMENT FEES**

On or before the first day of each month, Employer shall pay Plan Monthly Prepayment Fees of:

| <u>L20A1983</u> | <u>L20A1984</u> |  |
|-----------------|-----------------|--|
| \$389.00        | \$230.00        | for each Single Party enrollment             |
| \$680.00        | \$404.00        | for each Employee plus Child(ren) enrollment |
| \$778.00        | \$461.00        | for each Employee plus Spouse enrollment     |
| \$1,167.00      | \$689.00        | for each Family enrollment                   |

**B. ELIGIBILITY, PREPAYMENT AND ENROLLMENT CRITERIA**

Mandatory employee eligibility and enrollment requirements which Employer's group must satisfy as a condition to the initial and continued effectiveness of this contractual arrangement are as follows:

1. Scheduled hours of work per week 20
2. Average scheduled hours of work per week over the previous consecutive ninety (90) day period 20
3. Portion of Prepayment Fee to be contributed by Employer:  
Employee payroll deductions will be the same or less than any other plans offered.
4. Required minimum employee enrollment \_\_\_\_\_
5. Unmarried dependent children coverage up to age 19
6. Unmarried, financially dependent children coverage up to age 26
7. Retiree coverage \_\_\_\_\_  
If covered, "retiree" means:
8. Eligible employees granted a leave of absence by Employer up to 60 days or up to 12 weeks if the employee is on leave under the Family Medical Leave Act. For any employer who grants leaves of absence for eligible employees, including long term sick leave, that would fall under the definition of a Family Medical Leave Act (FMLA), the required leave of absence will run concurrently with any required FMLA leave of absence. Leave time can only be accrued and used by the employee using the leave time. Leave Banks beyond the legally allowed 12-weeks of FMLA, where employees share or purchase leave time from other employees, are not allowed.
9. Newly hired eligible employees who are hired between the 1st and 15th of the month and who enroll within 31 days of eligibility for coverage will be covered on the 16th of that month. Newly hired eligible employees who are hired between the 16th and the end of the month and who enroll within 31 days of eligibility for

coverage will be covered on 1st day of the following month. In the event a change of status is made within 31 days, the effective date will be the date of the status change. As long as the effective date of the event is equal to or greater than the coverage effective date.

10. Leased employees and independent contractors are not eligible for coverage by Plan.
11. Coverage will terminate on the 15th of the month if termination of employment occurs between the 1st and the 15th of the month. Coverage will terminate on the end of the month if termination of employment occurs between the 16th and the end of the month.

### **C. DURATION OF MASTER GROUP CONTRACT**

If Plan's minimum underwriting standards are satisfied, the Master Group Contract and its terms, shall:

Renew for an Effective Date of January 1, 2008, for a term of 12 months to December 31, 2008.

An Annual Open Enrollment Period of at least ten (10) working days shall be conducted prior to renewal of the Master Group Contract to allow eligible Employees the opportunity to enroll themselves and their Eligible Family Dependents in the Plan.

### **D. MEMBER PAYMENT SUMMARY**

In addition to any other applicable Prepayments, Members shall pay the Deductibles/Copayments/Coinsurance amount per occurrence indicated on the attached **Member Payment Summary** which is incorporated herein. "Not Covered" in the Member Payment Summary indicates that the service is not covered regardless of any other statement of coverage in Exhibit A or otherwise.

### **E. ADDITIONAL TERMS, CONDITIONS, AND/OR LIMITATIONS**

Refer to the following attached Benefit Riders: RX-Intro, RX-Mail, RX-Generic, RX-Tiered, LG-S Accident, and LG-M Health.

If your service ends, your coverage will stop at the end of the month in which the earliest of these dates occur, and you have the ability to elect to continue coverage for up to 12 months, if:

- Your employment classification changes from full-time or part-time to temporary (ineligible class);

- You become divorced and your divorced spouse wants to continue coverage. Coverage can continue for 12 months only for your former spouse. The full single premium is charged to your former spouse;
- Your service ends for any reasons except gross misconduct (for example, you retire, die or leave the District);
- You begin full-time military service in the armed forces of any country or international authority;
- You are a family member of a deceased employee. Coverage for each of your dependents ends when your coverage ends, or at the end of the month that he or she is no longer an eligible dependent.
- Your dependent is no longer an eligible dependent. Coverage can continue for 12 months only (the total premium is charged);

You have 60 days from your termination date to decide to continue coverage. You pay the cost to continue coverage. You will not receive a monthly bill. If you elect continued coverage but fail to make timely premium payments, your coverage will be terminated retroactively.

An ineligible dependent, deceased employee's family member or divorced spouse will have 60 days from the coverage end date to decide to continue coverage. They are responsible for the full cost to continue coverage. A monthly bill will not be sent. If timely payments are not made, coverage will be canceled. Furthermore, continued coverage will end if the Plans are terminated.

Plan will provide a certificate of creditable coverage as is required under the Health Insurance Portability and Accountability Act of 1996 for any Member covered by plan under this agreement. Plan will not be responsible for sending such notice to any employee that may have terminated employment while still in the employer's waiting period for coverage (i.e., before the employee's effective date of coverage with Plan) if any such period exists.

**F. OTHER HEALTH PLANS OFFERED**

Employer discloses the following, which are all additional health plans (if any) being sponsored for its employees in the Plan's service area during the initial term or any subsequent term of the Master Group Contract:

1. Name of Insurer, health plan, or administrator:

|       | <u>Total Monthly Rates Charged</u> |                  |               |
|-------|------------------------------------|------------------|---------------|
|       | <u>Single</u>                      | <u>Two Party</u> | <u>Family</u> |
| _____ |                                    |                  |               |
| _____ |                                    |                  |               |

2. Total Employer Contribution toward monthly rates for above plans

|       | <u>Single</u> | <u>Two Party</u> | <u>Family</u> |
|-------|---------------|------------------|---------------|
| _____ |               |                  |               |
| _____ |               |                  |               |

**Employer agrees to notify Plan in writing in advance if any change occurs in the items disclosed in F.1. or F.2. above, or if the benefits or eligibility for participation provided under any of the above coverages should change.**

This Master Group Contract Application, if finalized, is made on the basis of information provided to Plan and is subject to the above criteria as well as properly completed Member applications. Member applications are to be submitted to and approved by Plan's Underwriting Department before the proposed Effective Date. Otherwise, Plan may delay the Effective Date. Plan shall have the right to audit Employer's payroll records either before, during or following the term of the contract to verify enrollment and eligibility data.

**THE EXECUTION OF A MASTER GROUP CONTRACT BY BOTH PARTIES IS  
REQUIRED TO VALIDATE THIS CONTRACTUAL RELATIONSHIP.**

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

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

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

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

Address: \_\_\_\_\_  
\_\_\_\_\_

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

**SelectHealth, Inc., dba Select Care**

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

Printed Name: Sidney C. Paulson

Title: President / Chief Executive Officer

Address: 4646 West Lake Park Boulevard  
Salt Lake City, Utah 84120



**MEMBER PAYMENT SUMMARY**

**PARTICIPATING**

*(In-Network)*

When using participating providers, you are responsible to pay the amounts in this column. Services from nonparticipating providers are not covered (except emergencies).

**CONDITIONS AND LIMITATIONS**

|   |               |
|---|---------------|
| Lifetime Maximum Plan Payment - <i>Per Person</i> . . . . . | \$2,500,000   |
| Pre-Existing Conditions (PEC) . . . . .                     | None          |
| Benefit Accumulator Period . . . . .                        | calendar year |

**MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET**

**PARTICIPATING**

|   |               |
|---|---------------|
| Deductible - Per Person/Family (per calendar year) . . . . .            | No Deductible |
| Out-of-Pocket Maximum - Per Person/Family (per calendar year) . . . . . | \$1500/\$3000 |

**INPATIENT SERVICES**

**PARTICIPATING**

|   |     |
|---|-----|
| Medical, Surgical, Hospice, and Emergency Admissions . . . . .  | 20% |
| Maternity and Adoption <sup>1</sup> . . . . .   | 20% |
| Skilled Nursing Facility - Up to 60 days per calendar year . . . . .  | 20% |
| Inpatient Rehab Therapy: Physical, Speech, Occupational . . . . .<br>Up to 40 days per calendar year for all therapy types combined | 20% |

**PROFESSIONAL SERVICES**

**PARTICIPATING**

|   |                         |
|---|-------------------------|
| Office Visits & Minor Office Surgeries  |                         |
| Primary Care Provider (PCP) <sup>2</sup> . . . . .                                    | \$15                    |
| Secondary Care Provider (SCP) <sup>2</sup> . . . . .                                  | \$25                    |
| Preventive Care   |                         |
| Primary Care Provider (PCP) <sup>2</sup> . . . . .                                    | \$15                    |
| Secondary Care Provider (SCP) <sup>2</sup> . . . . .                                  | \$25                    |
| Adult and Pediatric Immunizations . . . . .   | Covered 100%            |
| Elective Immunizations . . . . .  | 20%                     |
| Diagnostic Tests: Minor . . . . .   | Covered 100%            |
| Allergy Tests . . . . .   | See Office Visits Above |
| Allergy Treatment and Serum . . . . .   | 20%                     |
| Major Office Surgery ( <i>Surgical and Endoscopic Services Over \$350</i> ) . . . . . | 20%                     |
| Physician's Fees - ( <i>Medical, Surgical, Maternity, Anesthesia</i> ) . . . . .      | 20%                     |

**OUTPATIENT SERVICES**

**PARTICIPATING**

|  |              |
|--|--------------|
| Outpatient Facility and Ambulatory Surgical - ( <i>all related services</i> ) . . . . .  | 20%          |
| Ambulance (Air or Ground) - <i>Emergencies Only</i> . . . . .  | 20%          |
| Emergency Room - ( <i>Participating facility</i> ) - <i>Includes all services rendered in conjunction with the ER</i> . . . . .      | \$50         |
| Emergency Room - ( <i>Nonparticipating facility</i> ) - <i>Includes all services rendered in conjunction with the ER</i> . . . . .   | \$100        |
| Intermountain InstaCare <sup>SM</sup> Facilities, Urgent Care Facilities . . . . .   | \$25         |
| Intermountain KidsCare <sup>SM</sup> Facilities . . . . .  | \$15         |
| Chemotherapy, Radiation and Dialysis . . . . .   | 20%          |
| Diagnostic Tests: Minor . . . . .  | Covered 100% |
| Diagnostic Tests: Major . . . . .  | 20%          |
| Home Health, Hospice, Outpatient Private Nurse . . . . .   | 20%          |
| Outpatient Rehab Therapy: Physical, Speech, Occupational . . . . .<br><i>Up to 20 visits per calendar year for each therapy type</i> | \$25         |



**MEMBER PAYMENT SUMMARY**

**PARTICIPATING**

*(In-Network)*

**PARTICIPATING**

**MISCELLANEOUS SERVICES**

|  |      |
|--|------|
| Durable Medical Equipment (DME) - <i>Inpatient or Outpatient</i> . . . . .   | 20%  |
| Infertility - <i>Selected Services</i> . . . . .<br><i>(Max Plan Payment \$1,500/ calendar year; \$5,000 lifetime)</i> | *50% |
| Miscellaneous Medical Supplies (MMS) . . . . .   | 20%  |

**BENEFIT RIDERS**

**PARTICIPATING**

|   |   |
|---|---|
| Catastrophic Mental Health and Chemical Dependency <i>(combined benefits)</i> | To access your Mental Health benefits<br>call: 1-800-876-1989                             |
| Mental Health Deductible - Per Person/Family - (per calendar year)            | No Deductible   |
| Mental Health Out-of-Pocket Maximum - Per Person/Family - (per calendar year) | \$1500/\$3000   |
| Mental Health Office Visits   | \$15  |
| Inpatient   | 50%   |
| Outpatient  | 50%   |
| Injectable Drugs and Specialty Medications +                                  | 20%   |
| Prescription Drugs - <i>Up to 30 Day Supply of Covered Medications</i> +      |   |
| Tier 1  | *\$5  |
| Tier 2  | *\$20   |
| Tier 3  | *\$40   |
| 90-Day Maintenance Home Delivery Benefit - <i>selected drugs</i> +            |   |
| Tier 1  | *\$5  |
| Tier 2  | *\$40   |
| Tier 3  | *\$120  |
| Generic Substitution Required   | Generic required or must pay copay plus cost<br>difference between name brand and generic |

1 SelectHealth provides an allowable adoption amount of \$4,000 as outlined by the state of Utah. Medical deductible and copay/coinsurance applies.  
 2 Refer to your SelectHealth Provider & Facility Directory to identify whether a provider is a primary or secondary care provider.  
 + Preauthorization is required on certain injectable and prescription drugs. If you fail to preauthorize, the drug will not be covered. Please refer to your membership guide for more information.  
 \* Not applied to Medical out-of-pocket maximum.

All deductible/copay/coinsurance amounts and plan payments are based on eligible charges only and not on the provider's billed or other charges. You are responsible to pay for charges in excess of eligible charges for covered services obtained from non-participating providers and facilities. Such excess charges are not applied to the medical out-of-pocket maximum. Refer to your Contract, Membership Guide, or Provider & Facility Directory for more information.

Select Care is administered and underwritten by SelectHealth.

MPS-HMO 01/01/08 v2-0

10/19/07

[www.selecthealth.org](http://www.selecthealth.org)



**MEMBER PAYMENT SUMMARY**

**PARTICIPATING**

*(In-Network)*

When using participating providers, you are responsible to pay the amounts in this column. Services from nonparticipating providers are not covered (except emergencies).

| <b>CONDITIONS AND LIMITATIONS</b>  |   |
|--|---|
| Lifetime Maximum Plan Payment - <i>Per Person</i> . . . . .  | \$2,500,000                             |
| Pre-Existing Conditions (PEC) . . . . .  | None                                    |
| Benefit Accumulator Period . . . . .   | calendar year                           |
| <b>MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET</b>  |   |
| Deductible - Per Person/Family (per calendar year) . . . . .   | \$1000/\$2000                           |
| Out-of-Pocket Maximum - Per Person/Family (per calendar year) . . . . .  | \$5000/\$10000<br>(Deductible Included) |
| <b>INPATIENT SERVICES</b>  |   |
| Medical, Surgical, Hospice, and Emergency Admissions . . . . .   | 20% after deductible                    |
| Maternity and Adoption <sup>1</sup> . . . . .  | 20% after deductible                    |
| Skilled Nursing Facility - Up to 60 days per calendar year . . . . .   | 20% after deductible                    |
| Inpatient Rehab Therapy: Physical, Speech, Occupational . . . . .<br>Up to 40 days per calendar year for all therapy types combined  | 20% after deductible                    |
| <b>PROFESSIONAL SERVICES</b>   |   |
| Office Visits & Minor Office Surgeries   |   |
| Primary Care Provider (PCP) <sup>2</sup> . . . . .   | \$15 after deductible                   |
| Secondary Care Provider (SCP) <sup>2</sup> . . . . .   | \$25 after deductible                   |
| Preventive Care  |   |
| Primary Care Provider (PCP) <sup>2</sup> . . . . .   | \$15 after deductible                   |
| Secondary Care Provider (SCP) <sup>2</sup> . . . . .   | \$25 after deductible                   |
| Adult and Pediatric Immunizations . . . . .  | Covered 100%                            |
| Elective Immunizations . . . . .   | 20%                                     |
| Diagnostic Tests: Minor . . . . .  | Covered 100% after deductible           |
| Allergy Tests . . . . .  | See Office Visits Above                 |
| Allergy Treatment and Serum . . . . .  | 20% after deductible                    |
| Major Office Surgery ( <i>Surgical and Endoscopic Services Over \$350</i> ) . . . . .  | 20% after deductible                    |
| Physician's Fees - ( <i>Medical, Surgical, Maternity, Anesthesia</i> ) . . . . .   | 20% after deductible                    |
| <b>OUTPATIENT SERVICES</b>   |   |
| Outpatient Facility and Ambulatory Surgical - ( <i>all related services</i> ) . . . . .  | 20% after deductible                    |
| Ambulance (Air or Ground) - <i>Emergencies Only</i> . . . . .  | 20% after deductible                    |
| Emergency Room - ( <i>Participating facility</i> ) - <i>Includes all services rendered in conjunction with the ER</i> . . . . .      | \$50 after deductible                   |
| Emergency Room - ( <i>Nonparticipating facility</i> ) - <i>Includes all services rendered in conjunction with the ER</i> . . . . .   | \$100 after deductible                  |
| Intermountain InstaCare <sup>SM</sup> Facilities, Urgent Care Facilities . . . . .   | \$25 after deductible                   |
| Intermountain KidsCare <sup>SM</sup> Facilities . . . . .  | \$15 after deductible                   |
| Chemotherapy, Radiation and Dialysis . . . . .   | 20% after deductible                    |
| Diagnostic Tests: Minor . . . . .  | Covered 100% after deductible           |
| Diagnostic Tests: Major . . . . .  | 20% after deductible                    |
| Home Health, Hospice, Outpatient Private Nurse . . . . .   | 20% after deductible                    |
| Outpatient Rehab Therapy: Physical, Speech, Occupational . . . . .<br><i>Up to 20 visits per calendar year for each therapy type</i> | \$25 after deductible                   |



**MEMBER PAYMENT SUMMARY**

**PARTICIPATING**

*(In-Network)*

**MISCELLANEOUS SERVICES**

**PARTICIPATING**

|  |                       |
|--|-----------------------|
| Durable Medical Equipment (DME) - <i>Inpatient or Outpatient</i> . . . . .   | 20% after deductible  |
| Infertility - <i>Selected Services</i> . . . . .<br><i>(Max Plan Payment \$1,500/ calendar year; \$5,000 lifetime)</i> | *50% after deductible |
| Miscellaneous Medical Supplies (MMS) . . . . .   | 20% after deductible  |

**BENEFIT RIDERS**

**PARTICIPATING**

|  |   |
|--|---|
| Catastrophic Mental Health and Chemical Dependency <i>(combined benefits)</i>  | To access your Mental Health benefits<br>call: 1-800-876-1989                             |
| Mental Health Deductible - Per Person/Family - (per calendar year)   | \$1000/\$2000   |
| Mental Health Out-of-Pocket Maximum - Per Person/Family - (per calendar year)  | \$5000/\$10000  |
| Mental Health Office Visits  | \$15 after mental health deductible   |
| Inpatient  | 50% after mental health deductible  |
| Outpatient   | 50% after mental health deductible  |
| Injectable Drugs and Specialty Medications +   | 20% after deductible  |
| Prescription Drugs - <i>Up to 30 Day Supply of Covered Medications</i> +   |   |
| Tier 1   | *\$5  |
| Tier 2   | *\$20   |
| Tier 3   | *\$40   |
| 90-Day Maintenance Home Delivery Benefit - <i>selected drugs</i> +   |   |
| Tier 1   | *\$5  |
| Tier 2   | *\$40   |
| Tier 3   | *\$120  |
| Generic Substitution Required  | Generic required or must pay copay plus cost<br>difference between name brand and generic |
| Supplemental Accident - <i>Deductible, copay &amp; coinsurance apply thereafter</i><br><i>(per person per calendar year within 1 year of accident)</i> | Covered 100% for 1st \$1000   |

- 1 SelectHealth provides an allowable adoption amount of \$4,000 as outlined by the state of Utah. Medical deductible and copay/coinsurance applies.
- 2 Refer to your SelectHealth Provider & Facility Directory to identify whether a provider is a primary or secondary care provider.
- + Preauthorization is required on certain injectable and prescription drugs. If you fail to preauthorize, the drug will not be covered. Please refer to your membership guide for more information.
- \* Not applied to Medical out-of-pocket maximum.
- Supplemental Accident benefit does not apply to Chiropractic Services.

All deductible/copay/coinsurance amounts and plan payments are based on eligible charges only and not on the provider's billed or other charges. You are responsible to pay for charges in excess of eligible charges for covered services obtained from non-participating providers and facilities. Such excess charges are not applied to the medical out-of-pocket maximum. Refer to your Contract, Membership Guide, or Provider & Facility Directory for more information.

Select Care is administered and underwritten by SelectHealth.  
MPS-HMO 01/01/08 v2-0

10/19/07

[www.selecthealth.org](http://www.selecthealth.org)