2016

Large Employer Certificate of Coverage

Idaho

selecthealth®

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	MEMBER PAYMENT SUMMARY	
	PARTICIPATING *(In-Network)* When using participating providers, you are responsible to pay the amounts in this column.	**NONPARTICIPATING** *(Out-of-Network)* When using nonparticipating providers, you are responsible to pay the amounts in this column.
CONDITIONS AND LIMITATIONS		
Pre-Existing Conditions (PEC)	None	
Benefit Accumulator Period	calendar year	
Maximum Annual Out-of-Network Payment - (per calendar year)	None	None
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5]	**PARTICIPATING**	**NONPARTICIPATING**
Deductible - Per Person/Family (per calendar year)	$1000/$2000	$2000/$4000
Total Out-of-Pocket Maximum - Per Person/Family (per calendar year) (Medical and Pharmacy Included in the Out-of-Pocket Maximum)	$3000/$6000	$6000/$12000
INPATIENT SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Medical, Surgical and Hospice[4]	20% after deductible	40% after deductible
Skilled Nursing Facility[4] - Up to 60 days per calendar year	20% after deductible	40% after deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4] Up to 40 days per calendar year for all therapy types combined	20% after deductible	40% after deductible
PROFESSIONAL SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP)[1]	$25 after deductible	40% after deductible
Secondary Care Provider (SCP)[1]	$45 after deductible	40% after deductible
Allergy Tests	See Office Visits Above	50% after deductible
Allergy Treatment and Serum	20% after deductible	50% after deductible
Major Surgery	20% after deductible	40% after deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after deductible	40% after deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**PARTICIPATING**	**NONPARTICIPATING**
Primary Care Provider (PCP)[1]	Covered 100%	50% after deductible
Secondary Care Provider (SCP)[1]	Covered 100%	50% after deductible
Adult and Pediatric Immunizations	Covered 100%	50% after deductible
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	50% after deductible
Diagnostic Tests: Minor	Covered 100%	50% after deductible
Other Preventive Services	Covered 100%	50% after deductible
OUTPATIENT SERVICES[4]	**PARTICIPATING**	**NONPARTICIPATING**
Outpatient Facility and Ambulatory Surgical	20% after deductible	40% after deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after deductible	See Participating Benefit
Emergency Room - *(Participating facility)*	$250 after deductible	See Participating Benefit
Emergency Room - *(Nonparticipating facility)*	$250 after deductible	See Participating Benefit
Urgent Care Facilities	$25 after deductible	40% after deductible
Chemotherapy, Radiation and Dialysis	20% after deductible	40% after deductible
Diagnostic Tests: Minor[2]	Covered 100% after deductible	40% after deductible
Diagnostic Tests: Major[2]	20% after deductible	40% after deductible
Home Health, Hospice, Outpatient Private Nurse	20% after deductible	40% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational *Up to 20 visits per calendar year for each therapy type*	$45 after deductible	40% after deductible

See other side for additional benefits

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	MEMBER PAYMENT SUMMARY	
	PARTICIPATING *(In-Network)*	**NONPARTICIPATING** *(Out-of-Network)*
MISCELLANEOUS SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Durable Medical Equipment (DME)[4]	20% after deductible	40% after deductible
Miscellaneous Medical Supplies (MMS)[3]	20% after deductible	40% after deductible
Maternity[4]	See Professional, Inpatient or Outpatient	40% after deductible
Cochlear Implants[4]	See Professional, Inpatient or Outpatient	50% after deductible
Infertility - *Select Services* *(Max Plan Payment $1,500/ calendar year; $5,000 lifetime)*	*50% after deductible	*50% after deductible
Donor Fees for Covered Organ Transplants	20% after deductible	50% after deductible
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient	50% after deductible
OPTIONAL BENEFITS	**PARTICIPATING**	**NONPARTICIPATING**
Mental Health and Chemical Dependency[4]		
Mental Health Office Visits	$25 after deductible	40% after deductible
Inpatient	20% after deductible	40% after deductible [4]
Outpatient	20% after deductible	40% after deductible [4]
Residential Treatment[2]	20% after deductible	40% after deductible [4]
Injectable Drugs and Specialty Medications[4]	20% after deductible	40% after deductible
PRESCRIPTION DRUGS		
Pharmacy Deductible - Per Person per calendar year	$100	
Prescription Drug List (formulary)	RxSelect®	
Prescription Drugs - *Up to 30 Day Supply of Covered Medications*[4]		
Tier 1	$15	
Tier 2	$30 after pharmacy deductible	
Tier 3	$50 after pharmacy deductible	
Tier 4	$100 after pharmacy deductible	
Maintenance Drugs - *90 Day Supply (Mail-Order, Retail90®)-selected drugs*[4]		
Tier 1	$15	
Tier 2	$60 after pharmacy deductible	
Tier 3	$150 after pharmacy deductible	
Generic Substitution Required	Generic required or must pay copay plus cost difference between name brand and generic	

To remain compliant with state and federal regulations including the Affordable Care Act (ACA), these benefits are subject to change.

1 Refer to **selecthealth.org/findadoctor** to identify whether a provider is a primary or secondary care provider.

2 Refer to your Certificate of Coverage for more information.

3 Frequency and/or quantity limitations apply to some preventive care and MMS services.

4 Preauthorization is required for the following: all inpatient services; certain injectable drugs and specialty medications; certain prescription drugs; certain DME items and prosthetic items; certain mental health and chemical dependency services; maternity stays longer than two days for normal delivery or longer than four days for cesarean and all deliveries outside of the service area; home health nursing; pain management/pain clinic services; outpatient private nurse; organ transplants; cochlear implants and certain genetic tests. Benefits may be reduced or denied if you do not preauthorize certain services. Please refer to Section 11-- "Healthcare Management", in your Certificate of Coverage, for details.

5 All deductible/copay/coinsurance amounts are based on the allowed amounts and not on the providers billed charges. Nonparticipating Providers or Facilities have not agreed to accept the Allowed Amount for Covered Services. When this occurs, you are responsible to pay for any charges that exceed the amount that SelectHealth pays for Covered Services. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

* Not applied to Medical out-of-pocket maximum.

All covered services obtained outside the United States, except for routine, urgent, or emergency conditions require preauthorization.

For more information, call Member Services at 800-538-5038 weekdays, from 7:00 a.m.to 8:00 p.m., and Saturdays from 9:00 a.m. to 2:00 p.m.

Benefits are administered and underwritten by SelectHealth.

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selecthealth.org

SECTION 1 INTRODUCTION

1.1 This Certificate

This Certificate of Coverage describes the terms and conditions of the health insurance Benefits provided under your employer's Group Health Insurance Contract with SelectHealth, Inc. Please read it carefully and keep it for future reference. Technical terms are capitalized and described in Section 16 Definitions. Your Member Payment Summary, which contains a quick summary of the Benefits by category of service, is attached to and considered part of this Certificate. This is not a Worker's Compensation policy.

1.2 SelectHealth

SelectHealth is a managed care organization licensed by the State of Idaho. SelectHealth is affiliated with Intermountain Healthcare, but is a separate company. The Contract does not involve Intermountain Healthcare or any affiliated Intermountain companies, or their officers or employees. Such companies are not responsible to you or any other Members for the obligations or actions of SelectHealth.

1.3 Managed Care

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

1.4 Your Agreement

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

1.5 No Vested Rights

You are only entitled to receive Benefits while the Contract is in effect and you, and your Dependent(s) if applicable, are properly enrolled and recognized by SelectHealth as Members. You do not have any permanent or vested interest in any Benefits under the Plan. Benefits may change as the Contract is renewed or modified from year to year. Unless otherwise expressly stated in this Certificate, all Benefits end when the Contract ends. You are not liable, assessable, or in any way subject to payment for the debts, liabilities, insolvency, impairment or any other financial obligations of SelectHealth.

1.6 Administration

SelectHealth establishes reasonable rules, regulations, policies, procedures, and protocols to help it in the administration of your Benefits. You are subject to these administrative practices when receiving Benefits, but they do not change the express provisions of this Certificate or the Contract. See Section 5.2 of this Certificate for explanation of extended coverages available for maternity and disability.

1.7 Non-Assignment

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

1.8 Notices

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

1.9 Nondiscrimination

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

1.10 Questions

If you have questions about your Benefits, call Member Services at 800-538-5038, or visit selecthealth.org. Member Services can also provide you with a provider directory and information about Participating Providers, such as medical school attended, residency completed, and board certification status. SelectHealth offers foreign language assistance.

1.11 Disclaimer

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

a. In the event of a discrepancy between information given by a SelectHealth employee and the written terms of the Contract, the terms of the Contract will control.

b. Any changes or modifications to Benefits must be provided in writing and signed by the president, vice president, or medical director of SelectHealth.

c. Administrative errors will not invalidate Benefits otherwise in force or give rise to rights or Benefits not otherwise provided for by the Plan.

SECTION 2 ELIGIBILITY

2.1 General

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

2.2 Subscriber Eligibility

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

2.3 Dependent Eligibility

Unless stated otherwise in the Group Application, your Dependent(s) are:

2.3.1 Spouse

Your lawful spouse.

2.3.2 Children

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

2.3.3 Disabled Children

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

a. Are medically certified as disabled;

b. Are chiefly dependent upon you or your lawful spouse for support and maintenance since they reached age 26; and

c. Have been continuously enrolled in some form of healthcare coverage, with no break in coverage of more than 63 days since the date they exceeded age 26.

SelectHealth may require you to provide proof of incapacity and dependency within 31 days of the Effective Date or the date the child reaches age 26 and annually after the two-year period following the child's 26th birthday.

2.3.4 Incarcerated Dependents

Despite otherwise qualifying as described above, a person incarcerated in a prison, jail, or other correctional facility is not a Dependent.

2.4 Court-Ordered Dependent Coverage

When you or your lawful spouse are required by a court or administrative order to provide health insurance coverage for a child, the child will be enrolled in your family coverage according to SelectHealth guidelines and only to the minimum extent required by applicable law. If you are not enrolled for coverage at the time the court or administrative order becomes effective, only you and the affected Dependent will be allowed to enroll for coverage.

2.4.1 Qualified Medical Child Support Order (QMCSO)

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

a. Your name and last known mailing address (if any) and the name and mailing address of each alternate recipient covered by the order;

b. A reasonable description of the type of coverage to be provided, or the manner in which the coverage will be determined; and

c. The period to which the order applies.

2.4.2 National Medical Support Notice (NMSN)

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

2.4.3 Eligibility and Enrollment

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

2.4.4 Duration of Coverage

Court-ordered coverage for a Dependent child will be provided to the age of 18.

SECTION 3 ENROLLMENT

3.1 General

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

You and your Dependent(s) will not be considered enrolled until:

a. All enrollment information is provided to SelectHealth; and

b. The Premium has been paid to SelectHealth by your employer.

3.2 Enrollment Process

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

3.3 Effective Date of Coverage

Coverage for you and your Dependent(s) will take effect as follows:

3.3.1 Annual Open Enrollment

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

3.3.2 Newly Eligible Employees

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

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

3.3.3 Court or Administrative Order

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

a. The start date indicated in the order;

b. The date any applicable Employer Waiting Period is satisfied; or

c. The date SelectHealth receives the order.

3.3.4 Hospitalization of Newly Eligible Person

The Effective Date for you and your Dependent(s) under this Contract is not affected by the absence of actively at work status resulting from hospitalization.

3.4 Special Enrollment Rights

SelectHealth provides Special Enrollment Rights in the following circumstances:

3.4.1 Loss of Other Coverage

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

a. You initially declined to enroll the Plan due to the existence of other health plan coverage;

b. The loss of the other health plan coverage occurred because of a loss of eligibility (this Special Enrollment Right will not apply if the other coverage is lost due to nonpayment of Premiums). One exception to this rule exists: if a Dependent is enrolled on another group health plan and the Annual Open Enrollment periods of the two plans do not coincide, the Dependent may voluntarily drop their coverage under their group health plan's open enrollment and a special enrollment period will be permitted under the Plan in order to avoid a gap in coverage; and

c. You and/or your Dependent(s) who lost the other coverage must enroll in the Plan within 31 days after the date the other coverage is lost.

Proof of loss of the other coverage (for example, a 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.

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

3.4.2 New Dependent(s)

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

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

a. As of the date of marriage;

b. As of the date of birth;

c. If the child is less than 61 days old when adopted or placed for adoption, as of the date of birth; if the child is more than 60 days old when adopted or placed for adoption, as of child's date of placement; or

d. As of the later of:

   i. The effective date of the guardianship court order or testamentary appointment; or

   ii. The date the guardianship court order or testamentary appointment is received by SelectHealth.

3.4.3 Loss of Medicaid or CHIP Coverage

If you and/or your Eligible Dependents lose coverage under a Medicaid or CHIP plan, you may enroll in the Plan if application is made within 60 days of the loss of coverage.

3.4.4 As Required by State or Federal Law

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

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

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

a. If enrolling the child requires additional Premium, you must enroll the child within 60 days of the child's birth, adoption, or placement for adoption or under legal guardianship. The due date for payment of any additional premium, if required, is 31 days following the date the monthly premium invoice is received by the employer and a notice of premium is provided to you by the employer.

b. If enrolling the child does not change the Premium, you must enroll the child within 60 days from the date SelectHealth mails notification that a claim for Services was received for the child.

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

A newly adopted child will be treated the same as a newborn child under this section provided the child is under the age of eighteen (18).

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

3.6 Leave of Absence

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

3.7 Family Medical Leave Act

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

a. You and your enrolled Dependent(s) may continue your coverage with SelectHealth to the minimum extent required by the FMLA as long as applicable Premiums continue to be paid to SelectHealth by your employer.

b. If Premiums are not paid, your coverage will be terminated. Upon your return to work, you and any previously enrolled Dependent(s) who are still Eligible will be prospectively reinstated if the applicable Premium for you is paid to SelectHealth by your employer within 30 days. SelectHealth will not be responsible for any claims incurred by you or your Dependent(s) during this break in coverage.

c. If Premiums are not paid and coverage is terminated, you and any previously enrolled Dependent(s) may be retroactively reinstated with no loss in coverage if all back Premiums are paid within 30 days of your return to work.

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

SECTION 4 TERMINATION

4.1 Group Termination

Coverage under the Plan for you and your Dependent(s) will terminate when the Contract terminates.

4.1.1 Termination by Employer

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

4.1.2 Termination of Employer Group by SelectHealth

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

a. Nonpayment of applicable Premiums by your employer;

b. Fraud or intentional misrepresentation of material fact to SelectHealth by your employer in any matter related to the Contract or the administration of the Plan;

c. Your employer's coverage under the Contract is through an association and your employer terminates membership in the association, but only if the coverage is terminated under this paragraph uniformly without regard to any health status related factor relating to any covered individual;

d. Your employer fails to satisfy the SelectHealth minimum group participation and/or employer contribution requirements of SelectHealth;

e. During the preceding calendar year, the employer had fewer than 51 employees on at least 50% of its working days, the majority of whom were employed within the State of Idaho;

f. SelectHealth withdraws from the market and discontinues all of its health benefit plans. In such a case SelectHealth will:

   i. Provide advance notice of its decision to the Director of Insurance in each state in which it is licensed; and

ii. Provide notice of the decision not to renew coverage to all affected employers and to the Idaho Director of Insurance at least 180 days prior to the withdrawal; or

g. The Director finds that the continuation of the coverage would:

i. Not be in the best interests of the policyholders or Certificate holders; or

ii. Impair the ability of SelectHealth to meet its contractual obligations.

In such instance the Director will assist affected employers in finding replacement coverage.

4.1.3 Notice of Termination

In the event of a termination of this Contract for any reason, SelectHealth will give notice of the termination to all Subscribers and Members. Notice to a Subscriber will be deemed sufficient notice to his or her enrolled Eligible Dependents. A Certificate of Creditable Coverage will be provided to every Member by SelectHealth.

4.2 Individual Termination

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

4.2.1 Termination Date

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

4.2.2 Fraud or Misrepresentation

a. Made During Enrollment.

i. Coverage for you and/or your Dependents may be terminated or Rescinded during the two-year period after you enroll if you or they make an intentional misrepresentation of material fact in connection with insurability.

ii. Coverage for you and/or your Dependents may be terminated or Rescinded at any time if you or they make any material misrepresentation in connection with insurability.

Please Note: If coverage is Rescinded as described above, the termination is retroactive to the Effective Date of coverage.

b. Made After Enrollment: Coverage for you and/or your Dependents may be terminated or Rescinded if you or they commit fraud or make an intentional misrepresentation of material fact in connection with Benefits or Eligibility. At the discretion of SelectHealth, the Rescission may be effective retroactively to the date of the fraud or misrepresentation.

c. If coverage for you or your Dependent is terminated or Rescinded for fraud or intentional misrepresentation of material fact, you or they are allowed to reenroll 12 months after the date of the termination, provided the Contract is still in force. You will be given notice of this provision at the time of termination.

d. The termination from the Plan of a Dependent for cause does not necessarily affect your Eligibility or enrollment or the Eligibility or enrollment of your other Dependents.

4.2.3 Leaving the Service Area

Coverage for you and/or your Dependent(s) terminates if you no longer live, work or reside in the Service Area.

4.2.4 Annual Open Enrollment

You can drop coverage for yourself and any Dependent(s) during an Annual Open Enrollment.

4.2.5 Nonpayment of Premium or Contributions

SelectHealth may terminate coverage for you and/or your Dependents for nonpayment of applicable Premiums or contributions. Termination may be retroactive to the beginning of the period for which Premiums or contributions were not paid, and SelectHealth may recover from you and/or your Dependent(s) the amount of any Benefits you or they received during the period of lost coverage.

4.2.6 Court or Administrative Order

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

4.3 Member Receiving Treatment at Termination

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

4.4 Reinstatement

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

SECTION 5 COBRA COVERAGE

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

5.1 COBRA Coverage

You and/or your Dependent(s) may have the right to temporarily continue your coverage under the Plan when coverage is lost due to certain events. The federal law that governs this right is called COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1986) and generally applies to employers with 20 or more employees.

5.1.1 Employer's Obligation

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

a. Notify persons entitled to COBRA Coverage;

b. Notify SelectHealth of such individuals; and

c. Collect and submit to SelectHealth all applicable Premiums.

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

5.1.2 Minimum Extent

COBRA Coverage will only be provided for the minimum time and only to the minimum extent required by applicable state and federal law. SelectHealth will not provide COBRA Coverage if you, your Dependent(s), or your employer fails to strictly comply with all applicable notices and other requirements and deadlines.

5.2 Extended Coverage for Maternity and Disability

5.2.1 Pregnancy

If a Member is pregnant when coverage is discontinued under this Contract and is not Eligible for any replacement group coverage within 60 days of discontinuance, benefits will be payable to the same extent as if discontinuance had not occurred for any covered benefits in connection with pregnancy, childbirth or miscarriage, up to 12 months.

5.2.2 Disability

If a Member becomes totally disabled during the period of this policy, and continues to be totally disabled when Coverage is discontinued under this Contract, benefits will be payable for covered expenses incurred as the result of the disabling condition beyond the date of discontinuance for a period 12 months. The benefits payable during this period will be subject to all limitations and restrictions contained in this policy. Any extension of benefits shall be terminated at such time as Member or dependent is no longer totally disabled.

SECTION 6 PROVIDERS/NETWORKS

6.1 Providers and Facilities

SelectHealth contracts with certain Providers and Facilities (known as Participating Providers and Participating Facilities) to provide Covered Services within the Service Area.

6.1.1 Participating Providers and Facilities

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

6.1.2 Nonparticipating Providers and Facilities

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

6.1.3 Other Networks

For Services received in Utah, you receive Participating Benefits when you use providers who are on the SelectMed provider network in Utah. For Services received outside of Idaho and Utah, you receive Participating Benefits when you use providers who are participating on networks that have contracted with SelectHealth for this plan. Contact Member Services for additional information.

6.2 Providers and Facilities not Agents/Employees of SelectHealth

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

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

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

6.3 Payments to Members

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

6.4 Provider/Patient Relationship

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

6.5 Continuity of Care

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

If you or your Dependent is under the care of a Provider when affiliation ceases, SelectHealth will continue to treat the Provider as a Participating Provider until the completion of the care (not to exceed 90 days), or until you or your Dependent is transferred to another Participating Provider, whichever occurs first. However, if you or your Dependent is receiving maternity care in the second or third trimester, you or they may continue such care through the first postpartum visit.

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

a. Accept the Allowed Amount as payment in full;

b. Follow the Healthcare Management policies and procedures of SelectHealth;

c. Continue treating you and/or your Dependent; and

d. Share information with SelectHealth regarding the treatment plan.

SECTION 7 ABOUT YOUR BENEFITS

7.1 General

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

7.2 Member Payment Summary

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

7.3 Identification (ID) Cards

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

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

7.4 Medical Necessity

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

7.5 Benefit Changes

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

7.6 Calendar-Year or Plan-Year Basis

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

7.7 Lifetime Maximums

Your Member Payment Summary will specify any applicable Lifetime Maximums.

7.8 Two Benefit Levels

7.8.1 Participating Benefits

You receive a higher level of Benefits (known as Participating Benefits) when you obtain Covered Services from a Participating Provider or Facility. Participating Providers and Facilities have agreed to accept the Allowed Amount and will not bill you for Excess Charges (i.e., you will only be responsible for the applicable Deductible, Copay, and Coinsurance).

7.8.2 Nonparticipating Benefits

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

7.9 Emergency Conditions

Participating Benefits apply to emergency room Services regardless of whether they are received at a Participating Facility or Nonparticipating Facility.

If you or your Dependent is hospitalized for an emergency:

a. You or your representative must contact SelectHealth within two working days, or as soon as reasonably possible; and

b. If you are in a Nonparticipating Facility, once the Emergency Condition has been stabilized, you may be asked to transfer to a Participating Facility in order to continue receiving Participating Benefits.

7.10 Urgent Conditions

Participating Benefits apply to Services received for Urgent Conditions rendered by a Participating Provider or Facility. Participating Benefits also apply to Services received for Urgent Conditions rendered by a Nonparticipating Provider or Facility more than 40 miles away from any Participating Provider or Facility.

7.11 Out-of-Area Benefits and Services

Other than for Emergency and Urgent Conditions, as described above, Nonparticipating Benefits apply for Covered Services rendered by Nonparticipating Providers or Facilities outside of the Service Area.

SECTION 8 COVERED SERVICES

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

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

a. Log in to My Health at selecthealth.org/myhealth;

b. Visit selecthealth.org;

c. Refer to your Provider & Facility Directory; or

d. Call Member Services at 800-538-5038.

8.1 Facility Services

8.1.1 Educational Training

Only for diabetes or asthma.

8.1.2 Emergency Room (ER)

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

8.1.3 Inpatient Hospital

a. Semiprivate room accommodations and other Hospital-related Services ordinarily furnished and billed by the Hospital.

b. Private room accommodations in connection with a medical condition requiring isolation. If you choose a private room when a semiprivate room is available or isolation is not necessary, you are responsible for paying the difference between the Hospital's semiprivate room rate and the private room rate. However, you will not be responsible for the additional charge if the Hospital only provides private room accommodations or if a private room is the only room available.

c. Intensive care unit.

d. Preadmission testing.

e. Short-term inpatient detoxification provided by a SelectHealth-approved treatment Facility for alcohol/drug dependency.

f. Maternity/obstetrical Services.

g. Services in connection with an otherwise covered inpatient Hospital stay.

8.1.4 Nutritional Therapy

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

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

8.1.5 Outpatient Facility and Ambulatory Surgical Facility

Outpatient surgical and medical Services.

8.1.6 Skilled Nursing Facility

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

8.1.7 Urgent Care Facility

8.2 Provider Services

8.2.1 After-Hours Visits

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

8.2.2 Anesthesia

Except when rendered in a Provider’s office, general anesthesia administered in connection with otherwise Covered Services and 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 is only covered when rendered in a Facility.

8.2.3 Dental Services

Only in three limited circumstances:

a. When rendered to diagnose or treat medical complications of a dental procedure and administered under the direction of a medical Provider whose primary practice is not dentistry or oral surgery.

b. When SelectHealth determines the following to be Medically Necessary:

i. Maxillary and/or mandibular procedures;

ii. Upper/lower jaw augmentation or reduction procedures, including developmental corrections or altering of vertical dimension;

iii. Orthognathic Services; and

iv. Services for Congenital Oligodontia /Anodontia.

c. For repairs of physical damage to sound natural teeth, crowns, and the natural supporting structures surrounding teeth when:

i. Such damage is a direct result of an accident independent of disease or bodily infirmity or any other cause;

ii. Medical advice, diagnosis, care, or treatment was recommended or received for the injury at the time of the accident; and

iii. Repairs are initiated within one year of the date of the accident.

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

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

8.2.4 Dietary Products

Only in the following limited circumstances:

a. For hereditary metabolic disorders when:

i. The Member has an error of amino acid or urea cycle metabolism;

ii. The product is specifically formulated and used for the treatment of errors of amino acid or urea cycle metabolism; and

iii. The product is used under the direction of a Physician, and its use remains under the supervision of the Physician.

b. Certain enteral formulas according to SelectHealth policy.

8.2.5 Genetic Counseling

Only when provided by a Provider who is a certified genetic counselor or board certified medical geneticist.

8.2.6 Genetic Testing

Only in the following circumstances and according to SelectHealth criteria or federal law:

a. Prenatal testing when performed as part of an amniocentesis to assess specific chromosomal abnormalities in women at high risk for inheritable conditions that can lead to significant immediate and/or long-term health consequences to the child after birth;

b. Neonatal testing for specific inheritable metabolic conditions (e.g., PKU);

c. When the Member has a more than five-percent probability of having an inheritable genetic condition and has signs or symptoms suggestive of a specific condition or 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; or

d. Pre-implantation embryonic genetic testing performed to identify an inherited genetic condition known to already exist in either parent’s family which has the potential to cause serious and impactful medical conditions for the child.

8.2.7 Home Visits

Only if you are physically incapable of traveling to the Provider’s office.

8.2.8 Infertility

Services for the diagnosis of Infertility are only covered in limited circumstances, including fulguration of ova ducts, hysteroscopy, hysterosalpingogram, certain laboratory tests, diagnostic laparoscopy, and some imaging studies. For a full list of Covered Infertility Services, please contact SelectHealth.

8.2.9 Major Surgery

8.2.10 Mammography Services

Mammography examination or equivalent examination coverage is provided, and shall include at least the following Benefits:

a. One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age;

b. A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician;

c. A mammogram every year for any woman who is fifty (50) years of age or older; and

d. A mammogram for any woman desiring a mammogram for medical cause.

Such coverage shall not exceed the cost of the examination. Mammography services performed for non-preventive purposes will apply to the minor diagnostic test benefit.

8.2.11 Mastectomy/Reconstructive Services

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

a. All stages of reconstruction on the breast on which the mastectomy was performed;

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

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

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

8.2.12 Maternity Services

Prenatal care, labor and delivery, and postnatal care, including complications of delivery.

8.2.13 Medical/Surgical

In an inpatient, outpatient, or Ambulatory Surgical Facility.

8.2.14 Preventive Services

8.2.15 Office Visits

For consultation, diagnosis, and treatment.

8.2.16 Sleep Studies

Only when provided by:

a. A board-certified sleep specialist or at a facility certified as a sleep center/lab by the American Board of Sleep Medicine; or

b. A board-certified sleep specialist in your home and you or your Dependent is 18 or older.

8.2.17 Sterilization Procedures

8.3 Miscellaneous Services

8.3.1 Allergy Tests, Treatment, or Serum

Must be received from a board certified allergist, immunologist, or otolaryngologist. Oral food challenge testing only when administered by a Provider who is board certified in allergy/immunology.

8.3.2 Ambulance/Transportation Services

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

8.3.3 Approved Clinical Trials

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

a. Eligible to participate in the trial according to the trial protocol;

b. The treatment is for cancer or another life-threatening disease (any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted); and

c. Either:

   i. The referring health care professional is a Participating Provider and has concluded that the Member's participation in such trial would be appropriate; or

   ii. The Subscriber or Member provides medical and scientific information establishing that the Member's participation in such trial would be appropriate.

8.3.4 Chemotherapy, Radiation Therapy, and Dialysis

8.3.5 Cochlear Implants

For congenital anomalies, prelingual deafness in children, or postlingual deafness in adults in limited circumstances that satisfy SelectHealth criteria. Must be Preauthorized.

8.3.6 Durable Medical Equipment (DME)

Only:

a. When used in conjunction with an otherwise covered condition and when:

   i. Prescribed by a Provider;

   ii. Primarily used for medical purposes and not for convenience, personal comfort, or other nontherapeutic purposes;

   iii. Required for Activities of Daily Living;

   iv. Not for duplication or replacement of lost, damaged, or stolen items; and

   v. Not attached to a home or vehicle.

b. Batteries only when used to power a wheelchair or an insulin pump for treatment of diabetes.

c. Continuous passive motion therapy for any indication for up to 21 days of continuous coverage from the first day applied.

SelectHealth will not provide payment for rental costs exceeding the purchase price. For covered rental DME that is subsequently purchased, cumulative rental costs are deducted from the purchase price.

8.3.7 Home Healthcare

a. When you:

   i. Have a condition that requires the services of a licensed Provider;

   ii. Are home bound for medical reasons;

   iii. Are physically unable to obtain necessary medical care on an outpatient basis; and

   iv. Are under the care of a Physician.

b. In order to be considered home bound, you must either:

   i. Have a medical condition that restricts your ability to leave the home without the assistance of another individual or supportive device or because absences from the home are medically contraindicated; or

ii. Leave the home only to receive medical treatment that cannot be provided in your home or other treatments that require equipment that cannot be made available in your home or infrequently and for short periods of time for nonmedical purposes.

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

8.3.8 Hospice Care

8.3.9 Injectable Drugs And Specialty Medications

Up to a 30-day supply, though exceptions can be made for travel purposes. In general, your Provider will coordinate the process for obtaining these drugs. Injectable drugs and specialty medications must be provided by a Participating Provider unless otherwise approved in writing in advance by SelectHealth. You may be required to receive the drug or medication in your Provider's office. Some Injectable Drugs and Specialty Medications may only be obtained from certain drug distributors. Call Member Services to determine if this is the case and to obtain information on participating drug vendors.

8.3.10 Miscellaneous Medical Supplies (MMS)

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

8.3.11 Neuropsychological Testing (Medical)

As a medical Benefit, only as follows:

a. Testing performed as part of the preoperative evaluation for patients undergoing:
   i. Seizure surgery;
   ii. Solid organ transplantation; or
   iii. Central nervous system malignancy.
b. Patients being evaluated for dementia/Alzheimer's disease;
c. Patients with Parkinson's Disease;
d. Stroke patients undergoing formal rehabilitation; and
e. Post-traumatic-brain-injury patients.

All other conditions are considered under the mental health Benefit, if applicable.

8.3.12 Organ Transplants

Only if preauthorized in advance by SelectHealth and only the following:

a. Bone marrow as outlined in SelectHealth criteria;
b. Combined heart/lung;
c. Combined pancreas/kidney;
d. Cornea;
e. Heart;
f. Kidney (but only to the extent not covered by any government program);
g. Liver;
h. Pancreas after kidney; and
i. Single or double lung.

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

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

8.3.13 Orthotics and Other Corrective Appliances for the Foot

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

8.3.14 Osteoporosis Screening

Only central bone density testing (DEXA scan).

8.3.15 Palliative Care

Only Hospice Care

8.3.16 Private Duty Nursing

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

8.3.17 Rehabilitation Therapy

Physical, occupational, and speech rehabilitative therapy when required to correct an impairment caused by a covered accident or illness or to restore the ability to perform Activities of Daily Living.

8.3.18 Temporomandibular Joint (TMJ)

8.3.19 Vision Aids

Only:

a. Contacts for Members diagnosed with keratoconus, congenital cataracts, or when used as a bandage after eye trauma/injury; or

b. Monofocal intraocular lenses after cataract surgery.

8.4 Prescription Drug Services

Refer to Section 9 Prescription Drug Benefits for details.

SECTION 9 PRESCRIPTION DRUG BENEFITS

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

9.1 Prescription Drug Benefit Resources

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

a. Log in to My Health at selecthealth.org/myhealth and use Pharmacy Tools;

b. Visit selecthealth.org/pharmacy;

c. Refer to your Provider & Facility Directory; or

d. Call Member Services at 800-538-5038.

9.2 Use Participating Pharmacies

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

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

9.3 Tiered Benefits

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

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

9.4 Filling Your Prescription

9.4.1 Copay/Coinsurance

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

9.4.2 Quantity and Day Supply

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

9.4.3 Refills

Refills are allowed after 80 percent of the last refill has been used for a 30-day supply, and 50 percent for a 10-day supply. Some exceptions may apply; call Pharmacy Services for more information.

9.5 Generic Drug Substitution Required

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

9.6 Maintenance Drugs

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

a. Have been using the drug for at least one month;

b. Expect to continue using the drug for the next year; and

c. Have filled the prescription at least once within the past six months.

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

9.7 Preauthorization of Prescription Drugs

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

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

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

9.8 Step Therapy

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

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

9.9 Coordination of Benefits (COB)

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

9.10 Inappropriate Prescription Practices

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

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

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

9.11 Prescription Drug Benefit Abuse

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

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

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

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

9.12 Pharmacy Injectable Drugs and Specialty Medications

Injectable drugs and specialty medications must be provided by a Participating Provider unless otherwise approved in writing in advance by SelectHealth. Most drugs received in a Provider's office or Facility are covered by your medical Benefits. For more specific information, please contact Member Services.

9.13 Prescription Drug List (PDL)

The PDL is a list containing the most commonly prescribed drugs in their most common strengths and formulations. It is not a complete list of all drugs covered by your PDL. Drugs not included on the Formulary may be covered at reduced benefits, or not covered at all, by your Plan. Refer to Appendix A Prescription Drug List for the PDL.

9.14 Exceptions Process

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

9.15 Prescriptions Dispensed in a Provider's Office

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

9.16 Disclaimer

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

SECTION 10 LIMITATIONS AND EXCLUSIONS

Unless otherwise noted in your Member Payment Summary or Section 17 Optional Benefits, the following Limitations and Exclusions apply.

10.1 Abortions/Termination of Pregnancy

Abortions are not covered except when medically necessary to save the life of the mother.

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

10.2 Acupuncture/Acupressure

Acupuncture and acupressure Services are not covered.

10.3 Administrative Services/Charges

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

Provider and Facility charges for completing insurance forms, duplication services, interest, finance charges, late fees, shipping and handling, missed appointments, and other administrative charges are not covered.

10.4 Allergy Tests/Treatments

a. The following allergy tests are not covered:
   i. Cytotoxic Test (Bryan's Test);
   ii. Leukocyte Histamine Release Test;
   iii. Mediator Release Test (MRT);
   iv. Passive Cutaneous Transfer Test (P-K Test);
   v. Provocative Conjunctival Test;
   vi. Provocative Nasal Test;
   vii. Rebuck Skin Window Test;
   viii. Rinkel Test;

ix. Subcutaneous Provocative Food and Chemical Test; and

x. Sublingual Provocative Food and Chemical Test.

b. The following allergy treatments are not covered:

i. Allergoids;

ii. Autogenous urine immunization;

iii. LEAP therapy;

iv. Medical devices (filtering air cleaner, electrostatic air cleaner, air conditioners etc.);

v. Neutralization therapy;

vi. Photo-inactivated extracts; and

vii. Polymerized extracts.

10.5 Attention-Deficit/Hyperactivity Disorder

Cognitive or behavioral therapies for the treatment of these disorders are not covered.

10.6 Bariatric Surgery

Surgery to facilitate weight loss is not covered. This Exclusion does not apply if your Member Payment Summary indicates that your Plan includes the Bariatric Surgery Optional Benefit.

10.7 Biofeedback/Neurofeedback

Biofeedback/neurofeedback is not covered.

10.8 Birthing Centers and Home Childbirth

Childbirth in any place other than a Hospital is not covered. This includes all Provider and/or Facility charges related to the delivery.

10.9 Certain Cancer Therapies

Neutron beam therapy is not covered.

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

a. Chordomas or chondrosarcomas arising at the base of the skull or along the axial skeleton without distant metastases;

b. Other central nervous system tumors located near vital structures;

c. Pituitary neoplasms;

d. Uveal melanomas confined to the globe (not distant metastases); or

e. In accordance with SelectHealth medical policy.

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

10.10 Certain Illegal Activities

The following are not covered:

a. Services or follow-up care are not covered for an illness, condition, accident, or injury arising from you or your Dependent:

i. Voluntarily participating in the commission of a felony;

ii. Voluntarily participating in disorderly conduct, riot, or other breach of the peace;

iii. Engaging in any conduct involving the illegal use or misuse of a firearm or other deadly weapon;

iv. Driving or otherwise being in physical control of a car, truck, motorcycle, scooter, off-road vehicle, boat, or other motor-driven vehicle where either:

1) A subsequent test shows that you or your Dependent has either a blood or breath alcohol concentration of .08 grams or greater at the time of the test; or

2) You or your Dependent has any illegal drug or other illegal substance in your body to a degree that it affected your ability to drive or operate the vehicle safely;

b. Driving or otherwise being in physical control of a car, truck, motorcycle, scooter, off-road vehicle, boat, or other motor-driven vehicle either without a valid driver's permit or license, if required under the circumstances or without the permission of the owner of the vehicle; or

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

10.11 Chiropractic Services

Chiropractic Services are not covered. This Exclusion does not apply if your Member Payment Summary indicates that your Plan includes a Benefit for chiropractic services.

10.12 Claims After One Year

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

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

10.13 Complementary and Alternative Medicine (CAM)

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

10.14 Complications

All Services provided or ordered to treat complications of a non-covered Service are not covered unless they arise one year or more after the date on which the non-Covered Service is performed.

10.15 Custodial Care

Custodial Care is not covered.

10.16 Debarred Providers

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

10.17 Hospital Anesthesia for Qualifying Dental Conditions

Facility and anesthesia Services are only covered in conjunction with a dental procedure if a Provider certifies that the Eligible Individual requires hospitalization and the Eligible Individual has one of the following conditions:

a. Brittle diabetes;

b. History of uncontrollable bleeding;

c. History of a life-endangering heart condition;

d. Severe bronchial asthma;

e. Children under ten years of age who require general anesthetic; or

f. Other non-dental life-endangering conditions that require hospitalization, subject to approval by SelectHealth.

Note: The dental procedure necessitating the facility and anesthesia Services will not be covered.

10.18 Dry Needling

Dry needling procedures are not covered.

10.19 Duplication of Coverage

The following are not covered:

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

b. Services that are covered by, or would have been covered if your employer had enrolled and maintained coverage in, Workers' Compensation insurance.

c. Services for which you have obtained a payment, settlement, judgment, or other recovery for future payment intended as compensation.

d. Services received by a Member incarcerated in a prison, jail, or other correctional facility at the time Services are provided, including care provided outside of a correctional facility to a person who has been arrested or is under a court order of incarceration.

10.20 Exercise Equipment or Fitness Training

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

10.21 Experimental and/or Investigational Services

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

10.22 Eye Surgery, Refractive

Radial keratotomy, LASIK, or other eye surgeries performed primarily to correct refractive errors are not covered. Additionally, reversals, revisions, and/or complications of such surgical procedures are excluded, except when required to correct an immediately life-endangering condition.

10.23 Food Supplements

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

10.24 Gender Reassignment Treatment and Surgery

Services, treatment, surgery, or counseling for gender dysphoria, including gender reassignment, are not covered.

10.25 Gene Therapy

Gene therapy or gene-based therapies are not covered.

10.26 Habilitation Therapy Services

Services designed to create or establish function that was not previously present are not covered.

10.27 Hearing Aids

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

10.28 Home Health Aides

Services provided by a home health aide are not covered.

10.29 Immunizations

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

10.30 Mental Health

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

10.31 Methadone Therapy

Methadone maintenance/therapy clinics or Services are not covered.

10.32 Non-Covered Service in Conjunction with a Covered Service

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

10.33 Pain Management Services

The following Services are not covered:

a. Prolotherapy;

b. Radiofrequency ablation of dorsal root ganglion; and

c. IV pamidronate therapy for the treatment of reflex sympathetic dystrophy.

10.34 Pervasive Developmental Disorder

Services for Pervasive Developmental Disorder are not covered.

10.35 Prescription Drugs/Injectable Drugs and Specialty Medications

The following are not covered:

a. Appetite suppressants and weight loss drugs;

b. Certain drugs with a therapeutic over-the-counter (OTC) equivalent;

c. Off-label drug usage, unless the use has been approved by a SelectHealth Medical Director or clinical pharmacist;

d. Compound drugs when alternative products are available commercially;

e. Cosmetic health and beauty aids;

f. Drugs purchased over the Internet;

g. Drugs purchased through a foreign pharmacy. However, please call Member Services if you have a special need for medications from a foreign pharmacy (for example, for an emergency while traveling out of the country);

h. Flu symptom drugs, except when approved by an expert panel of physicians and SelectHealth;

i. Human growth hormone for the treatment of idiopathic short stature;

j. Infertility drugs;

k. Medical foods;

l. Drugs not meeting the minimum levels of evidence based upon one or more of the following:

   i. Food and Drug Administration (FDA) approval;

   ii. The drug has no active ingredient and/or clinically relevant studies as determined by the SelectHealth Pharmacy & Therapeutics Committee;

   iii. DrugDex;

   iv. National Comprehensive Cancer Network (NCCN); or

   v. As defined within SelectHealth's Preauthorization criteria or medical policy.

m. Drugs used for infertility purposes;

n. Minerals, fluoride, and vitamins other than prenatal or when determined to be Medically Necessary to treat a specifically diagnosed disease;

o. New drugs approved by the FDA after May 1, 2013 unless approved for coverage by SelectHealth;

p. Nicotine and smoking cessation drugs, except in conjunction with a SelectHealth-sponsored smoking cessation program;

q. Non-Sedating Antihistamines;

r. Over-the-counter (OTC) drugs, except when all of the following conditions are met:

   i. The OTC drug is listed on a SelectHealth Formulary as a covered drug;

   ii. The SelectHealth Pharmacy & Therapeutics Committee has approved the OTC drug as a medically appropriate substitution of a Prescription Drug or drug; and

   iii. You or your Dependents have obtained a prescription for the OTC drug from a licensed Provider and filled the prescription at a Participating Pharmacy;

s. Pharmaceuticals approved by the Food and Drug Administration as a medical device;

t. Prescription Drugs used for cosmetic purposes;

u. Prescription drugs used to inhibit and/or suppress drowsiness, sleepiness, tiredness, or exhaustion, unless preauthorized by the Plan;

v. Prescriptions written by a licensed dentist, except for the prevention of infection or pain in conjunction with a dental procedure;

w. Raw powders or chemical ingredients are not covered unless specifically approved by SelectHealth or submitted as part of a compounded prescription;

x. Replacement of lost, stolen, or damaged drugs;

y. Sexual dysfunction drugs. This Exclusion does not apply if your Member Payment Summary indicates that your Plan includes the Sexual Dysfunction Optional Benefit; and

z. Travel-related medications, including preventive medication for the purpose of travel to other countries. See Immunizations in Section 10 Limitations and Exclusions.

10.36 Reconstructive, Corrective, and Cosmetic Services

a. Services provided for the following reasons are not covered:

   i. To improve form or appearance;

   ii. To correct a deformity, whether congenital or acquired, without restoring physical function;

   iii. To cope with psychological factors such as poor self-image or difficult social relations;

   iv. As the result of an accident unless the Service is reconstructive and rendered within five years of the cause or onset of the injury, illness, or therapeutic intervention, or a planned, staged series of Services (as specifically documented in the Member's medical record) is initiated within the five-year period; or

   v. To revise a scar, whether acquired through injury or surgery, except when the primary purpose is to improve or correct a functional impairment.

b. The following procedures and the treatment for the following conditions are not covered, except as indicated:

   i. Treatment for venous telangiectasias (spider veins).

   ii. Reconstructive surgery to correct congenital anomalies (to include cleft lip) in a Dependent child is covered.

10.37 Rehabilitation Therapy Services

The following are not covered:

a. Services for functional nervous disorders;

b. Speech therapy for developmental speech delay; and

c. Vision rehabilitation therapy Services.

10.38 Related Provider Services

Services provided to you or your Dependent by a Provider who ordinarily resides in the same household are not covered.

10.39 Respite Care

Respite Care is not covered.

10.40 Robot-Assisted Surgery

Robot-assisted surgery is limited to the procedures set forth in SelectHealth medical criteria. Direct costs for the use of the robot are not covered.

10.41 Sexual Dysfunction

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

10.42 Specialty Services

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

10.43 Specific Services

The following Services are not covered:

a. Anodyne infrared device for any indication;

b. Auditory brain implantation;

c. Automated home blood pressure monitoring equipment;

d. Chronic intermittent insulin IV therapy/metabolic activation therapy;

e. Coblation therapy of the soft tissues of the mouth, nose, throat, or tongue;

f. Computer-assisted interpretation of x-rays (except mammograms);

g. Computer-assisted navigation for orthopedic procedures;

h. Extracorporeal shock wave therapy for musculoskeletal indications;

i. Cryoablation therapy for plantar fasciitis and Morton's neuroma;

j. Freestanding/home cervical traction;

k. Home anticoagulation or hemoglobin A1C testing;

l. Infrared light coagulation for the treatment of hemorrhoids;

m. Interferential/neuromuscular stimulators;

n. Intimal Media Thickness (IMT) testing to assess risk of coronary disease;

o. Magnetic Source Imaging (MSI);

p. Manipulation under anesthesia for treatment of back and pelvic pain;

q. Mole mapping;

r. Nonsurgical spinal decompression therapy (e.g., VAX-D or DRS therapy);

s. Nucleoplasty or other forms of percutaneous disc decompression;

t. Oncofertility;

u. Pediatric/infant scales;

v. Peripheral nerve stimulation for occipital neuralgia and chronic headaches;

w. Platelet Rich Plasma or other blood derived therapies for orthopedic procedures;

x. Pressure Specified Sensory Device (PSSD) for neuropathy testing;

y. Prolotherapy;

z. Radiofrequency ablation for lateral epicondylitis;

aa. Radiofrequency ablation of the dorsal root ganglion;

bb. Secretin infusion therapy for the treatment of autism;

cc. Virtual colonoscopy as a screening for colon cancer; and

dd. Whole body scanning.

10.44 Telephone/E-mail Consultations

Charges for Provider telephone, e-mail, or other electronic consultations are not covered.

10.45 Travel-related Expenses

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

10.46 War

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

SECTION 11 HEALTHCARE MANAGEMENT

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

11.1 Preauthorization

Preauthorization is prior approval from SelectHealth for certain Services and is considered a Preservice Claim (refer to Section 12 Claims and Appeals). Preauthorization is not required when SelectHealth is your secondary plan. However, it is required for injectable drugs and inpatient services when Medicare is your primary insurance. Obtaining Preauthorization does not guarantee coverage (e.g. your Benefits are exhausted; you are not enrolled at the time the covered service is provided). Your Benefits for the Preauthorized Services are subject to the Eligibility requirements, Limitations, Exclusions and all other provisions of the Plan. Preauthorization is not required for emergency Services (see Section 7.9, Emergency Conditions).

11.1.1 Services Requiring Preauthorization

Preauthorization is required for the following major Services:

a. All admissions to facilities, including rehabilitation, transitional care, skilled nursing, and all hospitalizations that are not for Urgent or Emergency Conditions including all transplants;

b. All nonroutine obstetrics admissions, maternity stays longer than two days for a normal delivery or longer than four days for a cesarean section, and deliveries outside of the Service Area;

c. Home Healthcare, Hospice Care, and Private Duty Nursing;

d. Pain management/pain clinic Services;

e. Selected Prescription Drugs (Refer to the Prescription Drug List in Appendix A Prescription Drug Benefits);

f. All Services obtained outside of the United States unless a routine, Urgent or Emergency Condition;

g. Certain genetic testing;

h. The following Durable Medical Equipment:

iii. Insulin pumps and continuous glucose monitors;

iv. Prosthetics (except eye prosthetics);

v. Negative pressure wound therapy devices;

vi. Motorized or customized wheelchairs; and

vii. DME with a purchase price over $5,000;

i. The following medications (This list changes periodically. For the most current list, please visit selecthealth.org/pharmacy or call Pharmacy Services):

Abraxane
Absorica
Abstral
Actemra
Acthar
Actimmune
Actiq
Adcetris
Adcirca
Adempas
Adoxa
Afinitor
Alimta
Ampyra
Androderm
Arcalyst
Arzerra
Aubagio
Avastin
Axiron
Banzel
Benlysta
Berinert
Bexxar
Betaseron
Boniva (injectable)
Bosulif
Botox
Brisdelle
Caprelsa
Cayston
Cerezyme
Cialis
Cimzia
Cinryze
Cometriq
Cystaran
Diclegis
Dificid
Doryx
Dysport
Egrifta
Elelyso
Enbrel
Epaned
Erbitux
Erivedge
Erwinaze
Eylea
Extavia
Fentanyl Lozenges
Fentora
Firazyr
Flolan
Folotyn
Forteo
Fortesta
Gazyva
Gel-One
Genotropin
Gilenya
Gilotrif
Gleevec
Halaven
Hemophilia Factors
Humatrope
Humira
Hyalgan
Iclusig
Ilaris
Imbruvica
Incivek
Increlex
Inlyta
Intravenous Immunoglobulin (IVIG)
Istodax
Ixempra
Jakafi
Jetrea
Jevtana
Juxtapid
Kadcyla
Kalbitor
Kalydeco
Kineret
Korlym
Krystexxa
Kynamro
Kyprolis
Lazanda
Letairis
Lucentis
Macugen

Makena
Marqibo
Mekinist
MyoBloc
Nexavar
Norditropin
Novarel
NPlate
Nuedexta
Nulojix
Nutropin
Nuvigil
Olysio
Omnitrope
Onfi
Onmel
Opsumit
Oracea
Orencia
Orthovisc
Ovidrel
Ozurdex
Pegasys
PEG-Intron
Perjeta
Pomalyst
Pregnyl
Prialt
Procysbi
Prolia
Promacta
Protropin
Provenge
Provigil
Qutenza
Ravicti
Relistor
Remicade
Remodulin
Revatio
Revlimid
Sabril
Samsca
Saizen
Serostim
Signifor
Simponi
Sirturo
Solesta
Soliris
Solodyn
Somatuline
Somavert
Sovaldi
Sprycel
Stelara
Stivarga
Striant
Subsys
Sucraid
Supartz
Sutent
Sylatron
Synagis
Synribo
Tafinlar
Tarceva
Tasigna
Testim
Tev-Tropin
Thalomid
Tobi
Torisel
Tracleer
Treanda
Trokendi XR
Tykerb
Tysabri
Tyvaso
Valchlor
Varizig
Vecamyl
Vectibix
Velcade
Ventavis
Versacloz
Victrelis
Votrient
VPRIV
Xalkori
Xeljanz
Xenazine
Xeomin
Xgeva
Xiaflex
Xifaxan
Xofigo
Xolair
Xtandi
Xyrem
Yervoy
Zaltrap
Zelboraf
Zevalin
Zolinza

11.1.2 Who is responsible for obtaining Preauthorization

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

You are responsible for obtaining Preauthorization when using a Nonparticipating Provider or Facility, or when obtaining cochlear implants or organ transplants.

11.1.3 How to request Preauthorization

If you need to request Preauthorization, call Member Services at 800-538-5038.

You should call SelectHealth as soon as you know you will be using a Nonparticipating Provider or Facility for any of the Services listed. Preauthorization is valid for up to six months. After six months, if the Covered Service has not been provided, a new Preauthorization may be obtained.

11.1.4 Penalties

When you use a Nonparticipating Provider and are therefore responsible to Preauthorize and do not, Benefits may be reduced or denied. If reduced, the Allowed Amount will be cut by 50 percent and Benefits will apply to what remains according to regular Plan guidelines. You will be responsible for the 50 percent penalty, your Copay, Coinsurance, and Deductible, and you may be responsible for any amount that exceeds the Allowed Amount. Any amount you pay will not apply to the Out-of-Pocket Maximum.

Failure to obtain Preauthorization for cochlear implants, organ transplants, or certain prescription drugs will result in the denial of Benefits.

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

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

11.2 Case Management

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

11.3 Benefit Exceptions

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

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

11.4 Second Opinions/Physical Examinations

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

11.5 Medical Policies

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

SECTION 12 CLAIMS AND APPEALS

12.1 Administrative Consistency

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

12.2 Claims and Appeals Definitions

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

12.2.1 Adverse Benefit Determination

A determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness or has been determined to be an investigational service, and the requested service or payment for the service is therefore terminated, denied or reduced.

12.2.2 Appeal(s)

Review by SelectHealth of an Adverse Benefit Determination or the negative outcome of a Preservice Inquiry.

12.2.3 Authorized Representative

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

12.2.4 Benefit Determination

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

12.2.5 Claimant

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

12.2.6 Concurrent Care Decisions

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

12.2.7 External Review

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

12.2.8 Final Internal Adverse Benefit Determination

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

12.2.9 Independent Review Organization (IRO)

An entity that conducts independent External Reviews.

12.2.10 Postservice Appeal

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

12.2.11 Postservice Claim

Any claim related to Services you have already received.

12.2.12 Preservice Appeal

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

12.2.13 Preservice Claim

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

12.2.14 Preservice Inquiry

Your verbal or written inquiry to SelectHealth regarding the existence of coverage for proposed Services that do not involve a Preservice Claim, i.e., does not require prior approval for you to receive full Benefits. Preservice Inquiries are not claims and are not treated as Adverse Benefit Determinations.

12.2.15 Urgent Preservice Claim

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

12.3 How to Make a Preservice Inquiry

Preservice Inquiries should be directed to Member Services at 800-538-5038. A Preservice Inquiry is not a claim for Benefits.

12.4 How to File a Claim for Benefits

12.4.1 Urgent Preservice Claims

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

a. Information sufficient to determine to what extent Benefits are covered by the Plan; and

b. A description of the medical circumstances that give rise to the need for expedited review.

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

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

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

12.4.2 Other Preservice Claims

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

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

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

12.4.3 Postservice Claims

a. Participating Providers and Facilities. Participating Providers and Facilities file Postservice Claims with SelectHealth and SelectHealth makes payment to the Providers and Facilities.

b. Nonparticipating Providers and Facilities. Nonparticipating Providers and Facilities are not required to file claims with SelectHealth. If a Nonparticipating Provider or Facility does not submit a Postservice Claim to SelectHealth or you pay the Nonparticipating Provider or Facility, you must submit the claim in writing in a form approved by SelectHealth. Call Member Services or your employer to find out what information is needed to submit a Postservice Claim. All claims must be received by SelectHealth within a 12-month period from the date of the expense or as soon as reasonably possible. Claims received outside of this timeframe will be denied.

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

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

12.5 Problem Solving

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

12.6 Formal Appeals

If you are not satisfied with the result of working with Member Services, you may file a written formal Appeal of any Adverse Benefit Determination or the negative outcome of a Preservice 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.

12.6.1 General Rules and Procedures

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

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

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

12.6.2 Form and Timing

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

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

You may Appeal an Adverse Benefit Determination of an Urgent Preservice Claim on an expedited basis either verbally or in writing. You may Appeal verbally by calling the SelectHealth Appeals department at 800-538-5038, ext. 4684. If the request is made verbally, the SelectHealth Appeals department will within 24 hours send written confirmation acknowledging the receipt of your request.

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

You must file a formal Appeal within 180 days from the date you received notification of the Adverse Benefit Determination or made the Preservice Inquiry, as applicable.

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

12.6.3 Appeals Process

As described below, the Appeals process differs for Preservice Claims and Postservice Claims. In each case, there are both mandatory and voluntary reviews. For purposes of the Appeals process only, Preservice Inquiries will be treated like Preservice Claims.

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

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

12.6.4 Preservice Appeals

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

Mandatory Review

Your Appeal will be investigated by the Appeals department. All relevant, available information will be reviewed. The Appeals department will notify you in writing of the Appeal decision within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after the receipt of your Appeal.

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

Voluntary Review

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

Voluntary External Review

Voluntary External Review is available as set forth in Section 12.7 below. If you pursue a voluntary External Review, it will be your last level of Appeal.

Voluntary Internal Review

If you choose to pursue the voluntary internal review process, you may request a review of your Appeal. Depending on the nature of the Appeal, it will be considered by either the Administrative Appeal Review Committee or the Clinical Appeal Review Committee. Such a request must be made in writing to the Appeals Department within 60 days of the date the Appeals Department notifies you the Final Internal Adverse Benefit Determination. SelectHealth will notify you of the result of the review in writing within 30 days of the date you requested the review. If you are not satisfied with the decision made by the reviewing committee, you may request a review by the SelectHealth Appeals Committee. Such a request must be made in writing to the Appeals Department within 60 days of the date the reviewing committee notifies you of its decision.

12.6.5 Postservice Appeals

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

First Mandatory Review

Your Appeal will be investigated by the SelectHealth Appeals department. All relevant information will be reviewed and the Appeals department will notify you in writing of the Appeal decision within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after the receipt of your Appeal.

Second Mandatory Review

If you are dissatisfied with the decision of the first mandatory review, you may request further consideration of your Appeal. Depending on the nature of the Appeal, it will be considered either by the Administrative Appeal Review Committee or the Clinical Appeal Review Committee. Such a request must be made in writing to the Appeals Department within 60 days of the date the reviewing committee notifies you of its decision. SelectHealth will notify you of the result of the second mandatory review in writing within 30 days of the date you requested the review.

Voluntary Review

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

Voluntary External Review

Voluntary External Review is available as set forth in Section 12.7 below. If you pursue a voluntary External Review, it will be your last level of Appeal.

Voluntary Internal Review

If you choose to pursue the voluntary internal review process, you may request a voluntary internal review of your Final Internal Adverse Benefit Determination by the SelectHealth Appeals Committee. Such a request must be made in writing to the Appeals Department within 60 days of the date the Appeals Department notifies you of its decision.

12.6.6 Attorney's Fees

SelectHealth shall, in any action brought in any court or in any arbitration in the State of Idaho for recovery under the terms of the policy, pay such further amount as the court or arbitration shall adjudge reasonable as attorney's fees in such action. Attorney's fees may also be due to SelectHealth as a result of such actions.

12.7 Member’s Right to External Review

YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW

Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with your health plan. If you request an independent External Review of your claim, the decision made by the independent reviewer will be binding and final on the health carrier. You will have the right to further review of your claim by a court, arbitrator, mediator or other dispute resolution entity only if your plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), as more fully explained below under Binding Nature of the External Review Decision.

If we issue a Final Internal Adverse Benefit Determination of your request to provide or pay for a health care service or supply, you may have the right to have our decision reviewed by health care professionals who have no association with us. You have this right only if our denial decision involved:

- The Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of your health care Service; or
- Our determination your health care Service was Experimental and/or Investigational.

You must first exhaust our internal grievance and Appeal process. Exhaustion of that process includes completing all levels of Appeal, or unless you requested or agreed to a delay, our failure to respond to a standard Appeal within 35 days in writing or to an urgent Appeal within three business days of the date you filed your Appeal. We may also agree to waive the exhaustion requirement for an External Review request. You may file for an internal urgent appeal with us and for an expedited external review with the Idaho Department of Insurance at the same time if your request qualifies as an urgent care request defined below.

You may submit a written request for an External Review to:

Idaho Department of Insurance
ATTN: External Review
700 W State St, 3rd Floor
Boise ID 83720-0043

For more information and for an External Review request form:

- See the department's web site, doi.idaho.gov, or
- Call the department's telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

You may represent yourself in your request or you may name another person, including your treating health care Provider, to act as your Authorized Representative for your request. If you want someone else to represent you, you must include a signed Appointment of an Authorized Representative form with your request.

Your written External Review request to the Department of Insurance must include a completed form authorizing the release of any of your medical records the IRO may require to reach a decision on the External Review, including any judicial review of the External Review decision pursuant to ERISA, if applicable. The department will not act on an External Review request without your completed authorization form.

If your request qualifies for External Review, our Final Internal Adverse Benefit Determination will be reviewed by an IRO selected by the department. We will pay the costs of the review.

12.7.1 Standard External Review Request

You must file your written External Review request with the department within four months after the date we issue a final notice of denial.

a. Within seven days after the department receives your request, the department will send a copy to us.

b. Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may Appeal that determination to the department.

c. If your request is eligible for review, the department will assign an IRO to your review within seven days of receipt of our notice. The department will also notify you in writing.

d. Within seven days of the date you receive the department's notice of assignment to an IRO, you may submit any additional information in writing to the IRO that you want the organization to consider in its review.

e. The IRO must provide written notice of its decision to you, to us and to the department within 42 days after receipt of an External Review request.

12.7.2 Expedited External Review Request

You may file a written urgent care request with the department for an expedited External Review of a pre-service or concurrent service denial. You may file for an internal urgent appeal with us and for an expedited external review with the department at the same time.

Urgent care request means a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular External Review determination:

a. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;

b. In the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or

c. The treatment would be significantly less effective if not promptly initiated.

The department will send your request to us. We will determine, no later than the second full business day, if your request is eligible for review. We will notify you and the department no later than one business day after our decision if your request is eligible. If we deny your eligibility for review, you may Appeal that determination to the department.

If your request is eligible for review, the department will assign an IRO to your review upon receipt of our notice. The department will also notify you. The IRO must provide notice of its decision to you, to us and to the department within 72 hours after the date of receipt of the External Review request. The IRO must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses our denial, we will notify you and the department of our intent to pay the covered benefit as soon as reasonably practicable, but not later than one business day after receiving notice of the decision.

12.7.3 Binding Nature of the External Review Decision

If your plan is subject to federal ERISA laws (generally, any plan offered through an employer to its employees), the External Review decision by the IRO will be final and binding on us. You may have additional review rights provided under federal ERISA laws.

If your plan is not subject to ERISA requirements, the External Review decision by the IRO will be final and binding on both you and us. This means that if you elect to request External Review, you will be bound by the decision of the IRO. You will not have any further opportunity for review of our denial after the IRO issues its final decision. If you choose not to use the External Review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.

Under Idaho law, the IRO is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

SECTION 13 OTHER PROVISIONS AFFECTING YOUR BENEFITS

13.1 Coordination of Benefits (COB)

When you or your Dependents have healthcare coverage under more than one health benefit plan, SelectHealth will coordinate Benefits with the other healthcare coverage according to the COB rules set forth in Idaho DOI Rule 18.01.74.

Definitions

a. Allowable Expense. Any health care expense including coinsurance or copayments, and without reduction for any applicable deductible that is covered in full or in part by any of the plans covering the person. If a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in Section 223 (c) (2) (C) of the Internal Revenue Code of 1986. An expense that a provider by law or in accordance with contractual agreement is prohibited from charging a covered person is not an allowable expense. An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.

   i. The following are examples of expenses or services that are not an allowable expense:

      1) If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room (unless the patient's stay in the private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans provides coverage for private hospital rooms) is not an allowable expense.

      2) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees, or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.

      3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

4) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

ii. The definition of the allowable expense may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of Allowable Expenses in its contract to expenses that are similar to the expenses that it provides. When COB is restricted to specific coverages or benefits in a contract the definition of Allowable Expense shall include similar expenses to which COB applies.

iii. When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as an allowable expense and a benefit paid.

iv. The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan:

1) Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services: or

2) Because the covered person has a lower benefit because the covered person did not use a preferred provider.

b. Birthday. The month and day in a calendar year in which the individual is born.

c. Custodial Parent. The parent awarded custody by a court decree. In the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

d. Plan. A form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan. If a plan coordinates benefits, its contract shall state the types of coverage that will be considered in applying the COB provision of that contract.

i. Plan includes:

1) Group and nongroup insurance contracts and subscriber contracts;

2) Uninsured group or group-type coverage arrangements;

3) Group and nongroup coverage through closed panel plans;

4) Group-type contracts;

5) The medical care components of long-term care contracts, such as skilled nursing care;

6) Medicare or other governmental benefits, except as provided in Subsection (b)(ix) of this section. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

7) The medical benefits coverage in automobile no fault and traditional automobile fault type contracts. No plan is required to coordinate benefits provided that it pays benefits as a primary plan. If a plan coordinates benefits, it shall do so in compliance with the provisions of this chapter.

ii. Plan shall not include:

1) Hospital indemnity coverage or other fixed indemnity coverage;

2) School accident-type coverages, such as contracts that cover students for accidents only, including athletic injuries, either on a 24 hour basis or on a to and from school basis;

3) Specified disease or specified accident coverage;

4) Accident only coverage;

5) Benefits provided in long-term care insurance policies for non-medical service; for example, personal care, adult daycare, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

6) Limited benefit health coverage as defined in Idaho Administrative Code Rule 18.01.30, Individual Disability and Group Supplemental Disability Insurance Minimum Standards Rule, Sections 012 and 029.

7) Medicare supplement policies;

8) A state plan under Medicaid; or

9) A governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

e. Primary Plan. A plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if;

i. The plan either has no order of benefit determination rules, or its rules differ from those permitted by this rule; or

ii. All plans that cover the person use the order of benefit determination required by this rule, and under those rules the plan determines its benefits first.

f. Secondary Plan. A plan that is not a primary plan.

Order of Benefit Determination

Each plan determines its order of benefits using the first of the following rules that applies.

a. Non-dependent or dependent. The plan that covers the person other than as a dependent, for example, as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

b. Dependent Child covered under more than one plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

i. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

1) The plan of the parent whose birthday falls earlier in the calendar year is primary plan; or

2) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

ii. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provisions;

2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, then Subsection 13.1.3(2)(b)(i) of this provision shall determine the order of benefits;

3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, then Subsection 13.1.3 (2)(b)(i) of this provision shall determine the order of benefits, or

4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

    a) The plan covering the custodial parent;

    b) The plan covering the custodial parent's spouse;

    c) The plan covering the noncustodial parent; and then

    d) The plan covering the noncustodial parent's spouse.

5) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable under Subsection 13.1.3 (2)(b)(i) or Subsection 13.1.3 (2)(b)(ii) of this provision as if those individuals were parents of the child.

c. Active Employee or Retired or Laid-Off Employee. The plan that covers a person as an active employee; that is, an employee who is neither laid-off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under Subsection 13.1.3 (2)(a) of this provision.

d. Continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to federal or state law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This provision does not apply if the rule in Subsection 13.1.3 (2)(a) of this provision can determine the order of benefits.

e. Longer/shorter length of coverage. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for a shorter period of time is the secondary plan.

    i. To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within 24 hours after the coverage under the first plan ended.

ii. 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 that 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 a multiple employer plan.

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

f. If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans. All applicable Copayment or Coinsurance requirements, if any, will be taken into account and enforced in determining available benefits.

Miscellaneous Provisions

a. Benefits in the Form of Services. A secondary plan that provides benefits in the form of care, services, treatments, drugs, medications, supplies, or equipment may recover the reasonable cash value of the care, services, treatments, drugs, medications, supplies, or equipment from the primary plan, to the extent that benefits for the care, services, treatments, drugs, medications, supplies, or equipment are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of care, services, treatments, drugs, medications, supplies, or equipment provided by a plan which provides benefits in the form of care, services, treatments, drugs, medications, supplies, or equipment.

b. Complying Plan Versus Noncomplying Plan. A plan with order of Benefit Determination rules that comply with this rule (complying plan) may coordinate its benefits with a plan that is excess or always secondary or that uses order of Benefit Determination rules that are inconsistent with those contained in this rule (non-complying plan) on the following basis:

i. If the complying plan is the primary plan, it shall pay or provide its benefits first;

ii. If the complying plan is the secondary plan, it shall, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, the payment shall be the limit of the complying plan's liability; and

iii. If the non-complying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the non-complying plan are identical to its own and shall pay its benefits accordingly. If, within two years of payment, the complying plan receives information as the actual benefits of the non-complying plan, it shall adjust payments accordingly.

1) If the non-complying plan reduces its benefits so that the covered person receives less in benefits than the covered person would have received had the complying plan paid or provided its benefits as the secondary plan and the non-complying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan shall advance to the covered person or on behalf of the covered person an amount equal to the difference.

2) In no event shall the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or care, services, treatments, drugs, medications, supplies, or equipment. In consideration of the advance, the complying plan shall be subrogated to all rights of the covered person against the non-complying plan. The advance by the complying plan shall also be without prejudice to any claim it may have against the non-complying plan in the absence of such subrogation.

c. COB Versus Subrogation. COB differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

d. Timely Payment of Benefits. If the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been primary.

13.2 Subrogation/Restitution

As a condition to receiving Benefits under the Plan, you and your Dependent(s) (hereinafter you) agree that SelectHealth is automatically subrogated to, and has a right to receive equitable restitution from, any right of recovery you may have against any third party as the result of an accident, illness, injury, or other condition involving the third party (hereinafter third-party event) that causes you to obtain Covered Services that are paid for by SelectHealth. SelectHealth is entitled to receive as equitable restitution the proceeds of any judgment, settlement, or other payment paid or payable in satisfaction of any claim or potential claim that you have or could assert against the third party to the extent of all Benefits paid by SelectHealth or payable in the future by SelectHealth because of the third-party event.

Any funds you (or your agent or attorney) recover by way of settlement, judgment, or other award from a third party or from your own insurance due to a third-party event as described in this section shall be held by you (or your 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 section. SelectHealth shall have the right to bring a lawsuit against, or assert a counterclaim or cross-claim against, you (or your agent or attorney) for purposes of collecting SelectHealth's equitable restitution interest or to enforce the constructive trust required by this section.

Except for proceeds obtained from uninsured or underinsured motorist coverage, this contractual right of subrogation/restitution applies whether or not you believe that you have been made whole or otherwise fully compensated by any recovery or potential recovery from the third party and regardless of how the recovery may be characterized (e.g., as compensation for damages other than medical expenses).

You 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 take any action that prejudices SelectHealth's right of subrogation/restitution, including settling a dispute with a third party without protecting SelectHealth's subrogation/restitution interest;

d. Sign any papers required to enable SelectHealth to assert its subrogation/restitution interest;

e. Grant to SelectHealth a first priority lien against the proceeds of any settlement, verdict, or other amounts you receive; and

f. Assign to SelectHealth any benefits you may have under any other coverage to the extent of SelectHealth's claim for restitution.

SelectHealth's right of subrogation/restitution exists to the full extent of any payments made, Services provided, or expenses incurred on your behalf because of or reasonably related to the third-party event.

You (or your agent or attorney) will be personally liable for the equitable restitution amount to the extent that SelectHealth does not recover that amount through the process described above.

If you fail to fully cooperate with SelectHealth or its designated agent in asserting SelectHealth's subrogation/restitution right, then limited to the compensation you (or your agent or attorney) have received from a third party, SelectHealth may reduce or deny coverage under the Plan and offset against any future claims. Further, SelectHealth may compromise with you on any issue involving subrogation/restitution in a way that includes your surrendering the right to receive further Services under the Plan for the third-party event.

SelectHealth will reduce the equitable restitution required in this section to reflect reasonable costs or attorneys' fees incurred in obtaining compensation, as separately agreed to in writing between SelectHealth and your attorney.

13.3 Right of Recovery

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

SECTION 14 SUBSCRIBER RESPONSIBILITIES

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

14.1 Payment

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

14.2 Changes in Eligibility or Contact Information

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

14.3 Other Coverage

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

14.4 Information/Records

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

14.5 Notification of Members

Notify your enrolled Dependent(s) of all Benefit and other Plan changes.

SECTION 15 EMPLOYER RESPONSIBILITIES

15.1 Enrollment

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

15.2 Payment

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

15.3 Contract

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

15.4 Compliance

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

SECTION 16 DEFINITIONS

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

16.1 Activities of Daily Living

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

16.2 Affordable Care Act (ACA)

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

16.3 Allowed Amount

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

16.4 Ambulatory Surgical Facility

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

16.5 Annual Open Enrollment

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

16.6 Anodontia

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

16.7 Application

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

16.8 Approved Clinical Trials

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

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

b. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

c. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

16.9 Benefit(s)

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

16.10 Certificate of Coverage (Certificate)

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

16.11 COBRA Coverage

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

16.12 Coinsurance

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

16.13 Congenital Anomaly

A condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. A significant deviation is a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

16.14 Contraceptive

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

16.15 Contract

The Group Health Insurance Contract between SelectHealth and your employer.

16.16 Copay (Copayment)

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

16.17 Covered Services

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

16.18 Custodial Care

Services provided primarily to maintain rather than improve a Member's condition or for the purpose of controlling or changing the Member's environment. Services requested for the convenience of the Member or the Member's family that do not require the training and technical skills of a licensed Nurse or other licensed Provider, such as convalescent care, rest cures, nursing home services, etc. Services provided principally for personal hygiene, dressing, bathing, eating or similar activities that can be done by individuals not typically requiring a skilled level of training to complete are examples of activities meeting this definition.

16.19 Deductible(s)

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

16.20 Dental Services

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

16.21 Dependent(s)

Your Eligible dependents as set forth in Section 2 Eligibility.

16.22 Durable Medical Equipment (DME)

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

16.23 Effective Date

The date on which coverage for you and/or your Dependent(s) begins.

16.24 Eligible, Eligibility

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

16.25 Emergency Condition(s)

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

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

b. Placing the health of a pregnant woman or her unborn child in serious jeopardy;

c. Serious impairment to bodily functions; or

d. Serious dysfunction of any bodily organ or part.

16.26 Employer Waiting Period

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

16.27 Employer's Plan

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

16.28 Endorsement

A document that amends the Contract.

16.29 ERISA

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

16.30 Essential Health Benefits

As defined by the ACA and unless modified by future regulations, essential health benefits include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

16.31 Excess Charges

Charges from Providers and Facilities that exceed the Allowed Amount for Covered Services. You are responsible to pay for Excess Charges from Nonparticipating Providers and Facilities. These charges do not apply to your Out-of-Pocket Maximum.

16.32 Exclusion(s)

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

16.33 Experimental and/or Investigational

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

a. It cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use;

b. It is the subject of a current investigational new drug or new device application on file with the FDA;

c. It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial;

d. It is being or should be delivered or provided subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS); or

e. If the predominant opinion among appropriate experts as expressed in the peer-reviewed medical literature is that further research is necessary in order to define safety, toxicity, effectiveness, or comparative effectiveness, or there is no clear medical consensus about the role and value of the Service.

16.34 Facility

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

16.35 Formulary

The Prescription Drugs covered by your Plan.

16.36 Generic Drug(s)

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

16.37 Group Application

A form used by SelectHealth both as an application for coverage by your employer and to specify group-specific details of coverage. The Group Application may contain modifications to the language of the Contract. It also demonstrates your employer's acceptance of the Contract. Other documents, such as Endorsements, may be incorporated by reference into the Group Application. Specifics on length of leave of absence, required hours to be worked, length of eligibility waiting period, and amount of payroll deductions are available to Members from their Employer.

16.38 Group Health Insurance Contract

The agreement between your employer and SelectHealth that contains the terms and conditions under which SelectHealth provides group insurance coverage to you and your Dependent(s). The Group Application and this Certificate are part of the Group Health Insurance Contract.

16.39 Health Benefit Plan

Health Benefit Plan means any group hospital or medical policy or certificate, any group Subscriber contract provided by a Hospital or professional service corporation, or group health maintenance organization Subscriber contract. Health Benefit Plan does not include policies or certificates of insurance for specific disease, hospital confinement indemnity, accident only, credit, dental, vision, Medicare supplement, Long Term Care, or disability income insurance, student health benefits only coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or nonrenewable short term coverage issued for a period of twelve (12) months or less.

16.40 Healthcare Management Program

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

16.41 Home Healthcare

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

16.42 Hospice Care

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

16.43 Hospital

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

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

a. Operates primarily for the admission, acute care, and treatment of injured or sick persons as inpatients;

b. Has a 24-hour-a-day nursing service by or under the supervision of a graduate registered Nurse (R.N.) or a licensed practical Nurse (L.P.N.);

c. Has a staff of one or more licensed Physicians available at all times; and

d. Provides organized facilities for diagnosis and surgery either on its premises or in facilities available to the Hospital on a contractual prearranged basis.

16.44 Infertility

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

16.45 Injectable Drugs and Specialty Medications

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

a. Are often products of a living organism or produced by a living organism through genetic manipulation of the organism's natural function;

b. Are generally used to treat an ongoing chronic illness;

c. Require special training to administer;

d. Have special storage and handling requirements;

e. Are typically limited in their supply and distribution to patients or Providers; and

f. Often have additional monitoring requirements.

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

16.46 Initial Eligibility Period

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

16.47 Involuntary Complications of Pregnancy

Involuntary Complications of Pregnancy means: Cesarean section delivery, ectopic pregnancy that is terminated, a spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible, puerperal infection, eclampsia, and toxemia; and other conditions requiring hospital confinement (when pregnancy is not terminated), which can only occur associated with pregnancy such as false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, missed abortion, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy.

16.48 Lifetime Maximum

The maximum accumulated amount that SelectHealth will pay for certain Covered Services (as allowed by the Affordable Care Act) when a Member is enrolled under the Group Health Insurance Contract offered through this employer. If applicable, lifetime maximums are specified in your Member Payment Summary.

16.49 Limitation(s)

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

16.50 Major Diagnostic Tests

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

a. Cardiac nuclear studies or cardiovascular procedures such as coronary angiograms;

b. Gene-based testing and genetic testing;

c. Imaging studies such as MRIs, CT scans, and PET scans; and

d. Neurologic studies such as EMGs and nerve conduction studies.

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

16.51 Major Office Surgery

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

a. Performed within or upon the contents of the abdominal, pelvic, cranial or thoracic cavities;

b. Typically requiring general anesthesia;

c. Has a level of difficulty or length of time to perform which constitutes a hazard to life or function of an organ or tissue; or

d. Requires the special training to perform.

16.52 Mammography Services

Mammography examination or equivalent examination coverage is provided, and shall include the following:

a. One baseline mammogram for any woman who is 35 through 39 years of age;

b. A mammogram every two years for any woman who is 40 through 49 years of age, or more frequently if recommended by the woman's physician;

c. A mammogram every year for any woman who is 50 years of age or older; and

d. A mammogram for any woman desiring a mammogram for medical cause.

Such coverage shall not exceed the cost of the examination. Mammography services performed for non-preventive purposes will apply to the minor diagnostic test benefit.

16.53 Maximum Annual Out-of-Network Payment

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

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

16.54 Medical Director

The Physician(s) designated as such by SelectHealth.

16.55 Medical Necessity/Medically Necessary

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

a. In accordance with generally accepted standards of medical practice in the United States;

b. Clinically appropriate in terms of type, frequency, extent, site, and duration; and

c. Not primarily for the convenience of the patient, Physician, or other Provider.

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

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

16.56 Member

You and your Dependent(s), when properly enrolled in the Plan and accepted by SelectHealth.

16.57 Member Payment Summary

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

16.58 Minor Diagnostic Tests

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

a. Bone density tests;

b. Certain EKGs;

c. Echocardiograms;

d. Common blood and urine tests;

e. Simple x-rays such as chest and long bone x-rays; and

f. Spirometry/pulmonary function testing.

16.59 Miscellaneous Medical Supplies (MMS)

Supplies that are disposable or designed for temporary use.

16.60 Nonparticipating (Out-of-Network) Benefits

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

16.61 Nonparticipating (Out-of-Network) Facility

Healthcare Facilities that are not under contract with SelectHealth.

16.62 Nonparticipating (Out-of-Network) Pharmacies

Pharmacies that are not under contract with SelectHealth.

16.63 Nonparticipating (Out-of-Network) Provider

Providers that are not under contract with SelectHealth.

16.64 Nurse

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

16.65 Oligodontia

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

16.66 Optional Benefit

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

16.67 Out-of-Pocket Maximum

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

16.68 Palliative Care

Comprehensive, specialized care provided by an interdisciplinary team to patients and families living with a life-threatening or severe advanced illness where the focus of care is to alleviate suffering and maintain an acceptable quality of life. Hospice Care for terminally ill patients is one type of palliative care.

16.69 Participating (In-Network) Benefits

The higher level of Benefits available to you when you obtain Covered Services from a Participating Provider or Facility.

16.70 Participating (In-Network) Facility

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

16.71 Participating (In-Network) Pharmacies

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

16.72 Participating (In-Network) Providers

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

16.73 Pervasive Developmental Disorder (PDD/Developmental Delay)

A state in which an individual has not reached certain developmental milestones normal for that individual's age, yet no obvious medical diagnosis or condition has been identified that could explain the cause of this delay. PDD includes five disorders characterized by delays in the development of multiple basic functions, including socialization and communication. PDD includes:

a. Asperger's Syndrome;

b. Autistic Disorder;

c. Childhood Disintegrative Disorder;

d. Pervasive developmental disorder not otherwise specified; and

e. Rett's Disorder.

16.74 Physician

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

16.75 Placement

Physical placement in the care of the adoptive Member, or in those circumstances in which such physical Placement is prevented due to the medical needs of the child requiring Placement in a medical facility, when the adoptive Member signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child. Prior to legal finalization of adoption, the coverage continues in the same manner as it would with respect to a naturally born child of the Member until the first to occur of the following events:

a. date the child is removed permanently from that placement and the legal obligation terminates; or

b. the date the Member rescinds, in writing, the agreement of adoption or agreement assuming financial responsibility.

16.76 Plan

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

16.77 Plan Sponsor

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

16.78 Preauthorization (Preauthorize)

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

16.79 Premium(s)

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

16.80 Prescription Drugs

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

16.81 Preventive Services

Periodic health care that includes screenings, checkups, and patient counseling to prevent illness, disease, or other health problems not previously known to exist in the individual, and as defined by the Affordable Care Act and/or SelectHealth.

Some examples of these services are well-child exams, immunizations, pediatric vision screenings, and Contraceptives as required by the ACA. Preventive services also include a Contraceptive that is medically necessary for you as determined by your Provider and evidenced through written documentation submitted to SelectHealth.

16.82 Primary Care Physician or Primary Care Provider (PCP)

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

a. Certified Nurse Midwives;

b. Family Practice;

c. Geriatrics;

d. Internal Medicine;

e. Obstetrics and Gynecology (OB/GYN); and

f. Pediatrics.

16.83 Private Duty Nursing

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

16.84 Provider

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

16.85 Qualified Medical Child Support Order (QMCSO)

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

16.86 Rescission (Rescind)

A cancellation or discontinuance of coverage that has retro-active effect, except to the extent it is attributable to a failure to timely pay required Premiums or contributions towards the cost of coverage, in which case it is a permissible retroactive termination.

16.87 Residential Treatment Center

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

16.88 Respite Care

Care provided primarily for relief or rest from caretaking responsibilities.

16.89 Secondary Care Physician or Secondary Care Provider (SCP)

Physicians and other Providers who are not a Primary Care Physician or Primary Care Provider. Examples of an SCP include:

a. Cardiologists;

b. Dermatologists;

c. Neurologists;

d. Ophthalmologists;

e. Orthopedic Surgeons; and

f. Otolaryngologists (ENTs).

16.90 Service Area

All counties in Idaho.

16.91 Service(s)

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

16.92 Skilled Nursing Facility

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

a. Is being operated as required by law;

b. Is primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a Physician;

c. Provides 24 hours a day, seven days a week nursing service by or under the supervision of a Registered Nurse (R.N.); and

d. Maintains a daily medical record of each patient.

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

16.93 Special Enrollment Right

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

16.94 Subscriber

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

16.95 Urgent Condition(s)

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

16.96 Year

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

a. The calendar year begins on January 1 at 12:00 a.m. Mountain Standard Time and ends on December 31, at 11:59 p.m. Mountain Standard Time.

b. The plan year, if applicable, is indicated in the Group Application.

SECTION 17 OPTIONAL BENEFITS

Optional Benefits are options to the Plan which enhance your Benefits. This section contains the specific Optional Benefits selected by your employer.

selecthealth

ENDORSEMENT

This ENDORSEMENT is made to the 2016 Large Employer Idaho Group Health Insurance Contract made between your employer and us.

In addition to the coverage allowed in provision 10.1 of the Certificate of Coverage, abortions are covered where the pregnancy was caused by a rape or incest if evidence of the rape or incest is presented either from medical records or through the review of a police report or the filing of charges that a crime has been committed.

Patricia R. Richards
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