2024

Contract

INDIVIDUAL

Utah - BENCH NOPED

selecthealth

Fair Treatment Notice

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

We provide free:

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

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

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

Language Access Services

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

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

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

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

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

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

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

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

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

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

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

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

تنبيه: إذا كنت تتحدث عربى، فستتوفر لك خدمات المساعدة اللغوية مجانا. اتصل بـ Select Health.

توجه: اگر به زبان اردو صحبت می‌کنی، خدمات کمک زبانی، بصورت رایگان در اختیار شما ست. با Select Health تماس بگیری.

หมายเหตุ: หากคุณพูด ใส่ภาษา, การบริการภาษา โดยไม่มีค่าใช้จ่าย มีพร้อมบริการให้กับคุณ ติดต่อ Select Health

Select Health: 1-800-538-5038

INDIVIDUAL MEMBER PAYMENT SUMMARY (MPS) BENCHMARK 01/01/2024 I61A0130

Signature Benchmark Silver 0 Medical Deductible - no deductible for office visits - 94% AV

This is a Silver plan as defined by the Affordable Care Act.

Select Health
SIGNATURE NETWORK

	IN-NETWORK
	You must use In-Network Providers (except for emergencies)
DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM[4,5]	**IN-NETWORK**
Self Only Coverage, 1 person enrolled - per calendar Year	
Deductible	$0
Out-of-Pocket Maximum	$3,000
Family Coverage, 2 or more enrolled - per calendar Year	
Deductible - per person/family	$0/$0
Out-of-Pocket Maximum - per person/family	$3,000/$6,000
This amount is your Deductible + your Coinsurance and Copay (medical and Rx)	
INPATIENT SERVICES[3]	**IN-NETWORK**
Medical, Surgical, Hospice, Emergency Admissions	20%
Hospital level care at home	20%
Skilled Nursing Facility	20%
Up to 30 days/calendar Year	
Rehab Therapy: Physical, Speech, Occupational	$10
Up to 30 days/calendar Year for all therapy types combined	
Physician's Fees – *Medical, Surgical, Maternity, Anesthesia*	20%
PROFESSIONAL SERVICES[3]	**IN-NETWORK**
Office Visits and Office Surgeries	
Primary Care Provider (PCP)[1]	$0
Primary Care Provider (PCP) Virtual Visits[1]	Covered 100%
Specialist/Secondary Care Provider (SCP)[1]	$0
Allergy Tests	See office visits
Allergy Treatment and Serum	20%
Physician's Fees – *Surgical*	20%
Physician's Fees – *Medical, Maternity, Anesthesia*	20%
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2]	**IN-NETWORK**
Office Visits (PCP/SCP)[1]	Covered 100%
Adult and Pediatric Immunizations	Covered 100%
Diagnostic Tests: Minor	Covered 100%
Other Preventive Services	Covered 100%
VISION SERVICES	**IN-NETWORK**
Pediatric Preventive Eye Exams - Through Age 18 Years, Only[2]	Covered 100%
Adult Preventive Eye Exams - Age 19 and Over[2]	Not Covered
All Other Eye Exams - Adult/Pediatric	$0
Contacts and Corrective Lenses - Through Age 18 Years, Only	20%
Limit one pair of eyeglass lenses or contact lenses per Year	
OUTPATIENT SERVICES	**IN-NETWORK**
Outpatient Facility	20%
Ambulatory Surgical Center	10%
Imaging Center	$100
Ambulance (Air or Ground) – *emergencies only*	20%
Emergency Room	$150
Intermountain InstaCare® Facilities, Urgent Care Facilities	$10
Intermountain KidsCare® Facilities	$0
Intermountain Connect Care®	Covered 100%
Radiation	20%
Dialysis	20%
Diagnostic Tests: Minor, per Provider	$0
Diagnostic Tests: Major, per Provider	$95
Home Health[3]	20%
Up to 30 visits/calendar Year	
Hospice[3]	20%
Up to 6 months every 3 Years	
Outpatient Cardiac Rehab	Covered 100%
Outpatient Private Nurse	Not Covered
Outpatient Rehab Therapy: Physical, Speech, Occupational	$0
Up to 20 visits/calendar Year for all therapy types combined	
Outpatient Habilitative Therapy: Physical, Speech, Occupational	$0
Up to 20 visits/calendar Year for all therapy types combined	

See next page for additional benefits and footnotes.

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Select Health
SIGNATURE NETWORK

	IN-NETWORK
	You must use In-Network Providers (except for emergencies)
MISCELLANEOUS SERVICES	**IN-NETWORK**
Maternity and Adoption[3,6]	See Professional, Inpatient, or Outpatient Services
Includes all related maternity and adoption services. Enroll in SelectHealth Healthy Beginnings Program® : 866-442-5052	
Chiropractic Care	Not Covered
Miscellaneous Medical Supplies (MMS)[2]	20%
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Durable Medical Equipment (DME)[3]	20%
Prosthetic Devices[3]	Not Covered
Injectable Drugs and Specialty Medications[3]	50%
Chemotherapy[3]	50%
Infertility (*select services only)*	50%
Mental Health and Chemical Dependency[3]	
Office Visits	$0
Virtual Visits	Covered 100%
Inpatient	20%
Outpatient	20%
Residential Treatment Center	20%
Cochlear Implants[3]	See Professional, Inpatient, or Outpatient Services
TMJ (Temporomandibular Joint) Services	Not Covered
PRESCRIPTION DRUGS[3]	
Prescription Drug List (formulary)	RxCore®
Prescription Drug Deductible - *Per Person*	$0
Out-of-Pocket Maximum	Combined with medical
Prescription Drugs – *Up to a 30-day supply for covered medications*	
Tier 1	$0
Tier 2	$0
Tier 3	4%
Tier 4	15%
Tier 5	50%
Maintenance Drugs – *90-day supply*	
Tier 1 - *Mail-Order, Retail90* ®	$0
Tier 2 - *Mail-Order, Retail90* ®	$0
Tier 3 - *Intermountain Home Delivery Pharmacy*	4%
Tier 4 - *Intermountain Home Delivery Pharmacy*	15%
Generic Substitution Required	Generic required or must pay Copay plus cost difference between name brand and generic

FOOTNOTES

1. Visit **selecthealth.org/findadoctor** to find out whether a Provider is a Primary Care or Secondary Care Provider.
2. Frequency and/or quantity limitations apply to some preventive care and MMS services.
3. Preauthorization is required for certain services. Benefits may be reduced or denied if you do not preauthorize certain services with Out-of-Network Providers. Please refer to Section 11--" Healthcare Management", in your Certificate of Coverage, for details.
4. **All Deductible/Copay/Coinsurance amounts are based on the Allowed Amount and not on billed charges. Out-of-Network Providers or Facilities may not accept the Allowed Amount for Covered Services. When this occurs, you may be responsible for Excess Charges.**
5. Certain Services as noted on this document and in your Certificate of Coverage are not subject to the Deductible.
6. Select Health provides a $4,000 adoption indemnity benefit as outlined by the state of Utah. Deductible, Copay, or Coinsurance listed under the maternity benefit applies and may exhaust the benefits prior to any plan payment.
7. Select Health will cover an insulin from each therapeutic category with a cap of $28 per prescription of a 30-day supply.

For more information, refer to your Certificate of Coverage or Contract or 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. TTY users should call 711.

SECTION 1 – INTRODUCTION

1.1 The Contract

This health insurance Contract is made between SelectHealth, Inc. ("Select Health," "we," or "us") and you. In exchange for your payment of Premium, we provide you with defined healthcare Benefits. Please read it carefully and keep it for future reference. Technical terms are capitalized and described in Section 15 - Definitions. Your Member Payment Summary, which contains a quick summary of the Benefits by category of service, is attached to and considered part of the Contract. If you are not satisfied with this Contract for any reason, you may return it to us, or to the agent who took your application, together with a request for cancellation within 10 days after receipt. If you are eligible for Medicare, you may return the policy for any reason within 30 days after its delivery and have the premium refunded.

1.2 Select Health

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

1.3 Managed Care

Select Health provides managed healthcare coverage. Such management necessarily limits some choices of Providers and Facilities. The management features and procedures are described by the Contract. 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 Select Health, 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 and to all of the other terms and conditions of the Contract.

1.5 Term

The Contract begins on the date specified in the Individual Plan Coverage List and terminates at the end of that Year. However, your coverage is guaranteed renewable to the extent required by the Affordable Care Act.

1.6 No Vested Rights

You are only entitled to receive Benefits while the Contract is in effect and you, and your Dependents if applicable, are properly enrolled and recognized by Select Health 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 the Contract, all Benefits end when the Contract ends.

1.7 Administration

Select Health 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 the Contract.

1.8 Non-Assignment

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

1.9 Notices

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

1.10 Nondiscrimination

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

1.11 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 In-Network Providers, such as name, address, phone number, professional qualifications, specialty, medical school attended, residency completed, and board certification status. Select Health offers foreign language assistance. The provider directory also includes information about receiving care after business hours.

1.12 Benefit Changes

Select Health 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 Select Health employee and the written terms of the Contract, the terms of the Contract will control.

b. Any changes or modifications that would increase your Benefits must be provided in writing and signed by the president, vice president, or medical director of Select Health.

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

In order to become and remain a Member, you and your Dependents must continuously satisfy the Eligibility requirements described in this section and elsewhere in the Contract. No one may change, extend, expand, or waive the Eligibility requirements without first obtaining the advance, written approval of an officer of Select Health.

2.2 Subscriber Eligibility

To be Eligible for Benefits, you must live, work, or Reside in the Service Area.

2.3 Dependent Eligibility

Your Dependents 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 unable to engage in substantial gainful employment to the degree they can achieve economic independence due to medically determinable physical or mental impairment which can be expected to last for a continuous period of not less than 12 months or result in death;

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

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

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

2.3.4 Domestic Partner

a. Your domestic partner who shares your permanent residence, has resided with you for no less than 6 months, is not younger than 18, is not married to, or is not a domestic partner or tax dependent of another person, is not so closely related by blood to you that a legal marriage would otherwise be prohibited, and:

b. Has either 1) registered as a Domestic Partner with you in a state, city, or county which has a registration procedure for the Domestic Partners or 2) signed jointly with you in a notarized "Declaration of Domestic Partnership;" and

c. Is financially interdependent with you and has proven such interdependence to Select Health by providing documentation of at least two of the following arrangements:

   i. Common ownership of real property or a common leasehold interest in such property;

   ii. Common ownership of a motor vehicle;

   iii. A joint bank account or a joint credit account;

   iv. Designation as a beneficiary for life insurance or retirement benefits under your will;

   v. Assignment of durable power of attorney; and

   vi. Such other proof as is considered by Select Health to be sufficient to establish financial interdependency under the circumstances of the particular situation.

2.4 Changes in Member Information or Eligibility

Unless otherwise specified in this Contract, you must notify us within 31 days whenever there is a change in a Member's situation that may affect Eligibility or enrollment.

2.5 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 Select Health guidelines and only to the minimum extent required pursuant to Utah Code Annotated 31A-22-610 through 611. For more information about Select Health guidelines, please call Member Services.

2.5.1 Effective Date

For a qualified order, the Effective Date of coverage will be the later of the start date indicated in the order, or the first or the 16th day of the month following the date we receive the order.

2.5.2 Duration of Coverage

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

SECTION 3 - ENROLLMENT

3.1 General

No Services will be covered for anyone not listed on the application and accepted for coverage by Select Health. Enrollment changes for Plans purchased through the Marketplace may need to be effectuated through the Marketplace.

3.2 Enrollment Process

To enroll, you must use an application accepted by Select Health. You may enroll yourself and any Dependents by completing, signing, and submitting the application and any other required enrollment materials to Select Health.

3.3 Covered Members

Those listed on the application and accepted for coverage by Select Health are Members beginning on the date of the Contract's issuance.

3.4 Special Enrollment

3.4.1 New Dependents

If you gain a Dependent through marriage or placement under legal guardianship, you may enroll your spouse and any other new Dependents. If you gain a Dependent through birth, adoption, or placement for adoption of a child, you may enroll your spouse and all Dependents, even if they are not newly Eligible as a Dependent. If you choose to enroll the Dependent, enrollment must occur within the following timeframes:

a. If you gain a Dependent through marriage you must enroll the Dependent within 60 days of the marriage.

b. If you gain a Dependent through birth, adoption, placement for adoption or legal guardianship, and additional Premium is required, you must enroll the Dependent within 60 days of gaining the Dependent.

c. If you gain a Dependent through birth, adoption, or placement for adoption or legal guardianship, and it does not change the Premium, you must enroll the Dependent within 31 days from the date Select Health mails notification that a claim for Services was received for the Dependent.

If the Dependent is not enrolled within these timeframes, then you must submit an application during an Open Enrollment period and coverage will be effective on your renewal date.

Coverage of any Members properly enrolled under this provision will be effective on the date of birth, adoption, or placement for adoption or under legal guardianship. For Dependents properly enrolled due to marriage, the effective date will be the first day of the month following the date election.

3.4.2 Loss of Minimum Essential Coverage

If your Dependent loses Minimum Essential Coverage under another plan, you may enroll the Dependent within 60 days of the loss. A loss of coverage does not include a loss of coverage due to:

a. Failure to pay premiums on a timely basis, including COBRA premiums prior to expirations of COBRA coverage; or

b. Fraud or material misrepresentation.

If the loss of other coverage has already occurred, coverage for any Dependent properly enrolled under this provision will be effective the first of the month following the election. If the loss of other coverage has not happened yet, the coverage for any Dependent properly enrolled under this provision will be effective the first of the month following the loss of coverage.

If the Special Enrollment Right occurs because you or your spouse loses coverage, you can enroll yourself and all of your Eligible Dependents. If the Special Enrollment Right occurs because one of your Dependents reaches the limiting age specified in the Contract, then only that Dependent has the Special Enrollment Right.

If a Dependent is enrolled on a group health plan and the Annual Open Enrollment periods of the two plans do not coincide, the Dependent may voluntarily drop 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.

3.4.3 Permanent Move

If you gain access to a new health insurance plan as a result of a permanent move, you and your Dependents may be eligible for a Special Enrollment. Moving for the purpose of obtaining medical treatment does not qualify you for a Special Enrollment. If you do qualify for this Special Enrollment, you must enroll within 60 days of the permanent move.

Coverage of new Members properly enrolled under this provision will be effective the first day of the following month. Existing Members properly enrolled under this provision can choose an effective date of the first day of the current month or the first day of the following month.

3.4.4 Indians

If you are an Indian, as defined by section 4 of the Indian Health Care Improvement Act, you may enroll in a Qualified Health Plan (QHP) through the Marketplace or change from one QHP to another one time per month.

Coverage of any Members properly enrolled under this provision between the 1st and 15th of the month will be effective the first day of the following month. If enrolled on the 16th of the month or after, coverage will be effective the first day of the second following month.

3.4.5 As Required by State or Federal Law

Select Health will recognize other special enrollment rights as required by state or federal law and directed by the Marketplace.

3.5 Adding a Dependent through Open Enrollment

Other than under a special enrollment right you may only enroll a Dependent during an Open Enrollment If the Dependent is enrolled by December 15th, coverage will be effective as of January 1st. Thereafter, coverage for Dependents enrolled between the 1st and 15th of the month will be effective the first day of the following month. If enrolled on the 16th of the month or after, coverage will be effective the first day of the second following month.

3.6 Death of the Subscriber

If you did not enroll through the Marketplace and you die, your covered spouse will become the Subscriber. To make this change, your spouse would need to submit an application to Select Health within 60 days of your death. If you enrolled through the Marketplace and you die, your Dependents will have a special enrollment right through the Marketplace.

3.7 Divorce/Annulment

If you and your covered spouse divorce, or your marriage is annulled, your ex-spouse will have a special enrollment right. To make this change, your spouse would need to submit an application within 60 days of the divorce.

SECTION 4 - PREMIUM

4.1 Premiums

You are responsible to pay the Premium to Select Health within the timeframes indicated in the Contract.

4.1.1 Premium During the Term of the Contract

Subject to the provisions of the Contract, the Premiums will remain the same until the end of the term of the Contract. However, we may reasonably modify the Premium if federal or state law or regulations mandate that we adjust Benefits under the Contract.

4.1.2 Premium Rate Factors

Your Premiums are based on the following factors:

a. Age Bands

The age bands are as follows: 0-20 years, each year from 21 to 64 years (your Premium may change each year from age 21 to 64), and 65 years of age or older. If you or your Dependent has a birthday that moves you/them into the next age band, rates may increase upon renewal.

b. The Following Geographic Areas:

i. Cache and Rich counties;

ii. Box Elder, Morgan and Weber counties;

iii. Davis, Salt Lake, Summit, Tooele and Wasatch counties;

iv. Utah county;

v. Iron and Washington counties; and

vi. Beaver, Carbon, Daggett, Duchene, Emery, Garfield, Grand, Juab, Kane, Millard, Piute, San Juan, Sanpete, Sevier, Uintah and Wayne counties.

Your Premium may change if you move into a different geographic area.

c. Tobacco Use

You are considered a tobacco user if you have used tobacco on average four or more times per week during the past six months, excluding religious and ceremonial uses.

If your tobacco use status changes during the Year from user to non-user, your Premium may be reduced prospectively.

If you falsely or incorrectly report information about your tobacco use, we may retroactively apply the appropriate tobacco use rating factor to your Premium from the beginning of the Contract.

d. Family Size

You, your spouse, any children over age 21, and your oldest three children under 21 (if applicable) will be used to determine your family size. Your Premium may change if your family size changes.

4.1.3 Premium Due Date

Premiums are payable on the first day of each month at the Select Health office in Murray, Utah.

4.1.4 Premium Payments from Third Parties

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

a. Ryan White HIV/AIDS Program:

b. Indian tribes, tribal organizations, or urban Indian organizations: and

c. Local, state, or federal government programs, including grantees directed by a government program to make payments on its behalf.

Select Health will also accept Premium payments from not-for-profit organizations when the organization:

a. Provides assistance based on the Eligible Individual's financial need;

b. Is not a healthcare provider; and

c. Is not financially interested.

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

a. Select Health will accept Premium payments from your family and friends. When you make a payment directly to us, we will not require certification or verification of the source of the funds.

b. If Select Health refuses an appropriate premium payment from a third party, we will notify the Eligible Individual in writing of the reason for refusing the payment and their right to contact the Utah Insurance Department.

4.2 Grace Period

The grace period begins the day the Premium is due.

If you are receiving an Advanced Premium Tax Credit, and you have paid at least one month of Premium, the grace period is three months. We will continue to adjudicate claims for Services received during the first month of the grace period. We may pend claims for Services received during the second and third months of the grace period. If the full Premium is not received before the grace period expires, the Contract will terminate as of the end of the first month of the grace period. If you are receiving an Advanced Premium Tax Credit and you have not paid the first month's Premium, there is no grace period.

If you are not receiving an Advanced Premium Tax Credit the grace period is 30 days. We may pend claims for Services received during the grace period. If the Premium is not received before the grace period expires, the Contract will terminate as of the last day of the previous month for which Premium was paid in full. Coverage may be reinstated, in accordance with Select Health policy, if you submit payment within 60 days of the date your coverage ended.

4.3 Member Receiving Treatment at Termination

All Benefits under the Plan terminate when the Contract terminates, including coverage for you or your Dependents if you are hospitalized or otherwise within a course of care or treatment. All Services received after the date of termination are your responsibility no matter when the condition arose and despite care or treatment anticipated or already in progress.

SECTION 5 - TERMINATION

5.1 Termination by You

You may terminate the Contract by giving us advance written notice.

5.2 Termination by Us

We may terminate the Contract, and coverage for you and your Dependent under the Contract, for the reasons listed below:

a. You fail to pay Premiums in accordance with the Contract. Partial payment will be treated as nonpayment unless we, at our sole discretion, indicate otherwise in writing.

b. You perform an act or practice that constitutes fraud or make an intentional misrepresentation of material fact under the terms of the coverage.

c. You no longer live, reside, or work in the Service Area.

d. We cease to offer this particular health benefit product in accordance with applicable state and federal law. In such instance, we will give you at least 90 days' advance notice.

e. We withdraw from the market in accordance with applicable state and federal law. In such instance, we will give you at least 180 days' advance notice.

f. If this coverage becomes decertified as a QHP.

g. If we get notice that you have enrolled in another QHP during an Open Enrollment period or under a special enrollment right.

h. You no longer meet the Eligibility requirements of domestic partnership.

i. You or your Dependent loses Eligibility.

5.2.1 Fraud or Misrepresentation

a. Made During Enrollment:

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

iii. Please Note: If coverage is terminated, Rescinded, or Reformed as described above, the termination or Reformation 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 Select Health, the Rescission may be effective retroactively to the date of the fraud or misrepresentation.

c. 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.

5.2.2 Nonpayment of Premium or Contributions

Select Health 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 Select Health may recover from you and/or your Dependents the amount of any Benefits you or they received during the period of lost coverage.

5.2.3 Court or Administrative Order

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

5.3 Termination Date

The termination date will be at the end of the month in which the termination event or request occurs, except as indicated below:

a. If you request to be terminated from the Plan, coverage will terminate on the date of the request or on a future date of your choice.

b. If you become newly eligible for CHIP, Medicaid, or the Basic Health Program (as defined by the Affordable Care Act) then coverage will terminate the day before the effective date of the new coverage.

c. The date specified by the Marketplace.

d. When a Dependent child ceases to be a Dependent, coverage will terminate at the end of the year in which Dependent status is lost.

Note: When a loss of Eligibility is not reported in a timely fashion as required by the Contract, and federal or state law prevents Select Health from retroactively terminating coverage, Select Health has the discretion to determine the prospective date of termination. Select Health also has the discretion to determine the date of termination for Rescissions.

5.4 Reinstatement

If any renewal Premium is not paid within the time granted you for payment, a subsequent acceptance of Premium by Select Health or by any agent duly authorized by Select Health to accept the Premium, without also requiring an application for reinstatement, shall reinstate the policy. However, if Select Health or its authorized agent requires an application for reinstatement and issues a conditional receipt for the Premium tendered, the policy shall be reinstated upon approval of this application from Select Health or, lacking this approval, upon the 45th day following the date of the conditional receipt, unless Select Health has previously notified you in writing of its disapproval of the application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after that date. In all other respects you and Select Health have the same rights under the reinstated policy as under the policy immediately before the due date of the defaulted Premium, subject to any provisions endorsed on or attached to this policy in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

SECTION 6 - PROVIDERS/NETWORKS

6.1 Providers and Facilities

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

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

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

6.2 Access to Healthcare Providers

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

Independent Hospital(s)
Beaver Valley Hospital, Beaver, Beaver County, Utah
Blue Mountain Hospital, Blanding, San Juan County, Utah
Central Valley Medical Center, Nephi, Juab County, Utah
Gunnison Valley Hospital, Gunnison, Sanpete County, Utah
Kane County Hospital, Kanab, Kane County, Utah
Milford Valley Memorial Hospital, Milford, Beaver County, Utah
Moab Regional Hospital, Moab, Grand County, Utah
San Juan Hospital, Monticello, San Juan County, Utah
Uintah Basin Medical Center, Roosevelt, Duchesne County, Utah Federally Qualified Health Centers
Bear Lake Community Health Center, Garden City, Carbon County, Utah
Bear River Health Clinic, Tremonton, Box Elder County, Utah
Blanding Family Chiropractic, Blanding, San Juan County, Utah
Blanding Family Practice Community Health Center, Blanding, San Juan County, Utah
Blanding Family Vision Center, Blanding, San Juan County, Utah
Box Elder Community Health Center, Brigham City, Box Elder County, Utah
Brigham City Community Health Center, Brigham City, Box Elder County, Utah
Carbon Medical Service Association -- Helper Clinic, Helper, Carbon County, Utah
Carbon Medical Service Association, Sunnyside, Carbon County, Utah
Cedar Community Health Center, Cedar City, Iron County, Utah
Family Healthcare, Cedar City, Iron County, Utah
Green River Medical Center, Green River, Emery County, Utah
Kanosh Community Health Center, Kanosh, Millard County, Utah
Kazan Memorial Clinic, Escalante, Garfield County, Utah
Koosharem Community Health Center, Richfield, Sevier County, Utah
Montezuma Creek Health Center, Montezuma Creek, San Juan County, Utah
Mountainlands Community Health Center, Vernal, Uintah County, Utah
Southwest WCHC Mental Health, Panguitch, Garfield County, Utah
Wayne County Medical Clinic, Bicknell, Wayne County, Utah
Wayne Community Health Center, Hanksville, Wayne County, Utah

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

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

6.3 Providers and Facilities Not Agents/Employees of Select Health

Providers contract independently with Select Health and are not agents or employees of Select Health. They are entitled and required to exercise independent professional medical judgment in providing Covered Services. Select Health makes a reasonable effort to credential In-Network 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 Select Health, 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 Select Health or to cause Select Health to be legally bound by what they say. A recommendation, order, or referral from a Provider or Facility, including In-Network Providers and Facilities, does not guarantee coverage by Select Health.

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

6.4 Payment

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

6.4.1 Incentives

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

6.4.2 Payments to Members

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

6.5 Provider/Patient Relationship

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

6.6 Continuity of Care

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

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

a. undergoing a course of treatment from the Provider or Facility for a serious and complex condition;

b. undergoing a course of institutional or inpatient care from the Provider or Facility;

c. scheduled to undergo non-elective surgery from the Provider or Facility, including receipt of postoperative care from such Provider or Facility with respect to such surgery;

d. pregnant and undergoing a course of treatment for pregnancy from the Provider or Facility (any trimester); and

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

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

a. Accept the Allowed Amount as payment in full and to not collect Excess Charges;

b. Follow Select Health's Healthcare Management policies and procedures;

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

d. Share information with Select Health regarding the treatment plan.

6.7 Finding an In-Network Provider

For help finding an In-Network Provider, do any of the following:

a. Visit selecthealth.org;

b. Refer to your Provider & Facility Directory; or

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

SECTION 7 - ABOUT YOUR BENEFITS

7.1 General

You and your Dependents are entitled to receive Benefits while you are enrolled with Select Health 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, and expenses that do not count against your Out-of-Pocket Maximum.

7.3 Identification (ID) Cards

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

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

7.4 Medical Necessity

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

7.5 Calendar Year

Out-of-Pocket Maximums, Limitations, and Deductibles start over each January 1st.

7.6 Lifetime Maximums

Your Member Payment Summary will specify any applicable Lifetime Maximums.

7.7 In-Network Benefits

You must use In-Network Providers and Facilities to receive Benefits for Covered Services unless otherwise noted in the Contract. In-Network Providers and Facilities have agreed to accept the Allowed Amount and will not bill you for Excess Charges.

7.8 Emergency Conditions

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

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

If you or your Dependent is hospitalized for an emergency:

a. You or your representative must contact Select Health once the condition has been stabilized, or as soon as reasonably possible; and

b. If you are in an Out-of-Network Facility, once the Emergency Condition has been stabilized, you may be asked to transfer to an In-Network Facility in order to continue receiving In-Network Benefits.

7.9 Urgent Conditions

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

7.10 Surprise Billing Protections

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

7.11 Third Party Payments

To the extent permissible under federal or state law, third-party payments (including discounts and coupons) may not apply towards your Deductible and Out-of-Pocket Maximum.

7.12 Deductible Waiver

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

a. Retinopathy screening for diabetes;

b. Hemoglobin A1c testing for diabetes;

c. Peak flow meter for asthma;

d. International Normalized Ratio (INR) testing for liver disease and/or bleeding disorders; and

e. Low-density Lipoprotein (LDL) testing for heart disease.

7.13 Travel Outside the U.S.

If you are traveling outside of the country and need Urgent or Emergency care, visit the nearest doctor or Hospital. You may need to pay for the Service and then seek reimbursement. If the Service is covered, you will be reimbursed the Allowed Amount minus your Copay/Coinsurance and/or Deductible. Some Services received outside of the U.S. require preauthorization. Call Member Services at 800-538-5038 for details.

SECTION 8 - COVERED SERVICES

You and your Dependents are entitled to receive Benefits for Covered Services while you are enrolled with Select Health 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 Select Health. For additional information affecting Covered Services, refer to your Member Payment Summary and Section 10 - Limitations and Exclusions. In addition to this Contract, you can find further information about your Benefits by doing any of the following:

a. Log in to your Select Health account at selecthealth.org;

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 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.

8.1.2 Inpatient Hospital

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

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

c. Intensive care unit.

d. Preadmission testing.

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

f. Maternity/obstetrical Services.

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

8.1.3 Nutritional Therapy

Medical nutritional therapy is covered as a Preventive Service for up to five visits per Year for the following diagnoses:

a. Anorexia;

b. Anorexia Nervosa;

c. Bulimia;

d. Celiac Disease;

e. Congestive heart failure;

f. Coronary Artery Disease;

g. Crohn's Disease;

h. Chronic kidney disease;

i. Diabetes;

j. Dyslipidemia;

k. Food allergies;

l. GERD;

m. Hypercholesterolemia;

n. Hyperlipidemia;

o. Hypertension;

p. Metabolic Syndrome;

q. Obesity (and Morbid Obesity);

r. Polyphagia;

s. Renal failure; and

t. Small Bowel Syndrome.

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

8.1.4 Outpatient Facility and Ambulatory Surgical Facility

Outpatient surgical and medical Services.

8.1.5 Skilled Nursing Facility

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

8.1.6 Urgent Care Facility

8.2 Provider Services

8.2.1 After-Hours Visits

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

8.2.2 Anesthesia

General anesthesia, deep anesthesia, and Monitored Anesthesia Care (MAC) are only covered pursuant to Select Health policy when administered in connection with otherwise Covered Services and by a Physician certified as an anesthesiologist or by a Certified Registered Nurse Anesthetist (CRNA).

8.2.3 Dental Services

u. When Select Health determines the following to be Medically Necessary:

    a. Maxillary and/or mandibular procedures;

    b. Upper/lower jaw augmentation or reduction procedures, including developmental corrections, altering of vertical dimension, and orthognathic surgery; or

    c. Services for maxillary/mandibular bone or calcitite augmentation surgery when a Member is edentulous (missing all teeth) and the general health of the Member is at risk because of malnutrition or possible bone fracture.

8.2.4 Dietary Products

Only in the following limited circumstances:

a. For hereditary metabolic disorders when:

    i. You or your Dependent has an error of amino acid or urea cycle metabolism;

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

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

b. Certain enteral formulas according to Select Health policy.

8.2.5 Genetic Counseling

Only when required by the Affordable Care Act and rendered by an In-Network Provider.

8.2.6 Genetic Testing

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

a. Diagnostic results from physical examination, pedigree analysis, and conventional testing are inconclusive and a definitive diagnosis is uncertain;

b. The clinical utility of all requested genes and gene mutations must be established; and

c. The clinical record indicates how test results will guide decisions regarding disease treatment, prevention, or management.

8.2.7 Home Visits

8.2.8 Infertility

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

8.2.9 Mastectomy/Reconstructive Services

In accordance with the Women's Health and Cancer Rights Act (WHCRA), Select Health 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 Select Health's Healthcare Management 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 Select Health'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.

8.2.10 Maternity Services

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

8.2.11 Medical/Surgical

In an inpatient, outpatient, or Ambulatory Surgical Facility.

8.2.12 Office Visits including Office Surgery

For consultation, diagnosis, and treatment.

8.2.13 Preventive Services

8.2.14 Sterilization Procedures

8.3 Miscellaneous Services

8.3.1 Adoption Indemnity Benefit

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

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

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

8.3.2 Ambulance/Transportation Services

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

8.3.3 Approved Clinical Trials

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

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

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

c. Either:

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

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

8.3.4 Chemotherapy, Radiation Therapy, and Dialysis

8.3.5 Cochlear Implants

For prelingual deafness in children or postlingual deafness in adults in limited circumstances that satisfy Select Health criteria.

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;

   v. Not attached to a home or vehicle; and

   vi. Not specifically excluded in Section 10 – Limitations and Exclusions.

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

c. Batteries only when used to power an insulin pump for treatment of diabetes.

Certain DME items can only be rented. Others may be subject to a rental period prior to purchasing. Select Health 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 Habilitation Therapy Services

Visit limits, if indicated on your Member Payment Summary, do not apply when the primary diagnosis is Mental Health/Chemical Dependency.

8.3.8 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.

8.3.9 Hospice Care

8.3.10 Injectable Drugs and Specialty Medications

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

8.3.11 Psychological Testing

8.3.12 Mental Health/Chemical Dependency

Treatment of emotional conditions or chemical dependency listed as a mental disorder in the Diagnostic and Statistical Manual and which require professional intervention.

8.3.13 Miscellaneous Medical Supplies (MMS)

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

8.3.14 Organ Transplants

a. Only if provided by In-Network Providers in an In-Network Facility unless otherwise approved in writing in advance by Select Health; and

b. Only eligible transplants, including the following:

   i. Bone marrow as outlined in Select Health criteria;

   ii. Combined heart/lung;

   iii. Combined pancreas/kidney;

   iv. Cornea;

   v. Heart;

   vi. Kidney;

   vii. Liver;

   viii. Pancreas after kidney;

   ix. Single or double lung;

   x. Small bowel.

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

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

8.3.15 Osteoporosis Screening

Only for women age 60 or older.

8.3.16 Rehabilitation Therapy

Visit limits, if indicated on your Member Payment Summary, do not apply when the primary diagnosis is Mental Health/Chemical Dependency.

8.3.17 TeleHealth

Services are covered in accordance with Select Health's medical policy when rendered by an In-Network Provider. Interprofessional assessment or consultation between Providers as part of your treatment are payable under your office visit Benefit.

8.3.18 Tobacco Cessation

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

a. Four tobacco cessation counseling sessions; and

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

8.3.19 Vein Procedures

Only when performed at an accredited vein clinic or facility.

8.3.20 Vision Aids

Only:

a. Contacts if diagnosed with keratoconus or when used as a "bandage" after eye trauma/injury; and

b. Corrective lenses for children through age 18, one set per year.

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 Contract, you can find additional information about your Pharmacy Benefits by doing any of the following:

a. Log in to your Select Health account at selecthealth.org 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 In-Network Pharmacies

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

If you use an Out-of-Network Pharmacy, you must pay full price for the drug and submit to Select Health 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 Benefit allows you to choose the drugs that best meet your medical needs while encouraging you and your Provider to discuss treatment options and choose lower-tier drugs when therapeutically appropriate.

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

9.4 Filling Your Prescription

9.4.1 Copay/Coinsurance

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

9.4.2 Quantity and Day Supply

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

9.4.3 Refills

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

9.5 Generic Drug Substitution Required

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

9.6 Maintenance Drugs

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

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

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

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

Maintenance drugs are identified by the letter (M) on the Prescription Drug List. You have two options when filling prescriptions under the maintenance drug Benefit: (1) Retail90SM, which is available at certain retail pharmacies; and (2) mail order.

9.7 Preauthorization of Prescription Drugs

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

To obtain Preauthorization for these drugs, please have your Provider call Select Health 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 Select Health. This process is called step therapy. The alternative drug is generally a more cost-effective therapy that does not compromise clinical quality. If your Provider feels that the alternative drug does not meet your needs, Select Health may cover the drug without step therapy if Select Health determines it is Medically Necessary.

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

9.9 Coordination of Benefits

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 Select Health. In some circumstances, your secondary policy may pay a portion of your out-of-pocket expense. When you mail a secondary claim to Select Health, you must include a Prescription Reimbursement Form and the pharmacy receipt in order for Select Health 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, Select Health 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 or 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 Select Health 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

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

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

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

Select Health 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 Select Health, you may be permitted to retain your coverage if you comply with specified conditions.

9.12 Pharmacy Injectable Drugs and Specialty Medications

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

9.13 Prescription Drug List (PDL)

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

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 Select Health.

9.16 Disclaimer

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

SECTION 10 - LIMITATIONS AND EXCLUSIONS

Unless otherwise noted in your Member Payment Summary, the following Limitations and Exclusions apply.

10.1 Abortions/Termination of Pregnancy

Abortions are not covered except:

a. When determined by Select Health to be Medically Necessary to save the life of the mother; or

b. Where the pregnancy was caused by a rape or incest if evidence of the rape or incest is presented either from medical records or through the review of a police report or the filing of charges that a crime has been committed.

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

10.2 Acupuncture/Acupressure

Acupuncture and acupressure Services are not covered.

10.3 Administrative Services/Charges

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

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

10.4 Allergy Tests

Sublingual and colorimetric testing is not covered.

10.5 Bariatric Surgery

Surgery, including any revision or reversal of such surgery, to facilitate weight loss is not covered.

10.6 Biofeedback/Neurofeedback

Biofeedback/neurofeedback is not covered.

10.7 Birthing Centers and Home Childbirth

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

10.8 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 Select Health medical policy.

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

10.9 Chiropractic Services

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

10.10 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 Select Health unless the additional information relating to the claim was filed as soon as reasonably possible.

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

10.11 Compensated Services

Other than for an Approved Clinical Trial, Services for which the Member receives compensation are not covered, such as Services in connection with a prearranged surrogacy agreement, except for Services for the baby, where the Member relinquishes a baby and receives payment or other compensation arising out of such Services. Select Health may request information and documentation for a situation that appears to involve compensation, such as a surrogacy arrangement, and withhold payment of claims related to the Services in question if an adequate response is not provided.

10.12 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.

10.13 Custodial Care

Custodial Care is not covered.

10.14 Debarred Providers

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

10.15 Dental Anesthesia

Services including local, regional, general, and/or intravenous sedation anesthesia, are not covered.

10.16 Duplication of Coverage

The following are limited or are not covered:

a. Services that are covered by, or would have been covered if you or your Dependents had enrolled and maintained coverage, in automobile insurance, including no-fault type coverage up to the minimum amount required by law are not covered. 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 for which you have obtained a payment, settlement, judgment, or other recovery for future payment intended as compensation are not covered.

c. Services received by you or your Dependent while incarcerated in a prison, jail, or other correctional facility at the time Services are provided, including care provided outside of a correctional facility to a person who has been arrested or is under a court order of incarceration are not covered.

d. Coverage will be reduced to the extent that Workers Compensation Benefits are paid, including any claims that are resolved pursuant to a disputed claim settlement for which you have or had a right to compensation.

10.17 Exercise Equipment or Fitness Training

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

10.18 Experimental and/or Investigational Services

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

10.19 Eye Surgery, Refractive

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

10.20 Food Supplements

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

10.21 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.

10.22 Home Health Aides

Services provided by a home health aide are not covered.

10.23 Immunizations

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

10.24 Mental Health/Chemical Dependency

The following are not covered:

a. Behavior modification;

b. Counseling with a patient's family, friend(s), employer, school authorities, or others, except for approved Medically Necessary collateral visits, with or without the patient present, in connection with otherwise covered treatment of the patient's mental illness;

c. Education or training;

d. Long-term care;

e. Milieu therapy;

f. Self-care or self-help training (nonmedical);

g. Surgical procedures to remedy a condition diagnosed as psychological, emotional, or mental; and

h. Services for conduct disorder.

10.25 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.

10.26 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.

10.27 Prescription Drugs/Injectable Drugs and Specialty Medications

The following are not covered:

a. Appetite suppressants and weight loss drugs;

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

c. Certain off-label drug usage, unless the use has been approved by a Select Health Medical Director or clinical pharmacist;

d. Compound drugs when alternative products are available commercially;

e. Cosmetic health and beauty aids;

f. Drugs not on your Formulary;

g. Drugs purchased from Out-of-Network Providers over the Internet;

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

i. Flu symptom drugs, except when approved by an expert panel of physicians and Select Health;

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

k. Medical foods;

l. Infertility drugs;

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

   i. Food and Drug Administration (FDA) approval;

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

   iii. Nationally recognized compendium sources currently utilized by Select Health;

   iv. National Comprehensive Cancer Network (NCCN); or

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

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

o. Non-Sedating Antihistamines;

p. Over-the-counter (OTC) drugs, except as required by the Affordable Care Act, or when all of the following conditions are met:

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

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

   iii. You or your Dependent has obtained a prescription for the OTC drug from a licensed Provider and filled the prescription at an In-Network Pharmacy;

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

r. Prescription Drugs used for cosmetic purposes;

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

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

u. Raw powders or chemical ingredients are not covered unless specifically approved by Select Health or submitted as part of a compounded prescription.

v. Replacement of lost, stolen, or damaged drugs and drugs;

w. Sexual dysfunction drugs; and

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

10.28 Reconstructive, Corrective, and Cosmetic Services

a. Except as described in Section 8 - Covered Services, Services provided for the following reasons are not covered:

   i. To improve form or appearance;

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

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

iv. As the result of an accident unless the Service is reconstructive and rendered within 5 years of the cause or onset of the injury, illness, or therapeutic intervention; 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:

vi. Sclerotherapy of varicose veins; or

vii. Treatment for venous telangiectasias (spider veins).

10.29 Related Provider Services

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

10.30 Respite Care

Respite Care is not covered.

10.31 Robot-Assisted Surgery

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

10.32 Sexual Dysfunction

Services related to sexual dysfunction are not covered.

10.33 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.

10.34 Specific Services

The following Services are not covered:

a. Adult preventive eye exam;

b. Ankle-foot and foot orthotics;

c. Automated home blood pressure monitoring equipment (adult);

d. BiPAP and CPAP machines (including eligible attachments and supplies);

e. Blood storage - Autologuous for future use;

f. Cane or quad cane;

g. Cardiac rehab phase 4;

h. Chest compression vest, system generator and hoses;

i. Circumcision;

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

k. Computer-assisted navigation for orthopedic procedures;

l. Crutches;

m. Dynasplint;

n. Electrodes and accessories for stimulators;

o. Enuresis alarm unit;

p. Face masks;

q. Fracture frame;

r. Freestanding/home cervical traction;

s. Incontinence supplies;

t. Glucometer (blood glucose monitor);

u. Home anticoagulation or hemoglobin A1C testing;

v. Hospital beds and related parts or equipment;

w. Humidifiers;

x. Interferential/neuromuscular stimulators;

y. Lymphedema pump (pneumatic compressor), sleeves and supplies;

z. Magnetic Source Imaging (MSI);

aa. Manipulation under anesthesia;

bb. Mastectomy bra;

cc. Microphlebectomy (stab phlebectomy);

dd. Oncofertility;

ee. Pediatric/infant scales;

ff. Percussor, chest;

gg. Postural drainage board;

hh. Pressure pads, cushions and mattresses (with or without pumps);

ii. Private duty nursing, home health aide, custodial care, and respite care;

jj. Prosthesis, limb and supplies;

kk. Protonics knee orthosis;

ll. Radiofrequency ablation for lateral epicondylitis;

mm. Scooter board;

nn. Sleep studies;

oo. Speech generating device;

pp. Stander;

qq. Stereotactic radiosurgery;

rr. Support hose (elastic stockings, surgical stockings);

ss. Tracheostomy speaking valve;

tt. Transcutaneous Electrical Nerve stimulator (TENS);

uu. Virtual colonoscopy as a screening for colon cancer;

vv. Walkers and attachments (rental and purchase of both basic and specialty); and

ww. Wheelchair—certain parts and accessories.

10.35 Temporomandibular Joint (TMJ)

Services for TMJ conditions are not covered.

10.36 Terrorism or Nuclear Release

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

10.37 Travel-related Expenses

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

10.38 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

Select Health 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 Select Health to maintain reasonable Premium rates. The Healthcare Management process takes several forms.

11.1 Preauthorization

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

11.1.1 Services Requiring Preauthorization

Preauthorization is required for the following Services:

a. Adenoidectomy;

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

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

d. All Services obtained outside of the United States unless for Routine Care, an Urgent Condition, or an Emergency Condition;

e. Automatic blood pressure monitor (neonatal/pediatric)

f. Certain advanced imaging including Magnetic Resonance Imaging (MRI), Computerized Tomography (CT) scans, Positron Emission Tomography (PET) scans, and cardiac imaging;

g. Certain genetic testing;

h. Certain Home Healthcare;

i. Certain medical oncology drugs;

j. Certain radiation therapies;

k. Certain ultrasounds;

l. Certain vein procedures;

m. Cochlear implants;

n. Continuous glucose monitors;

o. Hospice Care;

p. Hospital level care at home;

q. Hysterectomy;

r. Insulin pumps;

s. Joint replacement;

t. Organ transplants;

u. Pain management/pain clinic Services;

v. Surgeries on vertebral bodies, vertebral joints, spinal discs;

w. Tonsillectomy;

x. The following Durable Medical Equipment:

   i. Continuous Positive Airway Pressure (CPAP) and Bilevel Positive Airway Pressure (BiPAP);

   ii. Negative pressure wound therapy electrical pump (wound vac);

   iii. Motorized or customized wheelchairs; and

   iv. DME with a purchase price over $5,000.

y. The following Mental Health/Chemical Dependency Services that are not for Emergency Conditions:

   i. Inpatient Psychiatric/Detoxification admissions;

   ii. Residential treatment after the third day of admission;

   iii. Day treatment;

   iv. Partial Hospitalization after 20 visits; and

   v. Intensive outpatient treatment after 35 visits.

z. The medications listed on selecthealth.org/pharmacy/pharmacy-benefits. You may also request this list by calling Pharmacy Services at 800-538-5038:

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

11.1.2 Who is responsible for obtaining Preauthorization

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

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

11.1.3 How to request Preauthorization

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

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

11.1.4 Penalties

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

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

Under federal law, health insurance issuers generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a 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), Select Health 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, Select Health may in its sole discretion extend or add Benefits that are not otherwise expressly covered or are limited by the Plan. In making this decision, Select Health will consider the medical appropriateness and cost effectiveness of the proposed exception.

When making such exceptions, Select Health 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 Select Health 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, Select Health 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. Select Health will be responsible for paying for any such physical examination.

11.5 Medical Policies

Select Health 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 Select Health. Medical policies do not supersede the express provisions of the Contract. 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 Select Health. For questions about the medical policies of Select Health, call Member Services at 800-538-5038.

SECTION 12 - CLAIMS AND APPEALS

12.1 Administrative Consistency

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

12.2 Claims and Appeals Definitions

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

12.2.1 Adverse Benefit Determination

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

12.2.2 Appeal(s)

Review by Select Health of an Adverse Benefit Determination.

12.2.3 Authorized Representative

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

12.2.4 Benefit Determination

The decision by Select Health 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 Select Health 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 Select Health at the completion of the mandatory Appeals process.

12.2.9 Independent Review Organization (IRO)

An entity that conducts independent External Reviews.

12.2.10 Postservice Appeal

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

12.2.11 Postservice Claim

Any claim related to Services you have already received.

12.2.12 Preservice Appeal

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

12.2.13 Preservice Claim

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

12.2.14 Urgent Preservice Claim

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

12.3 How to File a Claim for Benefits

12.3.1 Urgent Preservice Claims

In order to file an Urgent Preservice Claim, you must provide Select Health 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, Select Health will notify you of the failure and the proper procedures to be followed. Select Health 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 Select Health gives you notice of an incomplete claim, the notice will give you at least 48 hours to provide the requested information. Select Health will then provide a notice of Benefit Determination within 48 hours after receiving the specified information or the end of the period of time given you to provide the information, whichever occurs first. If the Benefit Determination is provided verbally, it will be followed in writing no later than three days after the verbal notice.

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

12.3.2 Other Preservice Claims

The procedure for filing most Preservice Claims (Preauthorization) is set forth in Section 11 - Healthcare Management. If there is any other Benefit that would be subject to a Preservice Claim, you may file a claim for that Benefit by contacting Member Services. Under certain circumstances provided by federal law, if you fail to follow the proper procedures for filing a Preservice Claim, Select Health 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, Select Health may extend this period for up to an additional 15 days if Select Health: 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 Select Health expects to render a decision. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information, and you will be given 60 days from your receipt of the notice to provide the requested information.

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

12.3.3 Postservice Claims

a. In-Network Providers and Facilities. In-Network Providers and Facilities file Postservice Claims with Select Health and Select Health makes payment to the Providers and Facilities.

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

Notice of Adverse Benefit Determinations will be provided in writing within a reasonable period of time, but no later than 30 days after receipt of the claim. However, Select Health may extend this period for up to an additional 15 days if Select Health: 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 Select Health expects to render a decision.

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

12.4 Problem Solving

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

12.5 Formal Appeals

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

12.5.1 General Rules and Procedures

You will have the opportunity to submit written comments, documents, records, and other information relating to your Appeal. Select Health 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 Select Health in connection with the Adverse Benefit Determination, whether or not the advice was relied upon in making the Adverse Benefit Determination.

Before Select Health 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 Select Health in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of a Final Internal Benefit Determination is required to be provided to give you a reasonable opportunity to respond prior to the date.

12.5.2 Form and Timing

All requests for an Appeal of an Adverse Benefit Determination (other than those involving an Urgent Preservice Claim) must be in writing and should include a copy of the Adverse Benefit Determination and any other pertinent information that you want Select Health to review in conjunction with your Appeal. Send all information to the Select Health 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 Select Health Appeals Department at 844-208-9012 by fax at 801-442-0762, or by emailing appeals@imail.org.

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

Appeals that do not comply with the above requirements are not subject to review by Select Health.

12.5.3 Appeals Process

The Appeals process includes both mandatory and voluntary reviews. Select Health agrees that any statute of limitations or other legal defense based on timeliness is suspended during the time that any external Appeal is pending. Your decision whether or not to seek external review will have no effect on your rights to any other Benefits. Select Health will provide you, upon request, sufficient information to enable you to make an informed decision about whether or not to engage in an external review.

After the mandatory review process, you may choose to pursue civil action. Failure to properly pursue the mandatory Appeals process may result in a waiver of the right to challenge the original decision of Select Health.

Preservice Appeals

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.

Postservice Appeals

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 60 days after the receipt of your Appeal.

Voluntary External Review

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, a Rescission of coverage, or any Adverse Benefit Determination relating to a surprise medical bill or surprise air ambulance bill subject to the No Surprises Act. To request an External Review, you must complete the Independent Review Request Form. For a copy of this form, or for other questions, contact the Utah Insurance Commissioner by mail at Suite 4315 S 2700 W Ste 2300 Taylorsville, UT 84129; by phone at 801-957-9280; or electronically at healthappeals@utah.gov. An External Review request must be made within 180 days from the date the Appeals Department notifies you of the Final Internal Adverse Benefit Determination. An authorization to obtain medical records may be required. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. The IRO will provide written notice of its decision within 45 days after receipt of the request. There is no additional cost for requesting an External Review.

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

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, Select Health will coordinate Benefits with the other healthcare coverage according to Utah Administrative Code R590-131 and other applicable laws.

13.1.1 Required Cooperation

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

13.1.2 Direct Payments

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

13.2 Subrogation/Restitution

13.2.1 Payment of Claims When Another Person or Entity is Liable

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

13.2.2 Select Health's Recovery Rights

If Select Health pays benefits under this Plan for an illness or injury and Select Health determines that a Recovery Party is or may be responsible or liable for damages to you or your Dependents, Select Health has the right to recover Benefits paid under this Plan and is subrogated to all and any of your or your Dependent's rights to recover from the Recovery Party and to any money paid in settlement of a claim, but only up to the amount of the Benefits provided by the Plan. Select Health is entitled to reimbursement and/or recovery under this section 13.2 from any judgment, award, and other types of recovery or settlement received by you, your Dependents and/or your or your Dependent's representatives, regardless of whether the recovery is characterized as relating to medical expenses. Select Health is entitled to reimbursement even if you or your covered Dependent is not made whole or fully compensated by the recovery. You and your Dependents are required by this Plan, and agree, to promptly notify Select Health when the terms of this Section 13.2 might apply.

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

13.2.3 Agreement by Members

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

If requested to do so by Select Health, you and your Dependents must execute a written recovery agreement as a condition of payment on claims arising from injuries or illnesses caused by third parties. If your Dependent is so injured or has such an illness, both you and your Dependent are required to execute the written recovery agreement. If the injured or ill person is a minor or legally incompetent, the written recovery agreement must be executed by the person's parent(s), managing conservator and/or guardian. If you or your Dependent has died, your or your Dependent's legal representative must execute the agreement. Any Plan benefits paid must be returned to Select Health immediately in the event that Select Health requests that a written recovery agreement be signed and there is a failure or refusal to execute the recovery agreement. Select Health's rights, however, are not waived if Select Health does not request a written recovery agreement under this section 13.2.

13.2.4 Constructive Trust and First Lien

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

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

13.2.5 Rights to Intervene and Sue

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

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

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

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

13.2.6 Special Subrogation Rules for Utah

Notwithstanding anything else in this Section 13.2 to the contrary, Select Health's rights under this section 13.2, when Select Health is asserting rights against underinsured/uninsured motorist coverage subject to Utah Code Annotated sections 31A-22-305 or 31A-22-305.3 shall be limited to situations in which you or your Dependents have been made whole.

13.3 Excess Payment

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

SECTION 14 - SUBSCRIBER RESPONSIBILITIES

As a condition to receiving Benefits, you are required to do the following:

14.1 Payment

Pay applicable Premiums to Select Health, 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 Select Health when there is a change in your situation that may affect your Eligibility, the Eligibility of your Dependents, or if your contact information changes. If you enrolled through the Marketplace, you may also need to notify the Marketplace.

If your income changes and your coverage is subsidized through the Marketplace (through either a cost-sharing reduction or an Advance Premium Tax Credit) you must notify the Marketplace. The change in income may affect your eligibility for these programs.

14.3 Other Coverage

Notify Select Health 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 Dependents of all Benefit and other Plan changes.

14.6 Compliance

Each party agrees to comply with all applicable laws, rules, and regulations.

SECTION 15 - DEFINITIONS

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

15.1 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.

15.2 Advanced Premium Tax Credit

Tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan through a Marketplace in accordance with the Affordable Care Act.

15.3 Affordable Care Act (ACA)

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

15.4 Allowed Amount

The dollar amount allowed by Select Health for a specific Covered Service.

15.5 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.

15.6 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), 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; or

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

15.7 Autism Spectrum Disorder

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

15.8 Benefit(s)

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

15.9 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.

15.10 Contract

This health insurance contract between you and Select Health that contains the terms and conditions under which Select Health provides insurance coverage to you and your Dependents. The application, Individual Plan Coverage List and Member Payment Summary are part of the contract.

15.11 Contraceptive

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

15.12 Copay (Copayment)

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

15.13 Covered Services

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

15.14 Custodial Care

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

15.15 Deductible(s)

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

15.16 Dental Services

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

15.17 Dependents

Your Eligible dependents as set forth in Section 2 - Eligibility.

15.18 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.

15.19 Effective Date

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

15.20 Eligible, Eligibility

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

15.21 Emergency Condition(s)

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

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

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

c. Serious impairment to bodily functions; or

d. Serious dysfunction of any bodily organ or part.

15.22 Excess Charges

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

15.23 Exclusion(s)

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

15.24 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.

15.25 Facility

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

15.26 Formulary

The Prescription Drugs covered by your Plan.

15.27 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.

15.28 Habilitation Services

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

15.29 Healthcare Management Program

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

15.30 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.

15.31 Hospice Care

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

15.32 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.

15.33 Individual Plan Coverage List

A document that executes the Contract and contains your Benefit selections and Premium rates.

15.34 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.

15.35 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.

15.36 In-Network Benefits

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

15.37 (In-Network) Facility

Facilities under contract with Select Health to accept Allowed Amounts as payment in full for Covered Services and to not collect Excess Charges.

15.38 In-Network Pharmacies

Pharmacies under contract with Select Health to accept Allowed Amounts as payment in full for Covered Services and to not collect Excess Charges.

15.39 In-NetworkProviders

Providers under contract with Select Health to accept Allowed Amounts as payment in full for Covered Services and to not collect Excess Charges.

15.40 Lifetime Maximum

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

15.41 Limitation(s)

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

15.42 Major Diagnostic Tests

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

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

b. Gene-based testing and genetic testing;

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

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

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

15.43 Marketplace

The Health Insurance Marketplace (formerly known as an Exchange) in Utah established under the Affordable Care Act that offers Qualified Health Plans to individuals and employers.

15.44 Medical Director

The Physician(s) designated as such by Select Health.

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

15.46 Member

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

15.47 Member Payment Summary

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

15.48 Mental Health/Chemical Dependency

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

15.49 Minimum Essential Coverage

As defined by the Affordable Care Act.

15.50 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.

15.51 Miscellaneous Medical Supplies (MMS)

Supplies that are disposable or designed for temporary use.

15.52 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.

15.53 Open Enrollment

The period of time each Year during which you are given the opportunity to enroll your Dependents on the Plan or request Plan changes.

15.54 Out-of-Network Facility

Healthcare Facilities that are not under contract with Select Health.

15.55 Out-of-Network Pharmacies

Pharmacies that are not under contract with Select Health.

15.56 Out-of-Network Provider

Providers that are not under contract with Select Health.

15.57 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, Select Health will pay 100 percent of Allowed Amounts during the remainder of the Year once the Out-of-Pocket Maximum is satisfied. Some categories of Benefits may be subject to separate Out-of-Pocket Maximum amounts. Payments you make for Excess Charges, noncovered Services, and certain categories of Services specified in your Member Payment Summary are not applied to the Out-of-Pocket Maximum.

15.58 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.

15.59 Plan

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

15.60 Preauthorization (Preauthorize)

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

15.61 Premium(s)

The amount you periodically pay to Select Health as consideration for providing Benefits under the Plan. The Premium is specified in the Individual Plan Coverage List.

15.62 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.

15.63 Preventive Services

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

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 Select Health.

15.64 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.

15.65 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.

15.66 Provider

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

15.67 Qualified Health Plan (QHP)

A health plan that is recognized and certified by the Marketplace according to standards established by the Affordable Care Act.

15.68 Reformation (Reform)

Select Health's right to change Benefits or Premium.

15.69 Rehabilitation Services

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

15.70 Rescission (Rescind)

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

15.71 Reside/Resident

You are a resident of Utah if you are able to provide satisfactory proof of currently residing in Utah, including without a fixed address. We may request proof of residency. The following are a few of the items accepted as proof of residency:

a. State Tax Returns
b. Driver License
c. Voter Registration
d. Vehicle Registration
e. Utility Bills

An inpatient hospital or similar medical facility-stay alone does not establish residency.

15.72 Residential Treatment Center

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

15.73 Respite Care

Care provided primarily for relief or "rest" from caretaking responsibilities.

15.74 Routine Care

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

15.75 Secondary Care Provider or Specialist (SCP)

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

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

15.76 Service Area

The geographical area in which Select Health arranges for Covered Services for Members from In-Network Providers and Facilities. To determine your Service Area, refer to your Identification Card or the attached copy of your application.

The Select Health Med Service Area is the State of Utah.

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

The Select Health Signature Service Area includes the following counties: Davis, Salt Lake, Utah, and Weber.

15.77 Service(s)

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

15.78 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.

15.79 Special Enrollment

An opportunity to enroll outside of the Annual Open Enrollment period under which all available Plans are open under defined circumstances described in Section 3 -"Enrollment."

15.80 Subscriber

The individual through whom Eligible Dependents may be enrolled with Select Health. Subscribers are also Members.

15.81 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.

15.82 Year

A calendar-year, which beings on January 1 at 12:00 a.m. Mountain Standard Time and ends on December 31, at 11:59 p.m. Mountain Standard Time.

SECTION 16 - OTHER PROGRAMS

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

Protecting Your Privacy

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

We understand the importance and sensitivity of your personal health information, and we have security in place to protect it. Access to your information is limited to those who need it to perform assigned tasks. We restrict access to work areas and use locking filing cabinets and password-protected computer systems. We follow all federal and state laws that govern the use of your health information. We use your health information in written, oral, and electronic formats (and allow others to use it) only as permitted by federal and state laws. These laws give you certain rights regarding your health information.

We participate in organized healthcare arrangements (OHCAs) with other entities including but not limited to, Intermountain Healthcare entities, The Intermountain Life and Health Benefit Plan, and the University of Utah Medical Group (with respect to certain defined pediatric specialty services). These OHCA members share information for treatment, payment and healthcare operations to improve, manage, and coordinate your care.

To learn more about activities and see a current list of all OHCA members, visit **https://selecthealth.org/plans/individual/services/Pages/ohca.aspx**.

YOUR HEALTH INFORMATION RIGHTS

You may:

- Review and get a paper copy of your policy or claims records as allowed by law, usually within 30 days of your request (you can also ask us to provide a copy in electronic form, and we will do that if we can readily produce it).
- Request and be provided a paper copy of our current Notice of Privacy Practices, or receive an electronic copy by email if you have agreed to receive an electronic copy.
- Ask us to contact you at a specific address or phone number if contacting you at your current address or phone number could endanger you.
- Request and receive an accounting, as specified by law, of certain situations when your information was shared without your consent.
- Receive a notice if SelectHealth or one of its Business Associates causes a breach of your unsecured information.
- Report a privacy concern and be assured that we will investigate your concern thoroughly, supporting you appropriately, and not retaliate against you in any way (in fact, SelectHealth will provide you with information on how to report any privacy concerns to the SelectHealth Privacy Coordinator, the Intermountain Corporate Privacy Office, or the Office for Civil Rights, U. S. Department of Health and Human Services).
- Request in writing other restrictions on the use of your health information or amendments to your health information if you think it is wrong, though we may not always be able to grant these requests.

HOW YOUR HEALTH INFORMATION IS USED

Common Uses of Health Information

As we provide health insurance benefits, we will gather some of your health information. The law allows us to use or share this health information for the following purposes.

- To receive payment of health coverage premiums and to determine and fulfill our responsibility to provide you benefits. For example, to make coverage determinations, administer claims, and coordinate benefits with other coverage you may have.
- To improve the overall Intermountain system as well as to help better manage your care. For example, Intermountain has programs in place to manage the treatment of chronic conditions, such as diabetes or asthma, and as part of these programs, we share information with affiliated providers and Intermountain Healthcare to facilitate improved coordination of the care you may receive for these conditions.
- To support healthcare providers in providing treatment.
- To share in limited circumstances health information with your plan sponsor. However, SelectHealth will only do so if the plan sponsor specifically requests health information for the administration of your health plan and agrees in writing not to use your health information for employment-related actions or decisions.
- To identify health-related services that may be beneficial to your health and then contact you about these services.
- To request your support for improving healthcare by contributing to one of Intermountain's charitable foundations. (If you don't want to be contacted for this purpose or other fundraising communications, call Intermountain's Privacy Office at **800 442-4845** to let us know).
- To improve our services to you by allowing companies with whom we contract, called "business associates," to perform certain specialized work for us. The law requires these business associates to protect your health information and obey the same privacy laws that we do.
- To perform a very limited, specific type of healthrelated research, where the researcher keeps any patient-identifiable information safe and confidential. Intermountain reviews every research request to make sure your privacy is appropriately protected before sharing any health information.
- To law enforcement, but only as authorized by law (e.g., to investigate a crime against SelectHealth or any of its members).

Required Uses of Health Information

The law sometimes requires us to share information for specific purposes, including the following:

- To the Department of Health to report communicable diseases, traumatic injuries, or birth defects, or for vital statistics, such as a baby's birth.
- To a funeral director or an organ-donation agency when a patient dies, or to a medical examiner when appropriate to investigate a suspicious death.
- To state authorities to report child or elderly abuse.
- To law enforcement.
- To a correctional institution, if a member is an inmate, to ensure the correctional institution's safety.
- To the Secret Service or NSA to protect, for example, the country or the President.
- To a medical device's manufacturer, as required by the FDA, to monitor the safety of a medical device.
- To court officers, as required by law, in response to a court order or a valid subpoena.
- To governmental authorities to prevent serious threats to the public's health or safety.
- To governmental agencies and other affected parties, to report a breach of health-information privacy.
- To a worker's compensation program if a person is injured at work and claims benefits under that program.

Uses According to Your Requests

Your preferences matter. If you let us know how you want us to disclose your information in the following situation, we will follow your directions. You decide if you want us to share any health or payment information related to your care with your family members or friends. Please let us know what you want us to share. If you can't tell us what health or payment information you want us to share, we may use our professional judgment to decide what to share with your family or friends for them to be able to help you.

Uses with Your Authorization

Any sharing of your health information, other than as explained above, requires your written authorization. For example, we will not use your health information unless you authorize us in writing to:

- share any of your health information with marketing companies.
- sell any of your health information.

You can change your mind at any time about sharing your health information. Simply notify us in writing. Please understand that we may not be able to get back health information that was shared before you changed your mind.

SPECIAL LEGAL PROTECTIONS FOR CERTAIN HEALTH INFORMATION

SelectHealth complies with federal laws that require extra protection for your health information if you receive treatment in an addiction treatment program, or from a psychotherapist who keeps notes on your therapy that are kept outside of your regular medical record.

SelectHealth is prohibited from using or disclosing genetic information for underwriting purposes.

IF YOU STILL HAVE QUESTIONS

Our Privacy Coordinator can help you with any questions you may have about the privacy of your health information. He can also address any privacy concerns you may have about your health information and can help you fill out any forms that are needed to exercise your privacy rights.

This privacy notice became effective on May 26, 2015. We may change this privacy notice at any time, and we may use new ways to protect your health information. We always post our current privacy notice on **selecthealth.org**.

You can request a copy of this notice by visiting our website or calling our Privacy Office at **801-442-7253**.

This notice of privacy practices describes the practices of SelectHealth and of our employees and volunteers. (For more information about the specific privacy practices of Intermountain Healthcare and its employees or volunteers working in its hospitals, clinics, doctors' offices or service departments, please contact them directly by visiting **intermountainhealthcare.org**, or by calling Intermountain's Privacy Office at **800-442-4845**.)

SELECTHEALTH MEMBER RIGHTS AND RESPONSIBILITIES

YOUR RIGHTS

You have the right to:

- Receive information about our services, providers, and members' rights and responsibilities.
- Receive considerate, courteous care and treatment with respect for personal privacy and dignity.
- Receive accurate information regarding your rights and responsibilities and benefits in member materials and through telephone contact.
- Be informed by your provider about your health so you may make thoughtful decisions before you receive treatment.
- Candidly discuss with your healthcare provider appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage. We do not have policies that restrict dialogue between provider and patient, and we do not direct providers to restrict information regarding treatment options.
- Participate with providers in decisions involving your health and the medical care you receive.
- Express concerns about SelectHealth and the care we provide, and receive a response in a reasonable period of time.
- Request a second opinion.
- Refuse recommended medical treatment.
- Select or change your primary care provider.
- Make recommendations regarding our members' rights and responsibilities policy.
- Have reasonable access to appropriate medical services regardless of your race, religion, nationality, disability, sex, or sexual orientation, and 24-hour access to urgent and emergency care.
- Receive care provided by or be referred by your primary care provider.
- Have all medical records and other information kept confidential.
- Have all claims paid accurately and in a timely manner.

YOUR RESPONSIBILITIES

You have the responsibility to:

- Treat all our providers and personnel at SelectHealth courteously.
- Read all plan materials carefully as soon as you enroll and ask questions when necessary.
- Ask questions and make certain you understand the explanation and instructions you are given.
- Understand the benefits of your plan and understand not all recommended medical treatment is eligible for coverage.
- Follow plans and instructions for care that have been agreed upon with the provider.
- Express constructively your opinions, concerns, and complaints to the appropriate people at SelectHealth.
- Follow the policies and procedures of your plan, and when appropriate, seek a referral from your primary care provider to SelectHealth providers or call SelectHealth for assistance.
- Ask questions and understand the consequences of refusing medical treatment.
- Communicate openly with your healthcare provider, develop a patient-provider relationship based on trust and cooperation, and participate in developing mutually agreed-upon treatment goals.
- Read and understand your plan benefits and limitations and call us with any questions.
- Keep scheduled appointments or give adequate notice of cancellation.
- Obtain services consistently according to the policies and procedures of your plan.
- Provide all pertinent information needed by your provider to assess your condition and recommend treatment.
- Use our providers when applicable, carry your ID Card, and pay copay/coinsurance amounts at the time of service.

selecthealth®

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selecthealth.org