2025

Medical Contract

Inventive, LLC, dba In the Ditch Towing Products

Select Health

ID – CONTRACT 01/01/25

GROUP APPLICATION

Product	**Select Health Idaho HDHP**
Employer	**Inventive, LLC, dba In the Ditch Towing Products**
Employer Address	**3190 Industrial Way, Mountain Home, ID 83647**

Affiliated Businesses/Subsidiaries Covered by this Application

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

1. **Monthly Premiums**. On or before the first day of each month, employer shall pay the following Premiums to Select Health:

$492.20	for each single party enrollment
$1033.20	for each employee plus spouse enrollment
$684.40	for each employee plus child enrollment
$969.80	for each employee plus children enrollment
$1525.20	for each family enrollment

2. **Eligibility, Prepayment and Enrollment Criteria**. In order to be Eligible, your employees and their Dependents must meet the criteria for participation and enrollment specified in this Group Application and elsewhere in the Contract. A person may only be considered an employee if the employer withholds and pays to the government Social Security and Medicare taxes and income tax withholding on the employee's wages.

2.1 Your employee must be scheduled to work 30 hours per week to be Eligible for coverage under the Plan, unless the employer is required to offer them coverage under the Affordable Care Act. During the Employer Waiting Period, the employee must work the minimum required hours except for paid time off or time the employee does not work due to health status, a medical condition, the receipt of health care, or disability. Select Health may require documentation to verify the number of hours an employee has worked.

2.2 Portion of Premium employer must contribute:

Applicable contributions and categories as specified by employer.

2.3 Children are eligible to the age of 26 except where the child meets the criteria for disabled children specified in Section 2 – "Eligibility" of the Certificate.

2.4 Retirees are not covered.

2.5 Domestic partners are covered. Refer to the Domestic Partner Optional Benefit in Section 17 – "Optional Benefits" of the Certificate.

2.6 Eligible employees may be granted up to a 90 day leave of absence by employer or up to the time allowed for a qualifying leave under the Family Medical Leave Act. Leave time can only be accrued and used by the employee using the leave time or applicable state law. Leave banks beyond what is required by the FMLA, i.e. where employees share or purchase leave time from other employees, are not allowed.

2.7 The Initial Eligibility Period is 31 days.

2.8 The Employer Waiting Period is 60 days and the Effective Date is the first day of the next calendar month following the Employer Waiting Period. An employee rehired within 90 days of termination can resume benefits first of the month following the date of rehire.

2.9 Leased employees and independent contractors are not Eligible for coverage by Select Health.

2.10 Coverage will terminate on the end of the calendar month in which Subscriber and/or Dependents lose Eligibility. However, when a Dependent child ceases to be a Dependent, coverage will terminate at the end of the month in which Dependent status is lost. When a loss of Eligibility is not reported in a timely fashion as required by the Contract, and federal or state law prevents 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.

3. **Duration of Contract**. This Contract is effective on January 1, 2025 to December 31, 2025, for a term of 12 months.

Product: **Select Health Idaho HDHP**

Acknowledged and agreed:

Employer: Inventive, LLC, dba In the Ditch Towing Products

By: Deborah Hernandez

Printed Name: Deborah Hernandez

Title: HR

Date: 11/19/2024

SelectHealth, Inc.

By: Todd Trettin

Printed Name: Todd Trettin

Title: CFO and President Large Group Commercial Markets

Date: 11/13/2024

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Select Health

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SECTION 1 INTRODUCTION

1.1 Contract

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

1.2 Select Health

Select Health is a MCO licensed by the State of Idaho. We are affiliated with Intermountain Health, but are a separate company. The Contract does not involve Intermountain Health or any other affiliated Intermountain Health companies, or their officers or employees. Such companies are not responsible for our obligations or actions.

1.3 Agency

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

1.4 Administration of Contract

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

1.5 ERISA and Select Health's Authority

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

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

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

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

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

SECTION 2 PREMIUM

2.1 Employer Responsibility

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

2.2 Premium Rates

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

2.3 Grace Period

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

2.4 Refund of Premium

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

SECTION 3 COVERAGE

3.1 Certificate of Coverage

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

3.2 Administrative Processes

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

3.3 No Vested Rights

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

SECTION 4 ELIGIBILITY AND ENROLLMENT

4.1 Eligibility

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

4.2 Changes in Member Information or Eligibility

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

a. Adoption of a child, birth of a child, or gaining legal guardianship of a child;

b. Child loses Dependent status;

c. Death;

d. Divorce;

e. Marriage;

f. Involuntary loss of other coverage;

g. Member called to active military duty;

h. You receive a Qualified Medical Child Support Order (QMCSO);

i. Reduction in employment hours;

j. Subscriber takes, returns from, or does not return from a leave of absence;

k. Termination of employment and

l. Other events as required by state or federal law.

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

4.3 Enrollment

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

4.4 Enrolling a Dependent Because of a Court Order

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

4.5 COBRA Coverage

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

4.5.1 Minimum Extent

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

4.5.2 Documentation

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

4.6 Extended Coverage

Members who become totally disabled during the period of this policy or who are pregnant when coverage is discontinued may be eligible for an extension of their coverage as described in Section 5.2 of the Certificate.

4.7 Right to Decline Enrollment

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

SECTION 5 RESPONSIBILITIES OF THE PARTIES

5.1 Compliance

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

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

5.2 Indemnification

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

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

5.3 Reports

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

5.4 Summary of Benefits and Coverage (SBC)

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

SECTION 6 TERMINATION

6.1 Reasons for Termination

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

6.1.1 Termination by Employer

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

6.1.2 Termination of Employer Group by Select Health

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

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

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

c. No Members live, reside, or work in the Service Area.

d. Your membership in an association, through which the Contract was made available, ceases.

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

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

g. You fail to satisfy our minimum participation requirements, if applicable.

6.2 Rescission

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

6.3 Liability for Services After Termination

We do not cover Services obtained after the date of termination, regardless of when a condition arose and despite care or treatment anticipated or already in progress, except for extended coverage for maternity and disability described in Section 5.2 of the Certificate.

SECTION 7 GENERAL

7.1 Binding Effect

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

7.2 Partial Invalidity

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

7.3 Non-Assignability

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

7.4 Choice of Law

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

7.5 Right to Audit Employer Records

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

7.6 Term

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

7.7 Circumstances Beyond Control

Neither party will be responsible for a delay in performing its obligations under the Contract due to circumstances reasonably beyond its control, such as natural disaster, epidemic, riot, or war. Members will not be discriminated against in obtaining Covered Services from Participating Providers and Facilities in such circumstances.

7.8 Workers' Compensation Insurance

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

7.9 Contract Modification

This Contract may only be modified by an endorsement or amendment, which must be issued and referenced in the Group Application or separately signed by an officer of Select Health. Employer will be responsible to notify Subscribers and/or Members of such changes, and Subscribers are responsible to notify their enrolled Eligible Dependents of such changes.

7.10 No Waiver

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

7.11 Equal Opportunity

The Equal Employment Opportunity Clause, as required by Section 202 of Executive Order 11246 (1965), as amended, as contained in and required by 41 CFR Parts 60 1 through 60 60, and Sections 402/503 and the regulations at 41 CFR Parts 60 250 and 60 741, "Equal Opportunity Clause," is incorporated herein by reference, if applicable.

7.12 Notices

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

a. Any notice we are required to send will be sufficient if mailed to the address we have on record.

b. Any notice we are required to send to a Dependent will be sufficient if given to the Subscriber.

c. Any notice you are required to send to us will be sufficient if mailed to the principal office of Select Health in Murray, Utah.

d. We do not provide COBRA notification services.

7.13 Other Services

In addition to Benefits made available to Members, Select Health may provide to Employer information and tools related to compliance with federal and state standards for health insurance and employee benefits.

SECTION 8 DEFINITIONS

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

8.1 Affordable Care Act (ACA)

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

8.2 Benefit(s)

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

8.3 Certificate of Coverage (Certificate)

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

8.4 COBRA Coverage

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

8.5 Contract

The group health insurance contract, including the Group Application, the Certificate of Coverage and all other documents expressly referred to and incorporated by reference.

8.6 Covered Services

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

8.7 Dependent(s)

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

8.8 Effective Date

The date on which coverage for a Member begins.

8.9 Eligible, Eligibility

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

8.10 Employer Waiting Period

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

8.11 Employer Plan

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

8.12 ERISA

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

8.13 Exclusion(s)

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

8.14 Facility

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

8.15 Group Application

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

8.16 Grace Period

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

8.17 Limitation(s)

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

8.18 Member

A Subscriber and any Dependent(s), when properly enrolled in the Plan and accepted by us.

8.19 Member Payment Summary

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

8.20 Optional Benefit

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

8.21 Plan

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

8.22 Plan Sponsor

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

8.23 Premium(s)

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

8.24 Provider

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

8.25 Qualified Medical Child Support Order

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

8.26 Rescission

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

8.27 Service Area

As defined in the Certificate(s) of Coverage.

8.28 Service(s)

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

8.29 Subscriber

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

Select Health

SELECTHEALTH NETWORK / HSA QUALIFIED

	MEMBER PAYMENT SUMMARY	
	IN-NETWORK When using In-Network Providers, you are responsible to pay the amounts in this column.	**OUT-OF-NETWORK** When using Out-of-Network Providers, you are responsible to pay the amounts in this column.
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5,6]	**IN-NETWORK**	**OUT-OF-NETWORK**
Self Only Coverage, 1 person enrolled - per calendar Year		
Deductible	$3,500	$5,500
Out-of-Pocket Maximum	$3,500	$6,500
Family Coverage, 2 or more enrolled - per calendar Year		
Deductible - per person/family	$3500/$7000	$5500/$11000
Out-of-Pocket Maximum - per person/family	$3500/$7000	$6500/$13000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)		
INPATIENT SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Medical, Surgical and Hospice[4]	Covered 100% after Deductible	40% after Deductible
Skilled Nursing Facility[4] - Up to 60 days per calendar Year	Covered 100% after Deductible	40% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	Covered 100% after Deductible	40% after Deductible
Up to 40 days per calendar Year for all therapy types combined		
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	Covered 100% after Deductible	40% after Deductible
PROFESSIONAL SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP)[1]	Covered 100% after Deductible	40% after Deductible
Primary Care Provider (PCP) Virtual Visits[1]	Covered 100% after Deductible	40% after Deductible
Specialist/Secondary Care Provider (SCP)[1]	Covered 100% after Deductible	40% after Deductible
Allergy Tests	See Office Visits Above	50% after Deductible
Allergy Treatment and Serum	Covered 100% after Deductible	50% after Deductible
Major Surgery	Covered 100% after Deductible	40% after Deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	Covered 100% after Deductible	40% after Deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Provider (PCP)[1]	Covered 100%	50% after Deductible
Specialist/Secondary Care Provider (SCP)[1]	Covered 100%	50% after Deductible
Adult and Pediatric Immunizations	Covered 100%	50% after Deductible
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	50% after Deductible
Diagnostic Tests: Minor	Covered 100%	50% after Deductible
Other Preventive Services	Covered 100%	50% after Deductible
VISION SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Preventive Eye Exams	Covered 100%	50% after Deductible
All Other Eye Exams	Covered 100% after Deductible	40% after Deductible
OUTPATIENT SERVICES[4]	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Facility and Ambulatory Surgical	Covered 100% after Deductible	40% after Deductible
Ambulance (Air or Ground) - *Emergencies Only*	Covered 100% after Deductible	See In-Network Benefit
Emergency Room	Covered 100% after Deductible	See In-Network Benefit
Urgent Care Facilities	Covered 100% after Deductible	40% after Deductible
Intermountain Connect Care®	Covered 100% after Deductible	See Professional, Inpatient, Outpatient, or Miscellaneous Services
Radiation	Covered 100% after Deductible	40% after Deductible
Dialysis	Covered 100% after Deductible	40% after Deductible
Diagnostic Tests: Minor[2]	Covered 100% after Deductible	40% after Deductible
Diagnostic Tests: Major[2]	Covered 100% after Deductible	40% after Deductible
Home Health, Hospice, Outpatient Private Nurse	Covered 100% after Deductible	40% after Deductible
Outpatient Cardiac Rehab	Covered 100% after Deductible	40% after Deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	Covered 100% after Deductible	40% after Deductible

See other side for additional benefits

Select Health

SELECTHEALTH NETWORK / HSA QUALIFIED

	MEMBER PAYMENT SUMMARY	
	IN-NETWORK	**OUT-OF-NETWORK**
MISCELLANEOUS SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Durable Medical Equipment (DME)[4]	Covered 100% after Deductible	40% after Deductible
Miscellaneous Medical Supplies (MMS)[3]	Covered 100% after Deductible	40% after Deductible
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Maternity[4]	See Professional, Inpatient or Outpatient	40% after Deductible
Cochlear Implants, Hearing Aids, or Auditory Osseointegrated Devices[2,4] *One device every 36 months per ear. Up to 45 language/speech therapy visits during the 12 months after the delivery of the covered device.*	See Professional, Inpatient or Outpatient	50% after Deductible
Infertility - *Select Services*	Covered 100% after Deductible	50% after Deductible
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient	50% after Deductible
OPTIONAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Mental Health and Substance Use Disorder[4] *(combined benefits)*		
Office Visits	Covered 100% after Deductible	40% after Deductible
Virtual Visits	Covered 100% after Deductible	40% after Deductible
Inpatient	Covered 100% after Deductible	40% after Deductible
Outpatient	Covered 100% after Deductible	40% after Deductible
Residential Treatment[2]	Covered 100% after Deductible	40% after Deductible
Chiropractic *(up to 20 visits per calendar Year)*	Covered 100% after Deductible	40% after Deductible
Healthcare Provider Administered Injectable or Infusible Drugs[4]	Covered 100% after Deductible	40% after Deductible
Bariatric Surgery *(Up to one surgery/lifetime)*[4]	See Professional, Inpatient or Outpatient	40% after Deductible
PRESCRIPTION DRUGS		
Prescription Drug List (formulary)	RxSelect®	
Prescription Drugs-*Up to 30 Day Supply of Covered Medications*[4]		
Tier 1	Covered 100% after In-Network Deductible	
Tier 2	Covered 100% after In-Network Deductible	
Tier 3	Covered 100% after In-Network Deductible	
Tier 4	Covered 100% after In-Network Deductible	
Maintenance Drugs-*90 Day Supply (Mail-Order, Retail90®)-selected drugs*[4]		
Tier 1	Covered 100% after In-Network Deductible	
Tier 2	Covered 100% after In-Network Deductible	
Tier 3	Covered 100% after In-Network Deductible	
Deductible Waiver	Certain prescription drugs are not subject to the Deductible	
Generic Substitution Required	Generic required or must pay Copay plus cost difference between name brand and generic	

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

2 Refer to your Certificate of Coverage for more information.

3 Frequency and/or quantity limitations apply to some Preventive care and MMS Services.

4 Preauthorization is required for certain Services. Benefits may be reduced or denied if you do not preauthorize certain Services with Out-of-Network Providers. Please refer to Section 11--" Healthcare Management", in your Certificate of Coverage, for details.

5 All Deductible/Copay/Coinsurance amounts are based on the Allowed Amount and not on billed charges. Out-of-Network Providers or Facilities may not accept the Allowed Amount for Covered Services. When this occurs, you may be responsible for Excess Charges.

6 Certain Services as noted on this document and in your Certificate of Coverage are not subject to the Deductible.

All Covered Services obtained outside the United States, except for routine, Urgent, or Emergency conditions require preauthorization.

To contact Member Services, call 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., Saturdays, from 9:00 a.m. to 2:00 p.m. TTY users should call 711.

Benefits are administered and underwritten by SelectHealth, Inc.℠ (domiciled in Utah).

Select Health

SELECTHEALTH NETWORK / HSA QUALIFIED

	MEMBER PAYMENT SUMMARY	
	IN-NETWORK When using In-Network Providers, you are responsible to pay the amounts in this column.	**OUT-OF-NETWORK** When using Out-of-Network Providers, you are responsible to pay the amounts in this column.
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5,6]	**IN-NETWORK**	**OUT-OF-NETWORK**
Self Only Coverage, 1 person enrolled - per calendar Year		
Deductible	$3,500	$5,500
Out-of-Pocket Maximum	$3,500	$6,500
Family Coverage, 2 or more enrolled - per calendar Year		
Deductible - per person/family	$3500/$7000	$5500/$11000
Out-of-Pocket Maximum - per person/family	$3500/$7000	$6500/$13000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)		
INPATIENT SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Medical, Surgical and Hospice[4]	Covered 100% after Deductible	40% after Deductible
Skilled Nursing Facility[4] - Up to 60 days per calendar Year	Covered 100% after Deductible	40% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	Covered 100% after Deductible	40% after Deductible
Up to 40 days per calendar Year for all therapy types combined		
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	Covered 100% after Deductible	40% after Deductible
PROFESSIONAL SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP)[1]	Covered 100% after Deductible	40% after Deductible
Primary Care Provider (PCP) Virtual Visits[1]	Covered 100% after Deductible	40% after Deductible
Specialist/Secondary Care Provider (SCP)[1]	Covered 100% after Deductible	40% after Deductible
Allergy Tests	See Office Visits Above	50% after Deductible
Allergy Treatment and Serum	Covered 100% after Deductible	50% after Deductible
Major Surgery	Covered 100% after Deductible	40% after Deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	Covered 100% after Deductible	40% after Deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Provider (PCP)[1]	Covered 100%	50% after Deductible
Specialist/Secondary Care Provider (SCP)[1]	Covered 100%	50% after Deductible
Adult and Pediatric Immunizations	Covered 100%	50% after Deductible
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	50% after Deductible
Diagnostic Tests: Minor	Covered 100%	50% after Deductible
Other Preventive Services	Covered 100%	50% after Deductible
VISION SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Preventive Eye Exams	Covered 100%	50% after Deductible
All Other Eye Exams	Covered 100% after Deductible	40% after Deductible
OUTPATIENT SERVICES[4]	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Facility and Ambulatory Surgical	Covered 100% after Deductible	40% after Deductible
Ambulance (Air or Ground) - *Emergencies Only*	Covered 100% after Deductible	See In-Network Benefit
Emergency Room	Covered 100% after Deductible	See In-Network Benefit
Urgent Care Facilities	Covered 100% after Deductible	40% after Deductible
Intermountain Connect Care®	Covered 100% after Deductible	See Professional, Inpatient, Outpatient, or Miscellaneous Services
Radiation	Covered 100% after Deductible	40% after Deductible
Dialysis	Covered 100% after Deductible	40% after Deductible
Diagnostic Tests: Minor[2]	Covered 100% after Deductible	40% after Deductible
Diagnostic Tests: Major[2]	Covered 100% after Deductible	40% after Deductible
Home Health, Hospice, Outpatient Private Nurse	Covered 100% after Deductible	40% after Deductible
Outpatient Cardiac Rehab	Covered 100% after Deductible	40% after Deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	Covered 100% after Deductible	40% after Deductible

See other side for additional benefits

Select Health

SELECTHEALTH NETWORK / HSA QUALIFIED

	MEMBER PAYMENT SUMMARY	
	IN-NETWORK	**OUT-OF-NETWORK**
MISCELLANEOUS SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Durable Medical Equipment (DME)[4]	Covered 100% after Deductible	40% after Deductible
Miscellaneous Medical Supplies (MMS)[3]	Covered 100% after Deductible	40% after Deductible
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Maternity[4]	See Professional, Inpatient or Outpatient	40% after Deductible
Cochlear Implants, Hearing Aids, or Auditory Osseointegrated Devices[2,4] *One device every 36 months per ear. Up to 45 language/speech therapy visits during the 12 months after the delivery of the covered device.*	See Professional, Inpatient or Outpatient	50% after Deductible
Infertility - *Select Services*	Covered 100% after Deductible	50% after Deductible
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient	50% after Deductible
OPTIONAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Mental Health and Substance Use Disorder[4] *(combined benefits)*		
Office Visits	Covered 100% after Deductible	40% after Deductible
Virtual Visits	Covered 100% after Deductible	40% after Deductible
Inpatient	Covered 100% after Deductible	40% after Deductible
Outpatient	Covered 100% after Deductible	40% after Deductible
Residential Treatment[2]	Covered 100% after Deductible	40% after Deductible
Chiropractic *(up to 20 visits per calendar Year)*	Covered 100% after Deductible	40% after Deductible
Healthcare Provider Administered Injectable or Infusible Drugs[4]	Covered 100% after Deductible	40% after Deductible
Bariatric Surgery *(Up to one surgery/lifetime)*[4]	See Professional, Inpatient or Outpatient	40% after Deductible
PRESCRIPTION DRUGS		
Prescription Drug List (formulary)	RxSelect®	
Prescription Drugs-*Up to 30 Day Supply of Covered Medications*[4]		
Tier 1	Covered 100% after In-Network Deductible	
Tier 2	Covered 100% after In-Network Deductible	
Tier 3	Covered 100% after In-Network Deductible	
Tier 4	Covered 100% after In-Network Deductible	
Maintenance Drugs-*90 Day Supply (Mail-Order, Retail90®)-selected drugs*[4]		
Tier 1	Covered 100% after In-Network Deductible	
Tier 2	Covered 100% after In-Network Deductible	
Tier 3	Covered 100% after In-Network Deductible	
Deductible Waiver	Certain prescription drugs are not subject to the Deductible	
Generic Substitution Required	Generic required or must pay Copay plus cost difference between name brand and generic	

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

2 Refer to your Certificate of Coverage for more information.

3 Frequency and/or quantity limitations apply to some Preventive care and MMS Services.

4 Preauthorization is required for certain Services. Benefits may be reduced or denied if you do not preauthorize certain Services with Out-of-Network Providers. Please refer to Section 11--" Healthcare Management", in your Certificate of Coverage, for details.

5 All Deductible/Copay/Coinsurance amounts are based on the Allowed Amount and not on billed charges. Out-of-Network Providers or Facilities may not accept the Allowed Amount for Covered Services. When this occurs, you may be responsible for Excess Charges.

6 Certain Services as noted on this document and in your Certificate of Coverage are not subject to the Deductible.

All Covered Services obtained outside the United States, except for routine, Urgent, or Emergency conditions require preauthorization.

To contact Member Services, call 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., Saturdays, from 9:00 a.m. to 2:00 p.m. TTY users should call 711.

Benefits are administered and underwritten by SelectHealth, Inc.℠ (domiciled in Utah).

medical

certificate of coverage

Select Health

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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

SECTION 1 INTRODUCTION

1.1 This Certificate

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

1.2 Select Health

SelectHealth, Inc. ("Select Health" or "we" or "us") is a managed care organization licensed by the State of Idaho. 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 this Certificate. The Plan is intended to meet basic healthcare needs, but not necessarily to satisfy every healthcare need or every desire Members may have for Services.

1.4 Your Agreement

As a condition to enrollment and to receiving Benefits from 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 in which you are enrolled and to all of the other terms and conditions of this Certificate and the Contract.

1.5 No Vested Rights

You are only entitled to receive Benefits while the Contract is in effect and you, and your Dependent(s). if applicable, are properly enrolled and recognized by 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 this Certificate, all Benefits end when the Contract ends. You are not liable, assessable, or in any way subject to payment for the debts, liabilities, insolvency, impairment or any other financial obligations of Select Health.

1.6 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 this Certificate or the Contract. See Section 5.2 of this Certificate for explanation of extended coverages available for maternity and disability.

1.7 Non-Assignment

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

1.8 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 Dependent(s) 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.

1.9 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 or refuse to enroll any Member because of the health status or the healthcare needs of the Member or because he or she exercised any right under the Select Health complaint resolution system.

1.10 Questions

If you have questions about your Benefits, call Member Services at 800-538-5038, or visit selecthealth.org. Member Services can also provide you with a provider directory and information about 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.

1.11 Disclaimer

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 to 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

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

2.2 Subscriber Eligibility

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

2.3 Dependent Eligibility

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

2.3.1 Spouse

Your lawful spouse.

2.3.2 Children

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

2.3.3 Disabled Children

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

a. Are medically certified as disabled;

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

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

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

2.4 Court-Ordered Dependent Coverage

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

2.4.1 Qualified Medical Child Support Order (QMCSO)

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

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

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

c. The period to which the order applies.

2.4.2 National Medical Support Notice (NMSN)

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

2.4.3 Eligibility and Enrollment

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

2.4.4 Duration of Coverage

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

SECTION 3 ENROLLMENT

3.1 General

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

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

a. All enrollment information is provided to Select Health; and

b. The Premium has been paid to Select Health by your employer.

3.2 Enrollment Process

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

3.3 Effective Date of Coverage

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

3.3.1 Annual Open Enrollment

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

3.3.2 Newly Eligible Employees

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

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

3.3.3 Court or Administrative Order

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

a. The start date indicated in the order;

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

c. The date Select Health receives the order.

3.3.4 Hospitalization of Newly Eligible Person

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

3.4 Special Enrollment Rights

Select Health provides Special Enrollment Rights in the following circumstances:

3.4.1 Loss of Other Coverage

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

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

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

c. You and/or your Dependent(s) who lost the other coverage must enroll in the Plan within 60 days after the date the other coverage is lost.

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

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

3.4.2 New Dependent(s)

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

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

a. As of the date of marriage;

b. As of the date of birth;

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

d. As of the later of:

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

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

3.4.3 Loss of Medicaid or CHIP Coverage

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

3.4.4 As Required by State or Federal Law

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

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

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

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

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

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

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

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

3.6 Leave of Absence

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

3.7 Family Medical Leave Act

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

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

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

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

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

SECTION 4 TERMINATION

4.1 Group Termination

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

4.1.1 Termination by Employer

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

4.1.2 Termination of Employer Group by Select Health

Select Health may terminate the Contract for any of the following reasons:

a. Nonpayment of applicable Premiums by your employer;

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

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

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

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

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

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

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

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

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

ii. Impair the ability of Select Health to meet its contractual obligations.

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

4.1.3 Notice of Termination

In the event of a termination of this Contract for any reason, Select Health will give notice of the termination to all Subscribers and Members. Notice to a Subscriber will be deemed sufficient notice to his or her enrolled Eligible Dependents.

4.2 Individual Termination

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

4.2.1 Termination Date

If you and/or your enrolled Dependent(s) lose Eligibility, then coverage will terminate either on the date Eligibility is lost or the end of the month in which Eligibility is lost, as specified in the Group Application. However, when a Dependent child ceases to be a Dependent, coverage will terminate at the end of the year in which Dependent status is lost. When a loss of Eligibility is not reported in a timely fashion as required by the Contract, and federal or state law prevents 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.

4.2.2 Fraud or Misrepresentation

a. Made During Enrollment.

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

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

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

a. 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.

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

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.

4.2.3 Leaving the Service Area

Coverage for you and/or your Dependent(s) terminates if you no longer live, work or reside in the Service Area except when allowed by Select Health policy.

4.2.4 Annual Open Enrollment

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

4.2.5 Nonpayment of Premium or Premium Contributions

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

4.2.6 Court or Administrative Order

In cases of court or administrative orders that grant a divorce or annul/declare void a marriage, subject to 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.

4.3 Member Receiving Treatment at Termination

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

4.4 Reinstatement

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

SECTION 5 COBRA COVERAGE

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

5.1 COBRA Coverage

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

5.1.1 Employer's Obligation

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

a. Notify persons entitled to COBRA Coverage;

b. Notify Select Health of such individuals; and

c. Collect and submit to Select Health all applicable Premiums.

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

5.1.2 Minimum Extent

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

5.2 Extended Coverage for Maternity and Disability

5.2.1 Pregnancy

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

5.2.2 Disability

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

SECTION 6 PROVIDERS/NETWORKS

6.1 Providers and Facilities

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.

If you need access to primary care, specialty care, Mental Health/Substance Use Disorder (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.

6.1.1 In-Network Providers and Facilities

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

6.1.2 Out-of-Network Providers and Facilities

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

6.1.3 Other Networks

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

a. Select Health Med in Utah and Nevada;

b. Select Health in Idaho; and

c. Other networks as listed on selecthealth.org.

Contact Member Services for additional information.

6.2 Providers and Facilities not Agents/Employees of Select Health

Providers contract independently with Select Health or an affiliated network 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 and its affiliated network(s) make a reasonable effort to credential In-Network Providers and Facilities, but do not guarantee the quality of Services rendered by Providers and Facilities or the outcomes of medical care or health-related Services. Providers and Facilities, not 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.

6.3 Payments to Members

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

6.4 Provider/Patient Relationship

Providers and Facilities are responsible for establishing and maintaining appropriate Provider/patient relationships with you, and 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.

6.5 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 participating with Select Health.

If you or your Dependent is under the care of a Provider or Facility when affiliation ceases, 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:

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

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

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;

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

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, must remain in the Service Area, and agree to all of the following:

a. Accept the Allowed Amount as payment in full;

b. Follow the Healthcare Management policies and procedures of Select Health;

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

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

SECTION 7 ABOUT YOUR BENEFITS

7.1 General

You and your Dependents are entitled to receive Benefits while you are enrolled with 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, Limitations on the use of Out-of-Network Providers and Facilities, and expenses that do not count against the 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 Dependent(s) 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 of under the Plan will be immediately terminated for you and/or your Dependents.

7.4 Medical Necessity

To qualify for Benefits, Covered Services must be Medically Necessary. Medical Necessity is determined by the Medical Director of Select Health 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 Benefit Changes

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

7.6 Calendar-Year or Plan-Year Basis

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

7.7 Lifetime Maximums

Your Member Payment Summary will specify any applicable Lifetime Maximums.

7.8 Two Benefit Levels

7.8.1 In-Network Benefits

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

7.8.2 Out-of-Network Benefits

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

7.9 Emergency Conditions

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

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

If you or your Dependent is hospitalized for an emergency:

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

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

7.10 Urgent Conditions

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

7.11 Out-of-Area Benefits and Services

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

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

7.12 Third Party Payments

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.

d. Your family and friends.

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

   i. Provides assistance based on your financial need;

   ii. Is not a healthcare provider; and

   iii. Is not financially interested.

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

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

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

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

7.13 Deductible Waiver

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

a. Retinopathy screening for diabetes;

b. Hemoglobin A1c testing for diabetes;

c. Peak flow meter for asthma;

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

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

SECTION 8 COVERED SERVICES

You and your Dependents are entitled to receive Benefits for Covered Services while you are enrolled with 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.

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 Certificate, you can find further information about your Benefits by doing any of the following:

a. Log in to your Member 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 Educational Training

Only for diabetes, asthma, or chronic kidney disease.

8.1.2 Emergency Room (ER)

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

8.1.3 Inpatient Hospital

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

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

c. Intensive care unit.

d. Preadmission testing.

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

f. Maternity/obstetrical Services.

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

8.1.4 Nutritional Therapy

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

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

8.1.5 Outpatient Facility and Ambulatory Surgical Facility

Outpatient surgical and medical Services.

8.1.6 Skilled Nursing Facility

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

8.1.7 Urgent Care Facility

8.2 Provider Services

8.2.1 Autism Spectrum Disorder

Services for autism spectrum disorder are covered, including those rendered by a provider who possesses Board Certified Behavior Analyst certification (even if that provider does not possess a state license).

8.2.2 After-Hours Visits

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

8.2.3 Anesthesia

Only:

a. General anesthesia, deep anesthesia, and Monitored Anesthesia Care (MAC) 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); and

b. Dental anesthesia according to Select Health policy.

8.2.4 Dental Services

Only in three limited circumstances:

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

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

   i. Maxillary and/or mandibular procedures;

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

   iii. Orthognathic Services; and

   iv. Services for Congenital Oligodontia /Anodontia.

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

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

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

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

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

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

8.2.5 Dietary Products

Only in the following limited circumstances:

a. For hereditary metabolic disorders when:

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

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

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

b. Certain enteral formulas according to Select Health policy.

8.2.6 Genetic Counseling

8.2.7 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.

8.2.8 Home Visits

8.2.9 Infertility

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

8.2.10 Major Surgery

8.2.11 Mammography Services

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

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

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

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

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

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

8.2.12 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 Program criteria and in a manner determined in consultation with you and the attending Physician, for:

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

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

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

Prophylactic mastectomies are covered in limited circumstances in accordance with 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.

8.2.13 Maternity Services

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

8.2.14 Medical/Surgical

In an inpatient, outpatient, or Ambulatory Surgical Facility.

8.2.15 Preventive Services

8.2.16 Office Visits

For consultation, diagnosis, and treatment.

8.2.17 Sleep Studies

8.2.18 Sterilization Procedures

8.3 Miscellaneous Services

8.3.1 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.

8.3.2 Approved Clinical Trials

Services for an Approved Clinical Trial, including routine Services in connection with an Approved Clinical Trial, but only to the extent required by federal or state law and only when the Member is:

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

b. The trial is in relation to the prevention, detection, or treatment of a disease or condition; and

c. Either:

   i. The referring health care 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.

8.3.3 Chemotherapy, Radiation Therapy, and Dialysis

8.3.4 Bariatric Surgery

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

8.3.5 Chiropractic Benefits

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

a. Chiropractic appliances;

b. Services for treatment of non-neuromusculoskeletal disorders;

c. Professional radiology services (reading of an X-ray); and

d. Services for children ages eight and under.

8.3.6 Durable Medical Equipment (DME)

Only:

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

   i. Prescribed by a Provider;

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

   iii. Required for Activities of Daily Living;

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

   v. Not attached to a home or vehicle.

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

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

Certain DME items can only be rented. Others may be subject to a rental period prior to purchasing. 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

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

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 may be covered. Call Member Services to obtain information on participating drug vendors.

8.3.11 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.

8.3.12 Organ Transplants

Only the following:

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

8.3.13 Orthotics and Other Corrective Appliances for the Foot

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

8.3.14 Osteoporosis Screening

Only central bone density testing (DEXA scan).

8.3.15 Private Duty Nursing

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

8.3.16 Rehabilitation Therapy

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

8.3.17 TeleHealth

Services are covered in accordance with Select Health's medical policy. Interprofessional assessment or consultation between Providers as part of your treatment are payable under your office visit Benefit.

8.3.18 Temporomandibular Joint (TMJ)

8.3.19 Vein Procedures

Only when performed at an accredited vein clinic or facility.

8.3.20 Vision Aids

Only:

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

b. Monofocal intraocular lenses after cataract surgery.

8.4 Prescription Drug Services

Refer to Section 9 Prescription Drug Benefits for details.

SECTION 9 PRESCRIPTION DRUG BENEFITS

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

9.1 Prescription Drug Benefit Resources

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

a. Log in to your Member 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 Idaho and 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 tiered Benefit allows you to choose the drugs that best meet your medical needs while encouraging you and your Provider to discuss treatment options and choose lower-tier drugs as therapeutically appropriate.

Drugs on each tier are selected by an expert panel of Physicians and pharmacists and may change periodically. To determine which tier a drug is assigned to, call Member Services or log in to your Member 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 that have been defined based upon FDA guidance or evidence-based literature. The most current information can be found by logging in to your Member 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 and 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 drug. This Benefit is available for maintenance drugs if you:

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

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

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

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

9.7 Preauthorization of Prescription Drugs

There are certain drugs that require Preauthorization by your Provider to be covered by 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 (COB)

If you have other health insurance that is your primary coverage, claims must be submitted first to your primary insurance carrier before being submitted to 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 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's, you may be permitted to retain your coverage if you comply with specified conditions.

9.12 Pharmacy Injectable Drugs and Specialty Medications

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 PDL. Drugs not included on the Formulary 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 this Certificate 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 or Section 18 Optional Benefits, the following Limitations and Exclusions apply.

10.1 Abortions/Termination of Pregnancy

Elective abortions are not covered except when medically necessary to save the life of the mother or when otherwise noted in an endorsement.

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, finance charges, late fees, shipping and handling, missed appointments, and other administrative charges are not covered.

10.4 Allergy Tests/Treatments

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

ix. Subcutaneous Provocative Food and Chemical Test; and

x. Sublingual Provocative Food and Chemical Test.

b. The following allergy treatments are not covered:

i. Allergoids;

ii. Autogenous urine immunization;

iii. LEAP therapy;

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

v. Neutralization therapy;

vi. Photo-inactivated extracts; and

vii. Polymerized extracts.

10.5 Automobile and Other Available Insurance

The following are not covered:

a. Services that are covered by automobile insurance (refer to Section 13 – Other Provisions Affecting Your Benefits for more on Coordination of Benefits). In the event of a claim, you should provide a copy of the Personal Injury Protection (PIP) documentation from the automobile insurance carrier.

b. Services that are covered by Workers' Compensation insurance.

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

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

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

10.8 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 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 (COB) 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.

10.10 Cochlear Implants, Hearing Aids, and Osseointegrated Auditory Devices

Services for cochlear implants, hearing aids, and osseointegrated auditory (bone conduction) devices are not covered, except:

a. When a Dependent child has a congenital anomaly or acquired hearing loss and may develop cognitive or speech development deficits without intervention; and
b. Cochlear implants and osseointegrated auditory devices for adult Members in accordance with Select Health medical policy. All other hearing aids are not covered for adult Members.

10.11 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.

10.12 Custodial Care

Custodial Care is not covered.

10.13 Debarred Providers

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

10.14 Dry Needling

Dry needling procedures are not covered.

10.15 Exercise Equipment or Fitness Training

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

10.16 Experimental and/or Investigational Services

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

10.17 Eye Surgery, Refractive

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

10.18 Food Supplements

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

10.19 Home Health Aides

Services provided by a home health aide are not covered.

10.20 Immunizations

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

10.21 Mental Health

Inpatient and outpatient mental health and substance use disorder Services are not covered. This Exclusion does not apply if your Member Payment Summary indicates that your Plan includes the Mental Health/Substance Use Disorder Optional Benefit.

10.22 Non-Covered Service in Conjunction with a Covered Service

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

10.23 Pain Management Services

The following Services are not covered:

a. Prolotherapy;

b. Radiofrequency ablation of dorsal root ganglion; and

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

10.24 Prescription Drugs/Injectable Drugs and Specialty Medications

The following are not covered:

a. Appetite suppressants and weight loss drugs;

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

c. 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 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. Infertility drugs;

l. Medical foods;

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

   i. Food and Drug Administration (FDA) approval;

   ii. The drug has no active ingredient and/or clinically relevant studies as determined by the 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. Drugs used for infertility purposes;

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

p. Non-Sedating Antihistamines;

q. Over-the-counter (OTC) drugs, except 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 Dependents have obtained a prescription for the OTC drug from a licensed Provider and filled the prescription at an In-Network Pharmacy;

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

s. Prescription Drugs used for cosmetic purposes;

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

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

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

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

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

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

10.25 Reconstructive, Corrective, and Cosmetic Services

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

   i. To improve form or appearance;

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

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

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

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

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

   i. Treatment for venous telangiectasias (spider veins).

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

10.26 Related Provider Services

Services provided to, ordered, and/or directed for you or your Dependent by a Provider who ordinarily resides in the same household are not covered.

10.27 Respite Care

Respite Care is not covered.

10.28 Robot-Assisted Surgery

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

10.29 Sexual Dysfunction

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

10.30 Specialty Services

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

10.31 Specific Services

The following Services are not covered:

a. Anodyne infrared device for any indication;

b. Auditory brain implantation;

c. Automated home blood pressure monitoring equipment;

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

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

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

g. Computer-assisted navigation for orthopedic procedures;

h. Extracorporeal shock wave therapy for musculoskeletal indications;

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

j. Freestanding/home cervical traction;

k. Infrared light coagulation for the treatment of hemorrhoids;

l. Interferential/neuromuscular stimulators;

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

n. Magnetic Source Imaging (MSI);

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

p. Mole mapping;

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

r. Nucleoplasty or other forms of percutaneous disc decompression;

s. Oncofertility;

t. Pediatric/infant scales;

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

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

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

x. Prolotherapy;

y. Radiofrequency ablation for lateral epicondylitis;

z. Radiofrequency ablation of the dorsal root ganglion;

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

bb. Whole body scanning:

10.32 Travel-related Expenses

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

10.33 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.

10.34 Wilderness Therapy

Wilderness Therapy is not covered.

SECTION 11 HEALTHCARE MANAGEMENT

SelectHealth works to manage costs while protecting the quality of care. The Healthcare Management Program reviews three aspects of medical care: appropriateness of the care setting, Medical Necessity, and appropriateness of Hospital lengths of stay. You benefit from this process because it reduces unnecessary medical expenses, enabling 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 (e.g. your Benefits are exhausted; you are not enrolled at the time the covered service is provided). Your Benefits for the Preauthorized Services are subject to the Eligibility requirements, Limitations, Exclusions and all other provisions of the Plan. Preauthorization is not required for emergency Services (see Section 7.9, Emergency Conditions). 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 including all transplants;

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 a Routine, Urgent Condition or Emergency Condition;

e. Bariatric Surgery

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

g. Certain arthroscopic procedures;

h. Certain genetic testing;

i. Certain Home Healthcare;

j. Certain medical oncology drugs;

k. Certain radiation therapies;

l. Certain sleep studies;

m. Certain ultrasounds;

n. Certain vein procedures;

o. Cochlear implants, hearing aids, and osseointegrated auditory devices;

p. Continuous glucose monitors;

q. Dental anesthesia;

r. Hospice Care, and Private Duty Nursing;

s. Hysterectomy;

t. Insulin pumps;

u. Joint replacement;

v. Organ transplants;

w. Outpatient Rehabilitative and Habilitative Services after 20 visits per therapy type per Year;

x. Pain management/pain clinic Services;

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

z. The following Durable Medical Equipment:

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

   ii. Prosthetics (except eye prosthetics);

   iii. Negative pressure wound therapy devices;

iv. Motorized or customized wheelchairs; and

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

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

bb. Tonsillectomy;

In addition to these Services, In-Network Providers must Preauthorize other Services as specified in 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 you use an Out-of-Network Provider and are therefore responsible to Preauthorize, Benefits may be reduced or denied. If reduced, the Allowed Amount will be cut by 50 percent and Benefits will apply to what remains according to regular Plan guidelines. You will be responsible for the 50 percent penalty, your Copay, Coinsurance, and Deductible, and you may be responsible for any amount that exceeds the Allowed Amount.

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

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

11.2 Case Management

If you have certain serious or chronic conditions (such as spinal cord injuries, diabetes, asthma, or premature births), 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 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 Certificate. Coverage decisions are subject to all terms and conditions of the applicable Plan, including specific Exclusions and Limitations. Because medical policies are based on constantly changing science, they are periodically reviewed and updated by Select Health. For questions about Select Health's medical policies, 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

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

12.2.2 Appeal(s)

Review by 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 and Grievances 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 or your employer 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.

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 Member 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 and Grievances Department. As the delegated claims review fiduciary under your Employer's Plan, 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 us in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of a Final Internal Benefit Determination is required to be provided to give you a reasonable opportunity to respond prior to the date.

12.5.2 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 and Grievances department in one of the following ways:

Online submittal:
https://selecthealth.org/resourses/forms

Email: appeals@selecthealth.org

Fax: 801-442-0762

Appeals and Grievances 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 and Grievances department at 844-208-9012, by fax at 801-442-0762, or by emailing appeals@selecthealth.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 or other challenge.

12.5.3 Appeals Process

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

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

12.5.4 Preservice Appeals

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

Mandatory Review

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

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

Voluntary Review

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

Voluntary External Review

Voluntary External Review is available as set forth in Section 12.6 below. If you pursue a voluntary External Review, it will be your last level of Appeal.

Voluntary Internal Review

If you choose to pursue the voluntary internal review process, you may request a review of your Appeal. Depending on the nature of the Appeal, it will be considered by either the Administrative and Clinical Appeal Review Committee. Such a request must be made in writing to the Appeals and Grievances Department within 60 days of the date the Appeals and Grievances Department notifies you the Final Internal Adverse Benefit Determination. Select Health will notify you of the result of the review in writing within 30 days of the date you requested the review. However, Select Health may extend this period 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.

12.5.5 Postservice Appeals

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

Mandatory Review

Your Appeal will be investigated by the Appeals and Grievances Department. All relevant information will be reviewed. The Appeals and Grievances Department will notify you in writing of the Appeal decision within a reasonable period of time appropriate to the medical circumstances, but no later than 60 days after the receipt of your Appeal. However, Select Health may extend this period 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 60-day period, of the circumstances requiring the extension and the date by which Select Health expects to render a decision.

Voluntary Review

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

Voluntary External Review

Voluntary External Review is available as set forth in Section 12.6 below. If you pursue a voluntary External Review, it will be your last level of Appeal.

Voluntary Internal Review

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

12.5.6 Attorney's Fees

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

12.6 Member's Right to External Review

YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW

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

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

- The Medical Necessity, appropriateness, health care setting, level of care, effectiveness of your health care Service, or any Adverse Benefit Determination relating to a surprise medical bill or surprise air ambulance bill subject to the No Surprise Act.; or
- Our determination your health care Service was Experimental and/or Investigational.

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

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

Idaho Department of Insurance

ATTN: External Review

700 W State St, 3rd Floor

Boise ID 83720-0043

For more information and for an External Review request form:

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

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

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

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

12.6.1 Standard External Review Request

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

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

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

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

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

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

12.6.2 Expedited External Review Request

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

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

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

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

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

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

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

12.6.3 Binding Nature of the External Review Decision

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

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

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

SECTION 13 OTHER PROVISIONS AFFECTING YOUR BENEFITS

13.1 Coordination of Benefits (COB)

When you or your Dependents have healthcare coverage under more than one health benefit plan, Select Health will coordinate Benefits with the other healthcare coverage according to the COB rules set forth in Idaho DOI Rule 18.04.14.

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

i. Plan includes:

1) Group and nongroup insurance contracts and subscriber contracts;

2) Uninsured group or group-type coverage arrangements;

3) Group and nongroup coverage through closed panel plans;

4) Group-type contracts;

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

6) Medicare or other governmental benefits, except as provided in Subsection (b)(ii)(9) of this section. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

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

ii. Plan shall not include:

1) Hospital indemnity coverage or other fixed indemnity coverage;

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

3) Specified disease or specified accident coverage;

4) Accident only coverage;

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

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

7) Medicare supplement policies;

8) A state plan under Medicaid; or

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

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

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

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

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

Order of Benefit Determination

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

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

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

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

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

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

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

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

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

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

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

    a) The plan covering the custodial parent;

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

    c) The plan covering the noncustodial parent; and then

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

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

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

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

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

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

ii. The start of a new plan does not include:

1) A change in the amount or scope of a plan's benefits;

2) A change in the entity that pays, provides or administers the plan's benefits; or

3) A change from one type of plan to another such as from a single employer plan to a multiple employer plan.

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

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

Miscellaneous Provisions

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

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

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

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

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

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

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

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

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

13.2 Subrogation, Reimbursement and Recovery

13.2.1 Payment of Claims When Another Person or Entity is Liable

When you or your Dependents have an illness or injury caused by another person or entity, regardless of whether the person or entity is also an insured under the Plan or any other insurance policy (hereinafter a Recovery Party), the Recovery Party or

an insurer for the Recovery Party may be liable for damages or may be willing to pay money in settlement of a claim. This Plan does not cover Benefits for Services you or your Dependents receive for illnesses and injuries when the medical expenses are the responsibility of, or are paid by, a Recovery Party who has caused the illness or injury or a Recovery Party insurer. In situations where 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 a Recovery Party to the extent of all Benefits paid by Select Health or payable in the future because of the Recovery Event; (c) not to bring or assert a make whole, common fund, collateral source or other apportionment action or claim in contravention of 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 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.

13.3 Excess Payment

Select Health will have the right to recover any payment made in excess of the obligations 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 Dependent(s). This right of recovery will apply to payments made to you, your Dependent(s), your employer, Providers, or Facilities. If an excess payment is made by 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:

14.1 Payment

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

14.2 Changes in Eligibility or Contact Information

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

14.3 Other Coverage

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

SECTION 15 EMPLOYER RESPONSIBILITIES

15.1 Enrollment

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

15.2 Payment

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

15.3 Contract

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

15.4 Compliance

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

SECTION 16 DEFINITIONS

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

16.1 Activities of Daily Living

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

16.2 Affordable Care Act (ACA)

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

16.3 Allowed Amount

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

16.4 Ambulatory Surgical Facility

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

16.5 Annual Open Enrollment

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

16.6 Anodontia

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

16.7 Application

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

16.8 Approved Clinical Trials

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

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

3) The Department of Energy.

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

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

16.9 Autism Spectrum Disorder

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

16.10 Benefit(s)

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

16.11 Certificate of Coverage (Certificate)

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

16.12 COBRA Coverage

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

16.13 Coinsurance

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

16.14 Congenital Anomaly

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

16.15 Contraceptive

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

16.16 Contract

The Group Health Insurance Contract between Select Health and your employer.

16.17 Copay (Copayment)

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

16.18 Covered Services

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

16.19 Custodial Care

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

16.20 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.

16.21 Dental Services

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

16.22 Dependent(s)

Your Eligible dependents as set forth in Section 2 Eligibility.

16.23 Durable Medical Equipment (DME)

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

16.24 Effective Date

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

16.25 Eligible, Eligibility

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

16.26 Emergency Condition(s)

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

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

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

c. Serious impairment to bodily functions; or

d. Serious dysfunction of any bodily organ or part.

16.27 Employer Waiting Period

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

16.28 Employer's Plan

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

16.29 Endorsement

A document that amends the Contract.

16.30 ERISA

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

16.31 Essential Health Benefits

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

16.32 Excess Charges

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

16.33 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 this Certificate and the Contract may have the effect of excluding coverage in particular situations.

16.34 Experimental and/or Investigational

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

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

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

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

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

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

16.35 Facility

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

16.36 Formulary

The Prescription Drugs covered by your Plan.

16.37 Generic Drug(s)

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

16.38 Group Application

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

16.39 Group Health Insurance Contract

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

16.40 Health Benefit Plan

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

16.41 Habilitation Services

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

16.42 Healthcare Management Program

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

16.43 Home Healthcare

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

16.44 Hospice Care

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

16.45 Hospital

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

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

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

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

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

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

16.46 Infertility

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

16.47 Injectable Drugs and Specialty Medications

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

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

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

c. Require special training to administer;

d. Have special storage and handling requirements;

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

f. Often have additional monitoring requirements.

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

16.48 Initial Eligibility Period

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

16.49 Involuntary Complications of Pregnancy

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

16.50 Lifetime Maximum

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

16.51 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 this Certificate and the Contract may have the effect of limiting coverage in particular situations.

16.52 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 Select Health Member Services.

16.53 Major Office Surgery

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

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

b. Typically requiring general anesthesia;

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

d. Requires the special training to perform.

16.54 Mammography Services

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

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

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

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

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

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

16.55 Maximum Annual Out-of-Network Payment

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

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

16.56 Medical Director

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

16.57 Medical Necessity/Medically Necessary

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

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

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

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

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

Medical Necessity is determined by the treating Physician and by 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.

16.58 Member

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

16.59 Member Payment Summary

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

16.60 Mental Health/Substance Use Disorder

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

16.61 Minor Diagnostic Tests

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

a. Bone density tests;

b. Certain EKGs;

c. Echocardiograms;

d. Common blood and urine tests;

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

f. Spirometry/pulmonary function testing.

16.62 Miscellaneous Medical Supplies (MMS)

Supplies that are disposable or designed for temporary use.

16.63 Out-of-Network Benefits

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

16.64 Out-of-Network Facility

Healthcare Facilities that are not under contract with Select Health.

16.65 Out-of-Network Pharmacies

Pharmacies that are not under contract with Select Health.

16.66 Out-of-Network Provider

Providers that are not under contract with Select Health.

16.67 Nurse

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

16.68 Oligodontia

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

16.69 Optional Benefit

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

16.70 Out-of-Pocket Maximum

The maximum amount specified in your Member Payment Summary that you must pay each Year to Providers and/or Facilities as Deductibles, Copays, and Coinsurance. Except when otherwise noted in your Member Payment Summary, 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 Maximums. Payments you make for Excess Charges, noncovered Services, and certain categories of Services specified in your Member Payment Summary are not applied to the Out-of-Pocket Maximum.

16.71 In-Network Benefits

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

16.72 In-Network Facility

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

16.73 In-Network Pharmacies

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

16.74 In-Network Providers

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

16.75 Physician

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

16.76 Placement

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

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

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

16.77 Plan

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

16.78 Plan Sponsor

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

16.79 Preauthorization (Preauthorize)

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

16.80 Premium(s)

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

16.81 Prescription Drugs

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

16.82 Preventive Services

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

16.83 Primary Care Physician or Primary Care Provider (PCP)

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

a. Certified Nurse Midwives;

b. Family Practice;

c. Geriatrics;

d. Internal Medicine;

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

f. Pediatrics.

16.84 Private Duty Nursing

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

16.85 Rehabilitation Services

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

16.86 Provider

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

16.87 Qualified Medical Child Support Order (QMCSO)

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

16.88 Rescission (Rescind)

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

16.89 Residential Treatment Center

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

16.90 Respite Care

Care provided primarily for relief or rest from caretaking responsibilities.

16.91 Routine Care

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

16.92 Secondary Care Provider or Specialist (SCP)

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

a. Cardiologists;

b. Dermatologists;

c. Neurologists;

d. Ophthalmologists;

e. Orthopedic Surgeons; and

f. Otolaryngologists (ENTs).

16.93 Service Area

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

The Select Health network and Med network Service Areas include all counties in Idaho.

The Saint Alphonsus Health Alliance (SAHA) network Service Area includes the following counties: Ada, Boise, Canyon, Gem, Payette, Washington.

16.94 Service(s)

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

16.95 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, substance use disorder, alcoholism, Custodial Care, nursing home care, or educational care.

16.96 Sound Natural Teeth

Teeth and implant protheses which are stable; free from active or chronic diseases, such as advanced periodontal disease or caries; and exhibit at least 50% bone support. Whether natural or appropriately restored for long-term durability, teeth must be in a healthy condition, requiring no augmentation, modification, or repair for any reason other than accidental injury. This definition not only includes sound natural teeth as described above but also extends to healthy implant prostheses.

16.97 Special Enrollment Right

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

16.98 Subscriber

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

16.99 Urgent Condition(s)

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

16.100 Wilderness Therapy

Recreational therapy, outdoor therapy or programs, and therapeutic recreation programs such as diabetes camps, adventure therapy, and outdoor behavioral health.

16.101 Year

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

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

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

SECTION 17 OTHER PROGRAMS

In addition to your Benefits, 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.

SECTION 18 OPTIONAL BENEFITS

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

SECTION 19 RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you receive Services for an Emergency Condition or Covered Services from an Out-of-Network Provider at an In-Network Facility, you are protected from paying Excess Charges, also called surprise billing or balance billing.

When you see a Provider, you may owe certain Out-of-Pocket costs, such as a Copayment, Coinsurance, and/or a Deductible. You may have other costs or have to pay the entire bill if you see an Out-of-Network Provider or Facility.

As stated above, Out-of-Network Providers can bill you for Excess Charges.

Excess Charges can constitute an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an In-Network Facility but are unexpectedly treated by an Out-of-Network provider.

You are protected from Excess Charges for:

Emergency services

If you receive Services for an Emergency Condition or Covered Services from an Out-of-Network Provider or Facility, the most the Out-of-Network Provider or Facility may bill you is the Allowed Amount. You will not be responsible for Excess Charges. For Emergency Conditions, this includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an In-Network Facility

When you get Services from an In-Network Facility, certain providers there may be Out-of-Network. In these cases, the most the Out-of-Network Provider may bill you is the Allowed Amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't bill you for Excess Charges and may not ask you to give up your protections.

If you get other services at these In-Network facilities, Out-of-Network Providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections. You also aren't required to get care Out-of-Network. You can choose an In-Network Provider or Facility.

When balance billing isn't allowed, you also have the following protections:

a. You are only responsible for paying your share of the Allowed Amount (like the Copayments, Coinsurance, and Deductibles that you would pay if the provider or facility was in-network). Your health plan will pay Out-of-Network Providers and Facilities directly.

b. Select Health generally must:

   i. Cover emergency Services without requiring you to Preauthorize the Service in advance.

   ii. Cover emergency Services by Out-of-Network Providers.

   iii. Base what you owe the provider or facility (cost-sharing) on what it would pay an In-Network Provider or Facility and show that amount in your explanation of benefits.

   iv. Count any amount you pay for emergency services or Out-of-Network Services toward your Deductible and Out-of-Pocket Maximum.

If you believe you've been wrongly billed, you may contact Idaho Department of Insurance by visiting the department's website at doi.idaho.gov/nosurprises or calling the Consumer Affairs section at 1-208-334-4319 or toll-free in Idaho at 1-800-721-3272.

Visit doi.idaho.gov/nosurprises for more information about your rights under this law.

appendix A
optional benefits

Select Health

MENTAL HEALTH/SUBSTANCE USE DISORDER OPTIONAL BENEFIT

1. Your Mental Health Benefits

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

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

2. Services requiring Preauthorization

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

a. Inpatient Psychiatric/Detoxification admissions;

b. Residential Treatment after the third day of admission;

c. Partial Hospitalization after 20 visits; and

d. Intensive Outpatient Treatment after 35 visits.

If you need to request Preauthorization, call the Behavioral Health Advocates. Refer to Section 11 Healthcare Management for additional information.

3. Exclusions

The following are not covered:

a. Behavior modification;

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

c. Education or training;

d. Long-term care;

e. Milieu therapy;

f. Rest cures;

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

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

i. Services for conduct disorder.

DOMESTIC PARTNER OPTIONAL BENEFIT

1. Your Domestic Partner Benefits:

This Optional Benefit provides coverage for domestic partners when the following criteria are met:

A person of the same or opposite sex who:

a. shares the employee's permanent residence;

b. has resided with the employee for no less than 12 months;

c. is not younger than 18;

d. is not married to, or is not a Domestic Partner or tax dependent of, another person;

e. is not so closely related by blood to the employee that a legal marriage would otherwise be prohibited;

f. has either 1) registered as a Domestic Partner with the employee in a state, city, or county which has a registration procedure for the Domestic Partners or 2) signed jointly with the employee in a notarized Declaration of Domestic Partnership that is submitted to the Employer; and

g. is financially interdependent with the employee and has proven such interdependence to the Employer 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 or under the employee's will;

   v. assignment of durable power of attorney;

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

2. Eligibility:

a. You may enroll yourself, a Domestic Partner, and Dependents of the Domestic Partner in the Employer's Plan during your Initial Eligibility Period, during an Annual Open Enrollment Period, or during a Special Enrollment Right.

b. If you are enrolled in this coverage (or are eligible to be covered but declined during a previous enrollment period), and gain a Domestic Partner, then you may enroll the Domestic Partner (and yourself), if not otherwise enrolled) in the Employer's Plan within 31 days of certification of the partnership.

c. You may terminate the coverage of a Domestic Partner when: 1) the Domestic Partner dies; 2) the Domestic Partnership ends and you submit a Declaration of Termination of a Domestic Partnership to your Employer; 3) the Domestic Partner marries; or 4) you stop sharing the same principal residence with the Domestic Partner.

d. Your employer must treat Domestic Partners the same as married individuals for all its employee health benefits plans.

ENDORSEMENT

This ENDORSEMENT is made to the 2025 Large Employer Idaho Group Health Insurance Contract made between your employer and us.

Provision 10.1 of the Certificate of Coverage is changed to allow coverage for abortions when medically necessary to save the life of the mother, and 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.

SelectHealth, Inc.

Todd Trettin

CFO and President Large Group Commercial Markets

2025 Endorsement to the Certificate of Coverage

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

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

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

Section 1.2 "Select Health" of the Certificate is replaced with the following:

1.2 Select Health

SelectHealth, Inc. ("Select Health" or "we" or "us") is a managed care organization licensed by the State of Idaho. 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.

Subsection 4.2.1 "Termination Date" of the Certificate is replaced with the following:

4.2.1 Termination Date

If you and/or your enrolled Dependent(s) lose Eligibility, then coverage will terminate either on the date Eligibility is lost or the end of the month in which Eligibility is lost, as specified in the Group Application. However, when a Dependent child ceases to be a Dependent, coverage will terminate at the end of the year in which Dependent status is lost. When a loss of Eligibility is not reported in a timely fashion as required by the Contract, and federal or state law prevents 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.

Section 6.1 "Providers and Facilities" of the Certificate is replaced with the following:

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.

If you need access to primary care, specialty care, Mental Health/Substance Use Disorder (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.

Section 8 "SECTION 8 COVERED SERVICES" of the Certificate is replaced with the following:

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.

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 Certificate, you can find further information about your Benefits by doing any of the following:

a. Log in to your Member account at selecthealth.org;

b. Visit selecthealth.org;

c. Refer to your Provider & Facility Directory; or

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

Subsection 8.1.1 "Educational Training" of the Certificate is added:

8.1.1 Educational Training

Only for diabetes, asthma, or chronic kidney disease.

Subsection 8.2.3 "Dental Services" of the Certificate is replaced with the following:

8.2.4 Dental Services

Only in three limited circumstances:

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

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

i. Maxillary and/or mandibular procedures;

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

ii. Orthognathic Services; and

iii. Services for Congenital Oligodontia /Anodontia.

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

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

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

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

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

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

Section 10.34 "Wilderness Therapy" of the Certificate is replaced with the following:

10.34 Wilderness Therapy

Wilderness Therapy is not covered.

Subsection 11.1.1 "Services Requiring Preauthorization" of the Certificate is replaced with the following:

11.1.1 Services Requiring Preauthorization

Preauthorization is required for the following Services:

…

e. Certain arthroscopic procedures;

…

Subsection 12.5.2 "Form and Timing" of the Certificate is replaced with the following:

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 and Grievances department in one of the following ways:

Online submittal: https://selecthealth.org/resourses/forms

Email: appeals@selecthealth.org

Fax: 801-442-0762

Appeals and Grievances 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 and Grievances department at 844-208-9012, by fax at 801-442-0762, or by emailing appeals@selecthealth.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 or other challenge.

Subsection 12.5.4 "Preservice Appeals…Voluntary External Review" of the Certificate is replaced with the following:

Voluntary Internal Review

If you choose to pursue the voluntary internal review process, you may request a review of your Appeal. Depending on the nature of the Appeal, it will be considered by either the Administrative and Clinical Appeal Review Committee. Such a request must be made in writing to the Appeals and

Grievances Department within 60 days of the date the Appeals and Grievances Department notifies you the Final Internal Adverse Benefit Determination. Select Health will notify you of the result of the review in writing within 30 days of the date you requested the review. However, Select Health may extend this period 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.

Section 13.1 "Coordination of Benefits (COB)" of the Certificate is replaced with the following:

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 the COB rules set forth in Idaho DOI Rule 18.04.14.
…

A new Section 16.96 "Sound Natural Teeth" of the Certificate is added:

16.96 Sound Natural Teeth

Teeth and implant protheses which are stable; free from active or chronic diseases, such as advanced periodontal disease or caries; and exhibit at least 50% bone support. Whether natural or appropriately restored for long-term durability, teeth must be in a healthy condition, requiring no augmentation, modification, or repair for any reason other than accidental injury. This definition not only includes sound natural teeth as described above but also extends to health implant prostheses.

A new Section 16.100 "Wilderness Therapy" of the Certificate is added:

16.100 Wilderness Therapy

Recreational therapy, outdoor therapy or programs, and therapeutic recreation programs such as diabetes camps, adventure therapy, and outdoor behavioral health.

All other terms and conditions of the Contract remain unchanged.

SelectHealth, Inc.

Todd Trettin
CFO and President Large Group Commercial Markets