Summary Plan Description
for
GRANITE SCHOOL DISTRICT
Select Med Plus

Effective: January 1, 1998
Restated: January 1, 2018

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Section 1 – Introduction

1.1 **This Summary Plan Description (SPD)**. Your employer as Plan Sponsor has established the Granite School District/Select Med Plus (the Plan). This document sets forth the provisions that constitute the Plan, including terms and conditions of Benefits, and serves as a Summary Plan Description (SPD). Please read it carefully and keep it for future reference. Technical terms are capitalized and described in Section 16 – "Definitions." Your Schedule of Benefits, which contains a quick summary of the Benefits by category of service, is attached to and considered part of this SPD.

1.2 **SelectHealth**. The Plan Administrator has contracted with SelectHealth to perform third-party claims administration and other specified services for the Plan. SelectHealth is affiliated with Intermountain Healthcare, but is a separate company. SelectHealth's agreement with the Plan does not involve Intermountain Healthcare or any other affiliated Intermountain companies, or their officers or employees.

1.3 **Managed Care**. The Plan provides managed healthcare. Such management necessarily limits some choices of Providers and Facilities. The management features and procedures are described by this SPD. The Plan is intended to meet basic healthcare needs, but not necessarily to satisfy every healthcare need or every desire you or your Dependents may have for Services.

1.4 **Your Agreement**. As a condition to enrollment and to receiving Benefits, you (the Participant) and every other Member enrolled through your coverage (your Dependents) agree to:

a. contribute to the cost of coverage under the Plan as determined by the Plan Sponsor;

b. the managed care features that are a part of the Plan; and

c. all of the other terms and conditions of the Plan.

1.5 **No Vested Rights**. You are only entitled to receive Benefits while the Plan is in effect and you, and your Dependents if applicable, are properly enrolled. You do not have any permanent or vested interest in any Benefits under the Plan. Benefits may change as the Plan is renewed or modified from year to year. Unless otherwise expressly stated in this SPD, all Benefits end when the Plan ends.

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

1.7 **Non-Assignment**. Benefits are not assignable or transferable. Any attempted assignment or transfer by any Member of the right to receive payment under the Plan will be invalid unless approved in advance in writing by the Plan Administrator.

1.8 **Notices**. Any notice required of the Plan will be sufficient if mailed to you at the address appearing on the records of SelectHealth or the Plan Administrator as applicable. Notice to your Dependents will be sufficient if given to you. Any notice to the Plan will be sufficient if mailed to the Plan Administrator. All required notices must be sent by at least first class mail.

1.9 **Nondiscrimination**. The Plan will not discriminate against any Member based on race, sex, religion, national origin, or any other basis forbidden by law. The Plan 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 Plan's complaint resolution system.

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

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

- **a.** In the event of a discrepancy between information given by a SelectHealth employee and the written terms of the Plan, the terms of the Plan will control.
- **b.** Any changes or modifications to Benefits must be provided in writing and signed by the Plan Administrator.
- **c.** Administrative errors will not invalidate Benefits otherwise in force or give rise to rights or Benefits not otherwise provided by the Plan.

Section 2 – Eligibility

2.1 **General**. Your employer as Plan Sponsor decides 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. In order to become and remain Eligible to participate in the Plan, you and your Dependents must continuously satisfy these requirements.

2.2 **Participant Eligibility**. You are eligible for Benefits under the Plan if you are a full-time or part time contract employee.

2.2.1 For full-time contract employees and their eligible dependents, the District pays the majority of premium costs for coverage. Contract employees working less than full-time can obtain coverage by paying their proportional share of premium costs by payroll deduction.

2.2.2 If your spouse is employed and medical coverage is available, your spouse should enroll in the medical plan at his or her place of employment.

2.3 **Dependent Eligibility**. Eligible Dependents are:

2.3.1 **Spouse**. The person to whom you are legally married.

2.3.2 **Children**. The children (natural, adopted, 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 all of the Eligibility requirements in Subsection 2.3.2 may enroll or remain enrolled as Dependents after reaching age 26 as long as they:

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

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

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

2.4 **Court-Ordered Dependent Coverage**. When you or your lawful spouse are required by a court or administrative order to provide health insurance coverage for a child, the child will be enrolled in your family coverage only to the minimum extent required by applicable law.

2.4.1 **Qualified Medical Child Support Order (QMCSO)**. A QMCSO can be issued by a court of law or by a state or local child welfare agency. In order for the medical child support order to be qualified, the order must specify the following:

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

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

c. The period to which the order applies.

2.4.2 **National Medical Support Notice (NMSN)**. An NMSN is a QMCSO issued by a state or local child welfare agency to withhold from your income any contributions required by the Plan to provide health insurance coverage for an Eligible child.

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

2.4.4 **Court or Administrative Order**.

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

a. The start date indicated in the order;

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

c. The date SelectHealth receives the order.

2.4.5 **Duration of Coverage**. Court-ordered coverage for the Dependent child will be provided to the age of 18.

Section 3 – Enrollment

3.1 **Enrollment and Effective Date of Coverage**. This section explains how to enroll yourself and/or your eligible dependents when first eligible, during a period of Special Enrollment or Annual Open Enrollment. This section also describes when coverage under the Plan begins for you and/or your eligible dependents. Coverage under this Medical Plan is not automatic. You need to follow the appropriate enrollment process for membership with The District Benefits Office before coverage can begin.

3.2 **How to Enroll When Coverage Begins**. To enroll, you must complete an enrollment form and file it with the District Benefits Office within 30 calendar days of your contract hire/eligibility date. If you enroll more than 30 calendar days after attaining eligibility, you may not enroll until an Annual Open Enrollment unless you experience an event that creates a Qualified Life Status Change or Special Enrollment Right. Enrollment in the Plan is binding for the Plan year.

3.2.1 **Enrollment in the Plan is Binding for the Plan Year** Mid-year cancellation is NOT permitted.

3.3 **When You and/or Your Dependents are Initially Eligible**. Upon first becoming eligible for coverage under the Plan, You shall be entitled to apply for coverage for you and your eligible dependents within 30 calendar days of becoming eligible. **Coverage starts the first of the month following date of hire.**

3.3.1 **Enrollment Form**. Coverage under this Plan shall become effective with respect to you and/or your eligible dependents provided an enrollment form is completed and submitted to the District Benefits Office within the applicable time period.

3.3.2 **Rehire After Terminated Contract Employment**. If you terminate contract employment and are rehired with a break in service of less than 365 calendar days, subject to providing an enrollment form within 30 calendar days of becoming eligible, you and your eligible dependent's coverage will be effective on your eligibility/contract rehire date.

3.4 **Enrollment By Others**. In the event your child is the subject of a court or administrative order requiring you to provide health coverage for the child and you are eligible for health coverage including the child, but fail to make application to cover the child, application for enrollment of the child may be made by the child's other parent, any state Medicaid agency or by the state agency administering 42 U.S.C. 651 through 699 (the child enforcement program).

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

a. The start date indicated in the order;

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

c. The date SelectHealth receives the order.

3.6 **Qualified Life Status Change**. The following are Qualified Life Status Changes recognized by the Plan. Qualified Life Status Changes do not allow you to change the type of your coverage, but you may modify the level of your coverage within 30 calendar days of the Qualified Life Status Change occurring. Recognized Qualified Life Status Changes are:

- Marriage
- Divorce or legal separation
- Birth/Adoption
- A dependent ceasing to satisfy dependent eligibility requirements
- Death
- Change in employment status (i.e. moving from a benefits ineligible position to a benefits eligible position or vice versa, change in full-time employment status.)

3.7 **Annual Open Enrollment**. The Annual Open Enrollment Period is the one time each year when contract employees may make insurance plan participation changes including modifying and/or revoking coverage. You must follow the appropriate enrollment process on behalf of you and all dependents you want enrolled. Changes made during the Annual Open Enrollment Period are effective January 1 of the following year.

3.8 **Special Enrollment Periods**. If you have not enrolled yourself and/or your spouse or children, you may enroll yourself, and your spouse and children during a Special Enrollment Period. A "Special Enrollment Period" means:

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

a. You initially declined to enroll in the Plan due to the existence of other health plan coverage, and you stated in writing at the time you, your spouse or child was first eligible to enroll in this Plan that the other plan or insurance was the reason for the declination of enrollment;

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 contributions). 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 health plan's open enrollment and a

special enrollment period will be permitted under the Plan in order to avoid a gap in coverage; and

c. You and/or your Dependents who lost the other coverage must enroll in the Plan within 30 days after the date the other coverage is lost.

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

If you properly enroll under this Special Enrollment Right, coverage will be effective on the date the other coverage was lost.

3.8.2. **New Dependents**. If you are enrolled in the Plan (or are Eligible to be covered but previously declined to enroll), and gain a Dependent through marriage, birth, adoption, placement for adoption or placement under legal guardianship with you or your lawful spouse, or annulment of a Dependent Child's marriage, then you may enroll the Dependents (and yourself, if applicable) in the Plan. In the case of birth, adoption or placement for adoption of a child, you may also enroll your Eligible spouse, even if he or she is not newly Eligible as a Dependent. However, this Special Enrollment Right is only available by enrolling within thirty (30) days of the marriage, birth, adoption, placement for adoption or placement under legal guardianship. In the case of annulment of a Dependent Child's Marriage, you may enroll a child of yourself or your lawful spouse who is under age twenty-six (26).

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

a. As of the date of marriage;

b. As of the date of birth;

c. If the child is less than 31 days old when adopted or placed for adoption, as of the date of birth;

d. If the child is more than 31 days old when adopted or placed for adoption, as of the child's date of placement;

e. As of the later of:

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

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

f. The effective date of the annulment if that date is within six (6) months of date of marriage. If the court signs the order granting the annulment more than six (6) months from the date of marriage, coverage for any child properly enrolled will be effective on the date the order is received by SelectHealth, without consideration of any retroactive effect stated in the order.

3.8.3 **As Required by Federal Law.** The Plan will recognize other special enrollment rights as required by federal law.

3.9 **Coverage for Active Employees Working Beyond Age 65**. Under current federal law, contract employees who continue active (not disabled or retired) employment beyond age 65 will receive primary medical coverage (for employee, eligible spouse and eligible dependents) under the District's group medical plan until they terminate employment. For such working employees, Medicare coverage is secondary to the District's Plan, and enrollment in Medicare is optional.

3.10 **Benefits for Early Retirement**.

3.10.1 **Eligible Employees who have retired prior July 1, 2008.** Eligible employees who retire prior to age 65 under one of the District's Early Retirement Incentive Programs may be eligible for coverage under the Plan for a period of five consecutive years or until reaching full Social Security eligibility, whichever occurs first. Contact the District Human

Resources Office for details. (At age 65, you are encouraged to contact the Social Security Administration for information related to Medicare.)

3.10.2 **Eligible Employees who have retired after July 1, 2008.** Eligible employees who retire prior to age 65 under one of the District's Early Retirement Incentive Programs may be eligible for coverage under the Plan for a period of five consecutive years or until reaching Medicare eligibility, whichever occurs first. Contact the District Human Resources Office for details. (At age 65, you are encouraged to contact the Social Security Administration for information related to Part B, D of Medicare.)

3.11 **Extension of Benefits if You Are Totally Disabled**. In the event that you are awarded long-term disability (as qualified by the disability carrier) and are also covered under the Plan, your employment terminates as of the date of your long-term disability award.

3.11.1 **Waiver of Premium and COBRA**. The Plan will provide up to a maximum of 24 continuous months of medical insurance coverage to the former employee only (not your dependents) at no cost to the employee as of the date of your long-term disability award*. The 24 continuous months of coverage is contingent upon your continued long-term disability status with the disability carrier through the 24 continuous month maximum period. Thereafter, if the former employee continues to be eligible for COBRA and elects continued COBRA participation, the former employee may continue to be covered under COBRA at the former employee's expense until applicable COBRA eligibility is exhausted.

* All employees, except 12-month contract employees and administrators, who have fulfilled their contractual obligations for the school year just ended, commence 24 continuous months as of September 1.

3.12 **Coordination of Benefits**. When you or your family members are also enrolled in another health program, payments for covered services will be determined by coordinating the benefits of each program. There are two types of coordination of benefits outlined below.

3.12.1 **Primary/Secondary Coverage.** While preventing payment duplication, the maximum benefit to which you may be entitled is through having a primary and secondary carrier. The primary carrier pays the full benefits covered under its program and then the secondary carrier(s) is responsible for payment of the balance of the covered expenses not to exceed that carrier's maximum payment level. In no event will payment be made in excess of expenses incurred. A health program covering a person under a state or federal continuation coverage (i.e., COBRA) will always be a secondary carrier. Primary responsibility for paying benefits is determined by the first of the following rules to apply:

a. If another plan does not contain a coordination of benefits provision like this one, the other plan has primary responsibility;

b. A plan which covers the person to whom the claim relates as other than a family dependent has primary responsibility over a plan covering the person as a family dependent;

c. If the claim is for a dependent child, the benefits of the Plan of the parent whose birthday falls earlier in the calendar year are paid first;

d. If the claim is for a dependent child of divorced or separated parents, the Plan which covers the child as a dependent of the custodial parent has primary responsibility. If the custodial parent has remarried, the Plan which covers the child as a dependent of the new spouse of the custodial parent is primary to the Plan of the non-custodial parent. If there is a court decree which establishes financial responsibility for health care expenses with respect to a child dependent, the Plan which covers the child as a dependent of the parent with such financial responsibility has primary responsibility regardless of the above rules based on custodial status;

e. The benefits of a health care program which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are

determined before those of a health care program which covers that person as a laid off or retired employee (or as that employee's dependent). If the other health care program does not have this rule, and if, as a result, this program and the other health care program do not agree on the order of benefits, this rule is ignored; and

f. If the order of responsibility cannot be determined by the above rules, the benefits of the Plan which has covered the person to whom the claim relates for the longer period of time has primary responsibility.

3.12.2 **Internal Dual Coverage.** If an employee who is eligible for coverage under the District's medical plan is also eligible as the spouse of another covered District employee, the two coverages will supplement one another so that the benefit payments for such individuals who elect internal dual coverage will be made up to 100% of the eligible medical expense. At the time of service, a copay may be required for those who elect internal dual coverage. In such circumstances, reimbursement from the Plan may be sought by you. In no event will payment be made in excess of expenses incurred.

3.13 **Third Party Liability**. If a third party is responsible for your illness or injury, the benefits paid under this plan may be subject to subrogation. Subrogation means that The Plan will recover the amounts it has paid in benefits out of the proceeds of any settlement or judgment that you receive as a recovery from the third party, whether or not you are made whole by the recovery and whether or not the recovery includes any amount for covered services.

3.14 **Change in Primary Residence**. An enrolled employee who moves outside of the Service Area of his or her medical plan may, within thirty (30) calendar days of the change in his primary residence, elect from among the other plans offered through the District.

3.15 **Inform the Plan of Changes**. You must submit an Employee Change Form to the District Benefits Office regarding a change in your address or telephone number. Use an employee change form to make other changes as described in Section 3.7.

Section 4 – Termination

4.1 **Plan Termination**. Coverage under the Plan for you and your Dependents will terminate when the Plan terminates. The Plan Sponsor may terminate the Plan at any time, in any manner, regardless of the health status of any Member.

4.2 **Individual Termination**. Your coverage under the Plan may terminate even though the Plan remains in force.

4.2.1 **Loss of Eligibility**. If you and/or your enrolled Dependents lose Eligibility, then coverage will terminate as follows:

- on the date of termination of employment (unless You are contracted less than 12 months and have completed Your employment contract for the year, in which case coverage will continue through August 31 of the same year); or
- Twenty-one calendar days after the final working day if on approved leave of absence during the contract year; or
- If the Plan is discontinued with respect to the classification of employees to which the employee belongs; or
- If your Spouse loses Eligibility because you divorce, he or she ceases to be a Member on the date the divorce or annulment is final/recorded with the courts (whether or not the decree finally decides all property, support, and custody issues).

4.2.2 If You Die – Extension of Dependent Coverage If you die, coverage for your surviving Enrolled Dependents will be extended for 30 calendar days from the date your death occurs.

4.2.3 Loss of Dependent Status

- For an enrolled child who is no longer an eligible dependent due to exceeding the dependent age limit, eligibility ends on the dependent child's 26th birthday.
- For an enrolled child who is no longer eligible due to disruption of placement prior to legal adoption and the child is removed from placement, eligibility ends on the date the child is removed from placement.
- For an enrolled child who is no longer an eligible dependent for any other cause (except by reason of divorce or your death), eligibility ends on the day the child is no longer a dependent.

If you fail to remove an ineligible Dependent from the Plan, the covered employee will be responsible to pay the actual claims payments made by the Plan for any care or services received by the ineligible Dependent after the loss of eligibility. When a loss of Eligibility is not reported in a timely fashion as required by the Plan, and applicable law prevents the Plan from retroactively terminating coverage, the Plan has the discretion to determine the prospective date of termination. The Plan also has the discretion to determine the date of termination for Recissions.

4.2.4 Fraud or Misrepresentation.

a. During Enrollment.

(i) Coverage for you and/or your Dependents may be terminated or Rescinded at any time if you or they commit fraud or make an intentional misrepresentation of material fact to the Plan, such as enrolling an ineligible individual or otherwise failing to comply with the Plan's requirements for eligibility. in connection with your coverage.

(ii) If coverage is Rescinded as described above, the termination is retroactive to the Effective Date of coverage.

b. After Enrollment.

(i) 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 Plan Administrator's discretion, the Rescission may be effective retroactively to the date of the fraud or misrepresentation.

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.

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

4.2.6 Retroactive Termination. When a loss of coverage is not reported in a timely fashion as required by the Plan, and federal or state law prohibits the Plan from retroactively terminating coverage, the Plan has the discretion to determine the prospective date of termination. The Plan also has the discretion to determine the date of termination for Rescissions. The Plan may be entitled to recover from you and/or your Dependents the amount of any Benefits you or they receive after losing Eligibility.

4.3 Receiving Treatment at Termination. All Benefits under the Plan terminate when the Plan terminates, including coverage for you or your Dependents hospitalized or otherwise within a course of care or treatment. All Services received after the date of termination are your responsibility and not the responsibility of the Plan no matter when the condition arose and despite care or treatment anticipated or already in progress.

Section 5 – Continuation Coverage

5.1 Qualifying Events. As mandated by federal law, the Plan offers optional continuation coverage (also referred to as COBRA coverage) to you and/or your Eligible Dependents if such coverage would otherwise end due to one of the following qualifying events:

- **a.** Termination of your employment for any reason except gross misconduct. Coverage may continue for you and/or your Eligible Dependents;
- **b.** A reduction in your hours. Coverage may continue for you and/or your Eligible Dependents;
- **c.** Your death. Coverage may continue for your Eligible Dependents;
- **d.** Your divorce or legal separation. Coverage may continue for your Eligible Dependents;
- **e.** Your becoming entitled to Medicare. Coverage may continue for your Eligible Dependents; and
- **f.** Your covered Dependent child's ceasing to be a Dependent child under the Plan. Coverage may continue for that Dependent.
- **g.** The District files a Chapter 11 bankruptcy petition and you are a retiree (coverage may be continued by you and/or your dependents)

Note: To choose this continuation coverage, an individual must be covered under the Plan on the day before the qualifying event. In addition, your newborn child or child placed for adoption with you during a period of continuation coverage will remain Eligible for continuation coverage for the remaining period of coverage even if you and/or your spouse terminate continuation coverage following the child's birth or placement for adoption.

5.2 Notification Requirements. You or the applicable Dependent have the responsibility to inform the Plan Administrator, in writing, within 60 days of a divorce or legal separation or of a child losing Dependent status under the Plan. Failure to provide this written notification within 60 days will result in the loss of continuation coverage rights.

Your employer has the responsibility to notify the Plan Administrator of your death, termination of employment, reduction in hours, or entitlement to Medicare within 30 days of the qualifying event.

Subject to the Plan Administrator being informed in a timely manner of the qualifying events described in the above paragraphs, the Plan will promptly notify you and other qualifying individuals of their continuation coverage rights. You and any applicable Dependents must elect continuation coverage within 60 days after Plan coverage would otherwise end, or, if later, within 60 days of the notice of continuation coverage rights. Failure to elect continuation coverage within this 60-day period will result in loss of continuation coverage rights.

5.2.1 Notice of Unavailability of Continuation Coverage. If the Plan Administrator receives a notice of a qualifying event from you or your Dependent and determines that the individual (you or your Dependent) is not entitled to continuation coverage, the Plan Administrator will provide to the individual an explanation as to why the individual is not entitled to continuation coverage. This notice will be provided within the same time frame that the Plan Administrator would have provided the notice of right to elect continuation coverage.

5.3 Maximum Period of Continuation Coverage. The maximum period of continuation coverage is 36 months from the date of the qualifying event, unless the qualifying event is your termination of employment or reduction in hours. In that case, the maximum period of continuation coverage is generally 18 months from the date of the qualifying event.

However, if a qualifying individual is disabled (as determined under the Social Security Act) at the time of your termination or reduction in hours or becomes disabled at any time during the first 60 days of continuation coverage, continuation coverage for the qualifying individual and any non-disabled Eligible Dependents who are also entitled to continuation coverage may be extended to 29 months provided the qualifying individual, if applicable, notifies the Plan Administrator in

writing within the 18-month continuation coverage period and within 60 days after receiving notification of determination of disability.

If a second qualifying event occurs (for example, your death or divorce) during the 18- or 29-month coverage period resulting from your termination of employment or reduction in hours, the maximum period of coverage will be computed from the date of the first qualifying event, but will be extended to the full 36 months if required by the subsequent qualifying event.

A special rule applies if the qualifying individual is your spouse or Dependent child whose qualifying event was the termination or reduction in hours of your employment and you became entitled to Medicare within 18 months before such qualifying event. In that case, the qualifying individual's maximum period of continuation coverage is the longer of 36 months from the date of your Medicare entitlement or their otherwise applicable maximum period of coverage.

5.4 Cost of Continuation Coverage. The cost of continuation coverage is determined by the employer and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable contribution cannot exceed 102 percent of the Plan's cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150 percent of the Plan's cost of coverage.

Contribution payments for continuation coverage for you or your Eligible Dependents' initial contribution month(s) are due by the 45th day after electing continuation coverage. The initial contribution month(s) are any months that end on or before the 45th day after you or the qualifying individual elects continuation coverage. All other contributions are due on the first of the month for which coverage is sought, subject to a 30-day grace period. Contribution rates are established by your employer and may change when necessary due to Plan modifications. The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event.

Failure to make the first payment within 45 days or any subsequent payment within 30 days of the established due date will result in the permanent cancellation of continuation coverage.

5.5 When Continuation Coverage Ends. Continuation of coverage ends on the earliest of:

- **a.** The date the maximum continuation coverage period expires;
- **b.** The date your employer no longer offers a group health plan to any of its employees;
- **c.** The first day for which timely payment is not made to the Plan;
- **d.** The date the qualifying individual becomes covered by another group health plan.
- **e.** The date the qualifying individual becomes entitled to coverage under Medicare; and
- **f.** The first day of the month that begins more than 30 days after the qualifying individual who was entitled to a 29-month maximum continuation period is subject to a final determination under the Social Security Act that he or she is no longer disabled.

5.6 Notice of Termination Before Maximum Period of COBRA Coverage Expires. If continuation coverage for a qualifying individual terminates before the expiration of the maximum period of continuation coverage, the Plan Administrator will provide notice to the individual of the reason that the continuation coverage terminated, and the date of termination. The notice will be provided as soon as practicable following the Plan Administrator's determination regarding termination of the continuation coverage.

5.7 Compliance with Applicable Laws. The Plan intends to comply with all applicable laws regarding continuation (COBRA) coverage. If for some reason the information presented in this Plan differs from actual COBRA requirements, the Plan reserves the right to administer COBRA in accordance with such actual COBRA requirements.

5.8 Uniformed Services Employment and Reemployment Rights Act (USERRA). If you were covered under this Plan immediately prior to taking a leave for service in the uniformed services, you may elect to continue your coverage under USERRA for up to 24 months from the date your leave for uniformed service began, if you pay any required contributions toward the cost of the coverage during the leave.

5.8.1 **Early Termination.** This USERRA continuation coverage will end earlier if one of the following events takes place:

a. You fail to make a premium payment within the required time;

b. You fail to report to work or to apply for reemployment within the time period required by USERRA following the completion of your service; or

c. You lose your rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or less, your contribution amount will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with any continuation coverage.

5.8.2 **Reinstatement.** If your coverage under the Plan terminated because of your service in the uniformed services, your coverage will be reinstated on the first day you return to employment if you are released under honorable conditions and you return to employment within the time period(s) required by USERRA.

When coverage under this Plan is reinstated, all of the Plan's provisions will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. This waiver does not provide coverage for any illness or injury caused or aggravated by your military service, as determined by the VA. (For complete information regarding your rights under USERRA, contact your employer.)

5.8.3 **Compliance with Applicable Laws.** The Plan intends to comply with all existing regulations of USERRA. If for some reason the information presented in the Plan differs from the actual regulations of USERRA, the Plan reserves the right to administer the Plan in accordance with such actual regulations.

5.8.4 **Uniformed Services.** Members of the uniformed services include the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

In this section, service means the performance of a duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes:

a. Active duty;

b. Active duty for training;

c. Initial active duty training;

d. Inactive duty training;

e. Full-time National Guard duty,

f. A period for which you are absent from your job for purpose of an examination to determine your fitness to perform any such duties;

g. A period for which you are absent from your job for the purpose of performing certain funereal honors duty; and

h. Certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).

Section 6 – Providers/Networks

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

6.1.1 **Participating Providers and Facilities**. You receive a higher level of Benefits (known as Participating Benefits) when you obtain Covered Services from a Participating Provider or Facility. Refer to your Schedule of Benefits for details.

6.1.2 **Nonparticipating Providers and Facilities**. In most cases, you receive a lower level of Benefits (known as Nonparticipating Benefits) when you obtain Covered Services from a Nonparticipating Provider or Facility. Refer to your Schedule of Benefits for details.

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

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

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 Plan.

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

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

6.3.2 **Payments to Members**. The Plan reserves the right to make payments directly to you or your Dependents instead of to Nonparticipating Providers and/or Facilities.

6.4 **Provider/Patient Relationship**. Providers and Facilities are responsible for establishing and maintaining appropriate Provider/patient relationships with you, and neither SelectHealth nor the Plan interferes with those relationships. SelectHealth is only involved in decisions about what Services will be covered and paid for by the Plan. Decisions about your Services should be made between you and your Provider without reference to coverage under the Plan.

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

If you or your Dependent is under the care of a Provider when affiliation ceases, SelectHealth will continue to treat the Provider as a Participating Provider until the completion of the care (not to exceed 90 days), or until you or your Dependent is transferred to another Participating Provider, whichever occurs first. However, if you or your covered spouse is receiving maternity care in the second or third trimester, you or they may continue such care through the first postpartum visit. (Also, see Section 10.29 Maternity Services for Dependents.)

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

a. to accept the Allowed Amount as payment in full;

b. to follow SelectHealth's Healthcare Management Program policies and procedures;

c. to continue treating you and/or your Dependent; and

d. to share information with SelectHealth regarding the treatment plan.

Section 7 – About Your Benefits

7.1 **General**. You and your Dependents are entitled to receive Benefits while you are enrolled in the Plan. This section describes those Benefits in greater detail.

7.2 **Schedule of Benefits**. Your Schedule of Benefits lists important information about the Plan. This includes information about Copay, Coinsurance, and/or Deductible requirements, Preauthorization requirements, visit limits, Limitations on the use of Nonparticipating Providers and Facilities, and expenses that do not count against the Out-of-Pocket Maximum.

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

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

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

7.5 **Benefit Changes**. Your Benefits may change if the Plan changes.

7.6 **Calendar-Year or Plan-Year Basis**. Your Schedule of Benefits 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 Plan.

7.7 **Lifetime Maximums**. Your Schedule of Benefits will specify any applicable Lifetime Maximums.

7.8 **Two Benefit Levels**.

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

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

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

If you or your Dependent is hospitalized for an emergency:

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

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

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

Section 8 – Covered Services

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

Benefits are limited; Services must satisfy all of the requirements of the Plan to be covered. For additional information affecting Covered Services, refer to your Schedule of Benefits and Section 10 – "Limitations and Exclusions." In addition to this SPD, you can find further information about your Benefits by doing any of the following:

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

b. Visit selecthealth.org

c. Refer to your Provider & Facility Directory; or

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

8.1 **Facility Services**.

8.1.1 **Educational Training**. Only when rendered by a Participating Facilities for diabetes or asthma.

8.1.2 **Emergency Room (ER)**. If you are admitted directly to the Hospital because of the condition for which emergency room Services were sought, the emergency room Copay, if applicable, will be waived.

8.1.3 **Inpatient Hospital**.

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

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

c. Intensive care unit.

d. Preadmission testing.

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

f. Maternity/obstetrical Services. Also see section 10.29 Maternity Services for Dependents.

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

8.1.4 **Nutritional Therapy**. Medical nutritional therapy Services are covered for up to five visits per Year as a Preventive Service, regardless of diagnosis. Subsequent visits are covered as a medical Benefit. Weight management as part of a program approved by SelectHealth is also covered once per year.

8.1.5 **Outpatient Facility and Ambulatory Surgical Facility**. Outpatient surgical and medical Services.

8.1.6 **Skilled Nursing Facility**. Only when Services cannot be provided adequately through a home health program.

8.1.7 **Urgent Care Facility**.

8.2 **Provider Services**.

8.2.1 **After-Hours Visits**. Office visits and minor surgery provided after the Provider's regular business hours.

8.2.2 **Anesthesia**. If administered in connection with otherwise Covered Services and by a Physician certified as an anesthesiologist or by a Certified Registered Nurse Anesthetist (CRNA) under the direct supervision of a Physician certified as an anesthesiologist.

General anesthesia is only covered when rendered in a Facility.

8.2.3 **Dental Services**. Only:

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

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

(i) Maxillary and/or mandibular procedures;

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

(iii) Orthognathic Services; or

(iv) Services for congenital Oligodontia or Anodontia.

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

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

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

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

Bleaching to restore teeth to pre-accident condition is limited to $200. Orthodontia and the replacement/repair of dental appliances are not covered, even after an accident. Repairs for physical damage resulting from biting or chewing are not covered.

8.2.4 **Dietary Products**. Only in the following limited circumstances:

a. For hereditary metabolic disorders when:

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

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

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

b. Certain enteral formulas according to SelectHealth policy.

(i) The formula is used under the direction of a Physician and can only be obtained by prescription and through a pharmacy; or

(ii) The formula is the Member's primary source of nutrition and is primarily given through a form of feeding tube; or

(iii) The Member has gastrointestinal dysfunction (e.g., malabsorption) and the product is specifically designed to be used in the management of the condition that prevents his or her ability to maintain adequate weight.

8.2.5 **Genetic Counseling**. Only when provided by a Participating Provider who is a certified genetic counselor or board certified medical geneticist.

8.2.6 **Genetic Testing**. Only in the following circumstances and according to SelectHealth criteria or required by state or federal law:

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

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

c. When the Member has a more than five-percent probability of having an inheritable genetic condition and has signs or symptoms suggestive of a specific condition or a strong family history of the condition (defined as two or more first-degree relatives with the condition) and results of the testing will directly affect the patient's treatment; or

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

8.2.7 **Home Visits**. Only if you are physically incapable of traveling to the Provider's office.

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

8.2.9 **Major Surgery**.

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

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

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

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

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

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

8.2.11 **Medical/Surgical**. In an inpatient, outpatient, or Ambulatory Surgical Facility.

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

8.2.13 **Office Visits**. For consultation, diagnosis, and treatment.

8.2.14 **Preventive Services**.

8.2.15 **Second Opinions**. Copay/Coinsurance/Deductible waived when requested by SelectHealth. If the Member requests a second opinion, then the Copayment/Coinsurance/Deductibles that apply for a regular office visit are required.

8.2.16 **Sleep Studies**. Only when provided by:

a. A Participating Provider who is a board-certified sleep specialist at a Facility certified as a sleep center/lab by the American Board of Sleep Medicine; or

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

8.2.17 **Sterilization Procedures**.

8.3 **Miscellaneous Services**.

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

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

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

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

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

c. Either:

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

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

8.3.4 **Autism Spectrum Disorder**. For children ages two through nine, coverage is limited to the following:

a. Evaluation, management, and assessment Services that are necessary to determine whether a Member has an autism spectrum diagnosis and are performed by;

(i) A board certified physician in psychiatry, neurology, or pediatrics and has experience diagnosing autism spectrum disorder, or

(ii) A licensed psychologist with experience diagnosing autism spectrum disorder;

b. Behavior training, management, and applied behavior analysis Services by certified therapists; and

c. Habilitative and rehabilitative Services, including occupational, physical, or speech therapy (both habilitative and rehabilitative Services are subject to the annual visit limit specified for Outpatient Rehab Therapy Services on your Schedule of Medical Benefits).

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

8.3.6 **Cochlear Implants**. For prelingual deafness in children or postlingual deafness in adults in limited circumstances that satisfy SelectHealth criteria. Must be Preauthorized.

8.3.7 **Durable Medical Equipment (DME)**.

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

(i) Prescribed by a Provider;

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

(iii) Required for Activities of Daily Living;

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

(v) Not attached to a home or vehicle.

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

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

The Plan 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.

8.3.8 **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, though exceptions can be made for travel purposes. Injectable drugs and specialty medications must be provided by a Participating Provider unless otherwise approved in writing in advance by SelectHealth. You may be required to receive the drug or medication in your Provider's office. Some Injectable Drugs and Specialty Medications may only be obtained from

certain drug distributors. Call Member Services to determine if this is the case and to obtain information on participating drug vendors.

8.3.11 **Miscellaneous Medical Supplies (MMS)**. Only when prescribed by a Provider and not generally usable in the absence of an illness or injury. Only ninety (90) days of diabetic supplies may be purchased at a time.

8.3.12 **Neuropsychological Testing (Medical)**. As a medical Benefit, only as follows:

a. Testing performed as part of the preoperative evaluation for patients undergoing:

(i) seizure surgery;

(ii) solid organ transplantation; or

(iii) central nervous system malignancy.

b. Patients being evaluated for dementia/Alzheimer's disease;

c. Patients with Parkinson's Disease;

d. Stroke patients undergoing formal rehabilitation; and

e. Post-traumatic-brain-injury patients.

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

8.3.13 **Organ Transplants**.

a. Only if:

(i) Preauthorized in advance by SelectHealth; and

(ii) provided by Participating Providers in a Participating Facility unless otherwise approved in writing in advance by SelectHealth.

b. And only the following:

(i) bone marrow as outlined in SelectHealth criteria;

(ii) combined heart/lung;

(iii) combined pancreas/kidney;

(iv) cornea;

(v) heart;

(vi) kidney (but only to the extent not covered by any government program);

(vii) liver;

(viii) pancreas after kidney; and

(ix) single or double lung.

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

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

8.3.14 **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.

8.3.15 **Osteoporosis Screening**. Only central bone density testing (DEXA scan).

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

8.3.17 **Rehabilitation Therapy**. Physical, occupational, and speech rehabilitative therapy when required to correct an impairment caused by a covered accident or illness or to restore an individual's ability to perform Activities of Daily Living.

8.3.18 **TeleHealth**. Otherwise covered evaluation and management, genetic counseling and mental health Services when rendered by a Participating Provider, and as otherwise indicated in medical policy.

8.3.19 **Vision Aids**. Only:

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

b. Prescribed eyeglasses for Members following covered cataract surgery. In such cases, coverage is limited to a lifetime maximum of $100.

c. 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.

9.1 **Prescription Drug Benefit Resources**. In addition to this SPD, you can find additional information about your Pharmacy Benefits by doing any of the following:

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

b. Visit selecthealth.org/pharmacy;

c. Refer to your Provider & Facility Directory; or

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

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

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

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

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

9.4 **Filling Your Prescription**.

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

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

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

9.5 **Generic Drug Substitution 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. The difference in cost between the Generic Drug and brand-name drug will not apply to your Out-of-Pocket Maximum. Based upon clinical circumstances determined by SelectHealth's Pharmacy and Therapeutics Committee, some Prescription Drugs are excluded from this requirement.

9.6 **Maintenance Drugs**. The Plan offers a maintenance drug Benefit, allowing you to obtain a 90-day supply of certain drugs. This Benefit is available for maintenance drugs if you:

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

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

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

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

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

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

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

9.8 **Step Therapy**. Certain drugs require your Provider to first prescribe an alternative drug preferred by the Plan. 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, the Plan may cover the drug without step therapy if SelectHealth determines it is Medically Necessary.

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

9.9 **Inappropriate Prescription Practices**. In the interest of safety for its Members, the Plan reserves the right to not cover certain prescription drugs.

a. These drugs include:

- **(i)** narcotic analgesics;
- **(ii)** other addictive or potentially addictive drugs; and
- **(iii)** drugs prescribed in quantities, dosages, or usages that are outside the usual standard of care for the medication in question.

b. These drugs are not covered when they are prescribed:

- **(i)** outside the usual standard of care for the practitioner prescribing the drug;
- **(ii)** in a manner inconsistent with accepted medical practice; or
- **(iii)** for indications that are Experimental and/or Investigational.

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

9.10 **<u>Prescription Drug Benefit Abuse</u>**. The Plan may limit the availability and filling of any Prescription Drug that is susceptible to abuse. SelectHealth may require you to:

- **a.** obtain prescriptions in limited dosages and supplies;
- **b.** obtain prescriptions only from a specified Provider;
- **c.** fill your prescriptions at a specified pharmacy;
- **d.** participate in specified treatment for any underlying medical problem (such as a pain management program);
- **e.** complete a drug treatment program; or
- **f.** adhere to any other specified limitation or program designed to reduce or eliminate drug abuse or dependence.

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

The Plan 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 the Plan, you may be permitted to retain your coverage if you comply with specified conditions.

9.11 **<u>Pharmacy Injectable Drugs and Specialty Medications</u>**. Injectable drugs and specialty medications must be provided by a Participating Provider unless otherwise approved in writing in advance by SelectHealth. Most drugs received in a Provider's office or Facility are covered by your medical Benefits. For more specific information, please contact SelectHealth Member Services. Infusion therapy is only covered at preapproved infusion locations.

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

9.13 **<u>Exceptions Process.</u>** 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.

9.14 **<u>Prescriptions Dispensed in a Provider's Office</u>**. Prescriptions dispensed in a Provider's office are not covered unless expressly approved by SelectHealth.

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

Section 10 – Limitations and Exclusions

Unless otherwise noted in your Schedule of Benefits or Appendix B – "Additional Benefits," the following Limitations and Exclusions apply.

10.1 **Abortions/Termination of Pregnancy**. Abortions are not covered except:

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

Medical complications resulting from an abortion for an employee or their covered spouse only are covered. Treatment of a miscarriage/spontaneous abortion (occurring from natural causes) for an employee or their covered spouse only is covered.

10.2 **Acupuncture/Acupressure**. Acupuncture and acupressure Services are not covered.

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

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

10.4 **Allergy Tests/Treatments**.

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

10.5 **Anesthesia**. General anesthesia rendered in a Provider's office is not covered.

10.6 **Bariatric Surgery**. Surgery to facilitate weight loss is not covered.

10.7 **Biofeedback/Neurofeedback**. Biofeedback/neurofeedback is not covered.

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

10.9 **Certain Cancer Therapies**. The following cancer therapies are not covered:

- **a.** Neutron beam therapy
- **b.** Proton beam therapy, except in the following limited circumstances:
  - **(i)** Chordomas or chondrosarcomas arising at the base of the skull or along the axial skeleton without distant metastases;
  - **(ii)** Other central nervous system tumors located near vital structures;
  - **(iii)** Pituitary neoplasms;
  - **(iv)** Uveal melanomas confined to the globe (not distant metastases); or
  - **(v)** In accordance with SelectHealth medical policy.

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

10.10 **Certain Illegal Activities.** The following are not covered:

- **a.** Services are not covered for an illness, condition, accident, or injury arising from you or your Dependent:
  - **(i)** Voluntarily participating in the commission of a felony;
  - **(ii)** Voluntarily participating in disorderly conduct, riot, or other breach of the peace;
  - **(iii)** Engaging in any conduct involving the illegal use or misuse of a firearm or other deadly weapon;
  - **(iv)** Driving or otherwise being in physical control of a car, truck, motorcycle, scooter, off-road vehicle, boat, or other motor-driven vehicle where either:
    - **1.** A subsequent test shows that you or your Dependent has either blood or breath alcohol concentration of .08 grams or greater at the time of the test; or
    - **2.** You or your Dependent has any illegal drug or other illegal substance in your body to a degree that it affected your ability to drive or operate the vehicle safely;
  - **(v)** Driving or otherwise being in physical control of a car, truck, motorcycle, scooter, off-road vehicle, boat, or other motor-driven vehicle either without a valid driver's permit or license, if required under the circumstances or without the permission of the owner of the vehicle.
- **b.** A complication of, or as the result of, or as follow-up care for, any illness, condition, accident, or injury that is not covered as the result of this exclusion.

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

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

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

10.12 **Complementary and Alternative Medicine (CAM)**. Complementary, alternative and nontraditional Services are not covered. Such Services include botanicals, homeopathy,

homeopathic drugs, certain bioidentical hormones, massage therapies, aromatherapies, yoga, hypnosis, rolfing, and thermography.

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

10.14 **Custodial Care**. Custodial Care is not covered.

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

10.16 **Dental Anesthesia**. Services including local, regional, general, and/or intravenous sedation anesthesia, are not covered except for at Participating Facilities when Members meet the following criteria:

- **a.** You or your Dependent is developmentally delayed, regardless of chronological age
- **b.** You or your Dependent, regardless of age, has a congenital cardiac or neurological condition and documentation is provided that the dental anesthesia is needed to closely monitor the condition; or
- **c.** You or your Dependent is younger than five years of age and:
  - **(i)** The proposed dental work involves three or more teeth;
  - **(ii)** The diagnosis is nursing bottle-mouth syndrome or extreme enamel hypoplasia; and
  - **(iii)** The proposed procedures are restoration or extraction for rampant decay.

10.17 **Dry Needling**. Dry needling procedures are not covered.

10.18 **Duplication of Coverage**. The following are not covered:

- **a.** Services that are covered by, or would have been covered if you or your Dependents had enrolled and maintained coverage in automobile insurance, including no-fault type coverage up to the minimum amount required by law. In the event of a claim, you should provide a copy of the Personal Injury Protection (PIP) documentation from the automobile insurance carrier.
- **b.** Services that are covered by, or would have been covered if your employer had enrolled and maintained coverage in, Workers' Compensation insurance.
- **c.** Services for which you have obtained a payment, settlement, judgment, or other recovery for future payment intended as compensation.
- **d.** Services received by you or one of your Dependents while incarcerated in a prison, jail, or other correctional facility at the time Services are provided, including care provided outside of a correctional facility to a person who has been arrested or is under a court order of incarceration.

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

10.20 **Eye Surgery, Refractive**. Radial keratotomy, LASIK, or other eye surgeries performed primarily to correct refractive errors are not covered.

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

10.22 **Food Supplements**. Except for Dietary Products, as described in Section 8 – "Covered Services," food supplements and substitutes are not covered.

10.23 **Gene Therapy**. Gene therapy or gene-based therapies are not covered.

10.24 **Habilitation Therapy Services**. Except Services for autism spectrum disorder as described in Section 8 – "Covered Services," Services designed to create or establish function that was not previously present are not covered.

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

10.26 **Home Health Aides**. Services provided by a home health aide are not covered.

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

10.28 **Maternity Services for Dependents**. There are no maternity benefits for dependent children, including services for pre-term labor and any other service that is pregnancy related. Dependent children are not eligible to participate in the Healthy Beginnings Program, including Care Management. Covered spouses are eligible for all maternity benefits and programs.

10.29 **Methadone Therapy**. Methadone maintenance/therapy clinics or Services are not covered.

10.30 **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.

10.31 **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

10.32 **Prescription Drugs/Injectable Drugs and Specialty Medications**. The following are not covered:

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

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

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

p. Non-Sedating Antihistamines;

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

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

(ii) The SelectHealth Pharmacy & Therapeutics Committee has approved the OTC medication as a medically appropriate substitution of a Prescription Drug; and

(iii) You or your Dependent has obtained a prescription for the OTC drug from a licensed Provider and filled the prescription at a Participating Pharmacy;

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

s. Prescription Drugs used for cosmetic purposes;

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

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

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

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

x. Sexual dysfunction drugs; and

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

10.33 Reconstructive, Corrective, and Cosmetic Services.

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

(i) to improve form or appearance;

(ii) to correct a deformity, whether congenital or acquired, without restoring physical function;

(iii) to cope with psychological factors such as poor self-image or difficult social relations;

(iv) as the result of an accident unless the Service is reconstructive and rendered within 5 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) Congenital cleft lip except for treatment rendered within 12 months of birth, or a planned, staged series of Services (as specifically documented in you or your Dependent's medical record) is initiated, or when congenital cleft lip surgery is performed as part of a cleft palate repair; or

(ii) Treatment for venous telangiectasias (spider veins).

10.34 Rehabilitation Therapy Services. Rehabilitation therapy services (physical, speech, and occupational) are not covered, unless required to correct an impairment caused by a covered accident or illness, or to restore an individual's ability to perform activities of daily living. See

Schedule of Benefits for benefit limitations. Rehabilitation services are not covered when used to assist a Member in establishing skills not previously possessed regardless of the medical history or age of the individual. This is considered habilitation therapy and is excluded from coverage. Additionally, rehabilitation therapy services in some specific clinical circumstances are excluded from coverage, as the benefit of rehabilitation therapy in these circumstances is unproven. These clinical circumstances include, but are not limited to, the following:

a. Services for functional nervous disorders; and

b. Vision rehabilitation therapy Services.

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

10.36 **Respite Care**. Respite Care is not covered.

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

10.38 **Sexual Dysfunction**. All services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment related to sexual dysfunction are not covered, including, but not limited to surgical procedures, appliances, drugs, and medical office visits.

10.39 **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.

10.40 **Specific Services**. The following Services are not covered:

a. Anodyne infrared device for any indication;

b. Auditory brain implantation;

c. Automated home blood pressure monitoring equipment;

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

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

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

g. Computer-assisted navigation for orthopedic procedures;

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

i. Extracorporeal shock wave therapy for musculoskeletal indications;

j. Freestanding/home cervical traction;

k. Home anticoagulation or hemoglobin A1C testing;

l. Infrared light coagulation for the treatment of hemorrhoids;

m. Interferential/neuromuscular stimulators;

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

o. Magnetic Source Imaging (MSI);

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

q. Mole mapping;

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

s. Nucleoplasty or other forms of percutaneous disc decompression;

t. Oncofertility;

u. Pediatric/infant scales;

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

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

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

y. Prolotherapy;

z. Radiofrequency ablation for lateral epicondylitis;

aa. Radiofrequency ablation of the dorsal root ganglion;

bb. Secretin infusion therapy for the treatment of autism;

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

dd. Whole body scanning.

10.41 **Telephone/E-mail Consultations**. Except for TeleHealth Services as described in "Section 8 – Covered Services," charges for Provider telephone, e-mail, or other electronic consultations are not covered.

10.42 **Temporomandibular Joint Disorder (TMJ**)

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

10.44 **Travel-related Expenses**. Costs associated with travel to a local or distant medical provider, including accommodation and meal costs, are not covered.

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

Section 11 – Healthcare Management

The Plan works to manage costs while protecting the quality of care. The Plan's 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 the Plan to manage health care costs for you. The Healthcare Management process takes several forms.

11.1 **Preauthorization**. Preauthorization is prior approval from SelectHealth for certain Services and is considered a Preservice Claim (refer to Section – 12 "Claims and Appeals"). Preauthorization is not required when this Plan is your secondary plan. However, it is required for injectable drugs and inpatient services when Medicare is your primary insurance. Obtaining Preauthorization does not guarantee coverage. Your Benefits for the Preauthorized Services are subject to the Eligibility requirements, Limitations, Exclusions and all other provisions of the Plan.

11.1.1 **Services requiring Preauthorization**. Preauthorization is required for the following major Services:

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

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

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

d. Joint replacement;

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

f. Pain management/pain clinic Services;

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

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

i. Certain genetic testing;

j. Continuous glucose monitors;

k. Hysterectomy;

l. Tonsillectomy;

m. Adenoidectomy;

n. The following Durable Medical Equipment:

(i) Insulin pumps;

(ii) Prosthetics (except eye prosthetics);

(iii) Negative pressure wound therapy electrical pump (wound vac);

(iv) Motorized or customized wheelchairs; and

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

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

Abraxane
Absorica
Abstral
Actemra
Acthar
Actimmune
Actiq
Adcetris
Adcirca
Adempas
Adoxa
Afinitor
Alimta
Ampyra
Androderm
Arcalyst
Arzerra
Aubagio
Avastin
Axiron
Banzel
Benlysta
Berinert
Bexxar
Betaseron
Boniva (injectable)
Bosulif
Botox
Brisdelle
Caprelsa
Cayston
Cerezyme
Cialis
Cimzia
Cinryze
Cometriq
Cystaran
Diclegis
Dificid
Doryx
Dysport
Egrifta
Elelyso
Enbrel
Epaned
Humira
Hyalgan
Iclusig
Ilaris
Imbruvica
Incivek
Increlex
Inlyta
Intravenous Immunoglobulin (IVIG)
Istodax
Ixempra
Jakafi
Jetrea
Jevtana
Juxtapid
Kadcyla
Kalbitor
Kalydeco
Kineret
Korlym
Krystexxa
Kynamro
Kyprolis
Lazanda
Letairis
Lucentis
Macugen
Makena
Marqibo
Mekinist
MyoBloc
Nexavar
Norditropin
Novarel
NPlate
Nuedexta
Nulojix
Nutropin Nuvigil
Olysio
Omnitrope
Onfi
Onmel
Opsumit
Oracea
Sabril
Samsca
Saizen
Serostim
Signifor
Simponi
Sirturo
Solesta
Soliris
Solodyn
Somatuline
Somavert
Sovaldi
Sprycel
Stelara
Stivarga
Striant
Subsys
Sucraid
SupartzSutent
Sylatron
Synagis
Synribo
Tafinlar
Tarceva
Tasigna
Testim
Tev-Tropin
Thalomid
Tobi
Torisel
Tracleer
Treanda
Trokendi XR
Tykerb
Tysabri
Tyvaso
Valchlor
Varizig
Vecamyl
Vectibix
Velcade
Ventavis
Versacloz
Victrelis

Erbitux	Orencia	Votrient
Erivedge	Orthovisc Ovidrel	VPRIV
Erwinaze	Ozurdex	Xalkori
Eylea	Pegasys	Xeljanz
Extavia	PEG-Intron	Xenazine
Fentanyl Lozenges	Perjeta	Xeomin
Fentora	Pomalyst	Xgeva
Firazyr	Pregnyl	Xiaflex
Flolan	Prialt	Xifaxan
Folotyn	Procysbi	Xofigo
Forteo	Prolia	Xolair
Fortesta	Promacta	Xtandi
Gazyva	Protropin Provenge	Xyrem
Gel-One	Provigil	Yervoy
Genotropin	Qutenza	Zaltrap
Gilenya	Ravicti	Zelboraf
Gilotrif	Relistor	Zevalin
Gleevec	Remicade	Zolinza
Halaven	Remodulin	Zorbtive
Hemophilia Factors	Revatio	Zytiga
Humatrope	Revlimid	

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

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

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

You should call SelectHealth as soon as you know you will be using a Nonparticipating Provider or Facility for any of the Services listed.

11.1.4 **Penalties**. When you are responsible to Preauthorize, Benefits may be reduced or denied if you do not Preauthorize certain Services. If reduced, the Allowed Amount will be cut by 50% and Benefits will apply to what remains according to regular Plan guidelines. You will be responsible for the 50% penalty, your Copay, Coinsurance, and Deductible, and you may be responsible for any amount that exceeds the Allowed Amount.

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

11.1.5 **Statement of Rights Under the Newborns' and Mothers' Health Protection Act**. The Plan Sponsor 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 may not, under federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

11.3 **Benefit Exceptions**. On a case-by-case basis, the Plan may in its discretion extend or add Benefits that are not otherwise expressly covered or are limited by the Plan. In making this

decision, the Plan will consider the medical appropriateness and cost effectiveness of the proposed exception.

When making such exceptions, the Plan 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 the Plan would have paid had the Service been provided in accordance with the other provisions of the Plan. Benefits paid under this section are subject to all other Member payment obligations of the Plan such as Copays, Coinsurance, and Deductibles.

11.4 **Second Opinions/Physical Examinations**. After enrollment, SelectHealth has the right to request that you be examined by a mutually agreed upon Provider concerning a claim, a second opinion request, or a request for Preauthorization. The Plan will be responsible for paying for any such physical examination.

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

Section 12 – Claims and Appeals

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

12.2 **Claims and Appeals Definitions**. This section uses the following additional (capitalized) defined terms:

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

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

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

12.2.4 **Benefit Determination**. The decision by SelectHealth regarding the acceptance or denial of a claim for Benefits.

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

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

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

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

12.2.9 **Independent Review Organization (IRO)**. An entity that conducts independent External Reviews.

12.2.10 **Postservice Appeal**. A request to change an Adverse Benefit Determination for Services you have already received.

12.2.11 **Postservice Claim**. Any claim related to Services you have already received.

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

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

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

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

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

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

12.4.1 **Urgent Preservice Claims**. In order to file an Urgent Preservice Claim, you must provide SelectHealth with:

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

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

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

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

If the Urgent Preservice Claim involves a Concurrent Care Decision, notice of the Benefit Determination will be provided as soon as possible but no later than 24 hours after

receipt of your claim for extension of treatment or care, as long as the claim is made at least 24 hours before the prescribed period of time expires or the prescribed number of treatments ends.

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

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

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

12.4.3 Postservice Claims.

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

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

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

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

12.5 Problem Solving. The Plan 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 SelectHealth Member Services representative. Call Member Services at 800-538-5038. SelectHealth offers foreign language assistance.

12.6 Formal Appeals. If you are not satisfied with the result of working with SelectHealth Member Services, you may file a written formal Appeal of any Adverse Benefit Determination or the negative outcome of a Preservice Inquiry. Written formal Appeals should be sent to the SelectHealth Appeals Department. As the delegated claims review fiduciary under the Plan, SelectHealth will conduct a full and fair review of your Appeal.

12.6.1 General Rules and Procedures. You will have the opportunity to submit written comments, documents, records, and other information relating to your Appeal. SelectHealth will consider this information regardless of whether it was considered in the Adverse Benefit Determination. For the purpose of the Appeals process, Preservice Inquiries will be treated like Preservice Claims.

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

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

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

SelectHealth Appeals Department

P.O. Box 30192

Salt Lake City, Utah 84130-0192

You may Appeal an Adverse Benefit Determination of an Urgent Preservice Claim on an expedited basis either verbally or in writing. You may Appeal verbally by calling the Appeals Department at 844-208-9012.

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

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

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

12.6.3 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. The Plan agrees that any statute of limitations or other legal defense based on timeliness is suspended during the

time that any voluntary Appeal is pending. Your decision whether or not to seek voluntary review will have no effect on your rights to any other Benefits. SelectHealth will provide you, upon request, sufficient information to enable you to make an informed decision about whether or not to engage in a voluntary review.

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

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

Mandatory Review

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

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

Voluntary Review

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

Voluntary External Review

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, or a Rescission of coverage. To request an External Review, you must complete the External Review Request Form. For a copy of this form, or for other questions, contact the SelectHealth Appeals Department. An External Review request must be made within 180 days from the date the Appeals Department notifies you of the Final Internal Adverse Benefit Determination. An authorization to obtain medical records may be required. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. The IRO will provide written notice of its decision within 45 days after receipt of the request.

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

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

Voluntary Internal Review

If you choose to pursue the voluntary internal review process, you may request a review of your Appeal. Depending on the nature of the Appeal, it will be considered by either the Administrative Appeal Review Committee or the Clinical

Appeal Review Committee. Such a request must be made in writing to the Appeals Department within 60 days of the date the Appeals Department notifies you the Final Internal Adverse Benefit Determination. SelectHealth will notify you of the result of the review in writing within 30 days of the date you requested the review. If you are not satisfied with the decision made by the reviewing committee, you may request a review by the SelectHealth Appeals Committee. Such a request must be made in writing to the Appeals Department within 60 days of the date the reviewing committeenotifies you of its decision.

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

Mandatory Review

Your Appeal will be investigated by the Appeals Department. All relevant information will be reviewed. The Appeals Department will notify you in writing of the Appeal decision within a reasonable period of time appropriate to the medical circumstances, but no later than 60 days after the receipt of your Appeal.

Voluntary Review

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

Voluntary External Review

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, or a Rescission of coverage. To request an External Review you must complete the External Review Request Form. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. For a copy of this form, or for other questions, contact the SelectHealth Appeals Department. An External Review request must be made within 180 days from the date SelectHealth sends a Final Internal Adverse Benefit Determination. An authorization to obtain medical records may be required. The IRO will provide written notice of its decision within 45 days after receipt of the request.

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

Voluntary Internal Review

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

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, the Plan will coordinate Benefits with the other healthcare coverage according to the COB rules set forth in Utah Code, Section 31A-22-619.

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

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

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

Any funds you (or your agent or attorney) recover by way of settlement, judgment, or other award from a third party or from your own insurance due to a third-party event as described in this section shall be held by you (or your agent or attorney) in a constructive trust for the benefit of the Plan until the Plan's equitable restitution interest has been satisfied.

The Plan shall have the right to intervene in any lawsuit, threatened lawsuit, or settlement negotiation involving a third party for purposes of asserting and collecting its equitable restitution interest as described in this section. The Plan 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 the Plan's equitable restitution interest or to enforce the constructive trust required by this section.

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

You are required to:

a. Promptly notify the Plan of all possible subrogation/restitution situations;

b. Help the Plan or its designated agent to assert its subrogation/restitution interest;

c. Not take any action that prejudices the Plan's right of subrogation/restitution, including settling a dispute with a third party without protecting the Plan's subrogation/restitution interest;

d. Sign any papers required to enable the Plan to assert its subrogation/restitution interest.

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

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

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

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

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

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

13.3 **Right of Recovery**. The Plan will have the right to recover any payment made in excess of the obligations of the Plan. This right of recovery will apply to payments made to you, your Dependents, your employer, Providers, or Facilities. If an excess payment is made by the Plan to you, you agree to promptly refund the amount of the excess. The Plan may, at its sole discretion, offset any future Benefits against any overpayment.

Section 14 – Participant Responsibilities

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

14.1 **Payment**. Pay applicable contributions to your employer, and pay the Coinsurance, Copay, and/or Deductible amounts listed in your Schedule of Benefits to your Provider(s) and/or Facilities.

14.2 **Changes in Eligibility or Contact Information**. Notify your employer when there is a change in your situation that may affect your Eligibility, the Eligibility of your Dependents, or if your contact information changes.

14.3 **Other Coverage**. Notify the Plan 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 the Plan all information necessary to administer your coverage, including the medical history and records for you and your Dependents and, if requested, your social security number(s).

14.5 **Notification of Members**. Notify your enrolled Dependents of all Benefit and other Plan changes.

Section 15 – Plan Administrator

15.1 **Authority of the Plan Administrator.** The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including determinations regarding eligibility for Benefits, construction of the terms of the Plan, and resolution of possible ambiguities, inconsistencies, or omissions. All determinations of the Plan Administrator with respect to any matter on which it has the power, duty, and/or authority to act shall be made by it in its sole discretion and shall be conclusive and binding on all persons.

In addition, the Plan Administrator may:

a. Prescribe such forms, procedures, and policies as may be necessary for efficient Plan administration.

b. Designate other persons to carry out any of its duties or powers and employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan.

15.2 **Delegation of Claims Review Fiduciary Authority.** The Plan Administrator has delegated to SelectHealth its discretionary authority with respect to making and reviewing benefit claims determinations. As a claims review fiduciary, SelectHealth has sole discretionary authority to determine the availability of Benefits and to interpret, construe, and administer the applicable terms of the Plan. Its determinations shall be conclusive and binding subject to the Appeals process set forth in Section 12 – "Claims and Appeals."

Section 16 – Definitions

This SPD 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 the Plan 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 specified by Granite School District during which you are given the opportunity to enroll yourself and your Dependents in the Plan.

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

16.7 **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.

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

a. Aspeger's Syndrome;

b. Autistic Disorder;

c. Childhood Disintegrative Disorder; and

d. Pervasive developmental disorder not otherwise specified.

16.9 **Benefit(s)**. The payments and privileges to which you are entitled by the Plan, as described in this SPD.

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

16.11 **Coinsurance**. A percentage of the Allowed Amount stated in your Schedule of Benefits that you must pay for Covered Services to the Provider and/or Facility.

16.12 **Continuation Coverage**. COBRA Coverage.

16.13 **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.

16.14 **Copay (Copayment)**. A fixed amount stated in your Schedule of Benefits that you must pay for Covered Services to a Provider or Facility.

16.15 **Covered Services**. The Services listed as covered in Section 8 – “Covered Services,” Section 9 “Prescription Drug Benefits,” Section 10 “Limitations and Exclusions,” and Appendix B – “Additional Benefits,” and not excluded in this Plan.

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

16.17 **Deductible(s)**. An amount stated in your Schedule of Benefits that you must pay each Year for Covered Services before the Plan makes any payment. Some categories of Benefits may be subject to separate Deductibles.

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

16.19 **Dependent(s)**. Your eligible dependents as set forth in Section 2 – “Eligibility.”

16.20 **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.

16.21 **Effective Date**. The date on which coverage for you and/or your Dependents begins.

16.22 **Eligible, Eligibility**. In order to be Eligible, you or your Dependents must meet the criteria for participation specified in Section 2 – “Eligibility.”

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

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

16.24 **Employer Waiting Period**. The period that you must wait after becoming Eligible for coverage before your Effective Date. Your employer specifies the length of this period.

16.25 **Employer's Plan**. The group health plan sponsored by Granite School District.

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

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

16.28 **Exclusion(s)**. Situations and Services that are not covered by the Plan. Most Exclusions are set forth in Section 10 – "Limitations and Exclusions," but other provisions throughout this SPD may have the effect of excluding coverage in particular situations.

16.29 **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.

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

16.31 **Formulary**. The prescription Drugs covered by your Plan.

16.32 **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.

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

16.34 **Home Healthcare**. Services provided to Beneficiaries at their home by a licensed Provider who works for an organization that is licensed by the state where Services are provided.

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

16.36 **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.

16.37 **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.

16.38 **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
- **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.

16.39 **Initial Eligibility Period**. The period during which you may enroll yourself and your Dependents in the Plan. The Initial Eligibility Period is identified in Section 2 – “Eligibility.”

16.40 **Lifetime Maximum**. The maximum accumulated amount that the Plan will pay for certain Covered Services (as allowed by the Affordable Care Act) during a Member's lifetime. This may include all amounts paid on behalf of the Member under any prior health benefit plans offered by the Plan Sponsor. In addition, some categories of Benefits are subject to a separate lifetime maximum amount. If applicable, lifetime maximums are specified in your Schedule of Benefits.

16.41 **Limitation(s)**. Situations and Services in which coverage is limited by the Plan. Most Limitations are set forth in Section 10 – “Limitations and Exclusions,” but other provisions throughout this SPD may have the effect of limiting coverage in particular situations.

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

- **a.** imaging studies such as MRIs, CT scans, and PET scans;
- **b.** neurologic studies such as EMGs and nerve conduction studies;
- **c.** cardiac nuclear studies or cardiovascular procedures such as coronary angiograms; and
- **d.** gene-based testing and genetic testing.

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

16.43 **Major Surgery**. A surgical procedure having one or more of the following characteristics:

- **a.** Performed within or upon the contents of the abdominal, pelvic, cranial or thoracic cavities;
- **b.** Typically requiring general anesthesia;

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

d. Requires the special training to perform.

16.44 **Maximum Annual Out-of-Network Payment**. The maximum accumulated amount the Plan will pay each Year for Covered Services applied to the Nonparticipating (Out-of-Network) Benefit.

The limit may include all amounts paid on behalf of the Member under any prior health benefit plans offered by the Plan Sponsor. The Maximum Annual Out-of-Network Payment amount is specified in your Schedule of Benefits.

16.45 **Medical Director**. The Physician(s) designated as such by SelectHealth.

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

16.47 **Member**. You and your Dependents, when properly enrolled in the Plan.

16.48 **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

f. spirometry/pulmonary function testing

16.49 **Miscellaneous Medical Supplies (MMS)**. Supplies that are disposable or designed for temporary use.

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

16.51 **Nonparticipating (Out-of-Network) Facility**. Healthcare Facilities that are not under contract with SelectHealth.

16.52 **Nonparticipating (Out-of-Network) Pharmacies**. Pharmacies that are not under contract with SelectHealth.

16.53 **Nonparticipating (Out-of-Network) Provider**. Providers that are not under contract with SelectHealth.

16.54 **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.

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

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

16.57 **Participant**. You, the individual with an employment or other defined relationship to the Plan Sponsor, through whom Dependents may be enrolled with the Plan.

16.58 **Participating (In-Network) Benefits**. The higher level of Benefits available to you when you obtain Covered Services from a Participating Provider or Facility.

16.59 **Participating (In-Network) Facility**. Facilities under contract with SelectHealth to accept Allowed Amounts as payment in full for Covered Services.

16.60 **Participating (In-Network) Pharmacies**. Pharmacies under contract with SelectHealth to accept Allowed Amounts as payment in full for Covered Services.

16.61 **Participating (In-Network) Providers**. Providers under contract with SelectHealth to accept Allowed Amounts as payment in full for Covered Services.

16.62 **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.

16.63 **Plan**. Granite School District/ Select Med Plus

16.64 **Plan Administrator.** Granite School District

16.65 **Plan Sponsor**. As defined in ERISA. The Plan Sponsor is typically your employer. The Plan Sponsor has the right to amend, modify or terminate the Plan in any manner, at any time, regardless of the health status of any Member.

16.66 **Preauthorization (Preauthorize)**. Prior approval from SelectHealth for certain Services. Refer to Section 11 – “Healthcare Management” and your Schedule of Benefits.

16.67 **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.

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

16.69 **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.

16.70 **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.

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

16.72 **Qualified Medical Child Support Order (QMCSO)**. A court order for the medical support of a child as defined in ERISA.

16.73 **Rescission (Rescind)**. A cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay contributions towards the cost of coverage.

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

16.75 **Respite Care**. Care provided primarily for relief or rest from caretaking responsibilities.

16.76 **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.

16.77 **Schedule of Benefits**. A summary of your Benefits by category of service, attached to and considered part of this SPD.

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

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

16.79 **Service Area**. The geographical area in which SelectHealth arranges for Covered Services for Members from Participating Providers and Facilities. Contact SelectHealth for Service Area information if the U.S. Postal Service changes or adds ZIP codes after the beginning of the Year.

Select Med PLUS® Service Area is the State of Utah.

16.80 **Service(s)**. Services, care, tests, treatments, drugs, medications, supplies, or equipment.

16.81 **Skilled Nursing Facility**. A Facility that provides Services that improve, rather than maintain, your health condition, that require the skills of a Nurse in order to be provided safely and effectively, and that:

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

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

16.82 **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.”

16.83 Summary Plan Description (SPD). This document, which describes the terms and conditions of the health care Benefits provided by the Plan Administrator and administered by SelectHealth. Your Schedule of Benefits is attached to and considered part of this SPD.

16.84 TeleHealth. Services provided via interactive (synchronous) video and audio telecommunications systems.

16.85 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.

16.86 Waiting Period. The period that you must wait after becoming Eligible for coverage before your Effective Date, as specified in Section 2 – "Eligibility."

16.87 Year. Benefits are calculated on either a calendar-year basis, as indicated on your Schedule of Benefits. 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.

Section 17 – Your Rights Under the Employee Retirement Income Security Act (ERISA)

As a Participant in the Plan (which is a type of employee welfare plan called a group health plan) you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all group health plan participants shall be entitled to:

17.1 Receive Information About Your Plan and Benefits. Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

17.2 Continue Group Health Plan Coverage. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

17.3 Prudent Actions by Plan Fiduciaries. In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

17.4 Enforce Your Rights. If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the

materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim if frivolous.

17.5 **Assistance with Your Questions.** If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section 18 – Specific Plan Information

18.1 **Plan Name**. Granite School District/ Select Med Plus

18.2 **Type of Plan**. A group health plan (a type of welfare benefits plan subject to the provisions of ERISA).

18.3 **Plan Year**. January 1 to December 31

18.4 **Employer / Plan Sponsor**.

Granite School District

2500 South State Street

Salt Lake City, Utah 84115

18.5 **Plan Funding and Type of Administration**. Health benefits are self-funded from accumulated assets and are provided directly from the Plan Sponsor, in part by employees' payroll deductions. The Plan Sponsor may purchase excess risk insurance coverage which is intended to reimburse the Plan Sponsor for certain losses incurred and paid under the Plan by the Plan Sponsor. Such excess risk coverage, if any, is not part of the Plan.

SelectHealth performs specified administrative services in relation to the Plan for the Plan Administrator. SelectHealth is the claims review fiduciary of the Plan but is not an insurer of Benefits under the Plan, and does not exercise any other final discretionary authority and responsibility granted to the Plan Administrator. SelectHealth is not responsible for Plan financing and does not guarantee the availability of Benefits under this Plan.

18.6 **Plan Sponsor's Employer Identification Number**. 87-6000494

18.7 **Plan Administrator**.

Granite School District

18.8 **Named Fiduciary**.

Granite School District

18.9 **Agent for Service of Legal Process**.

Granite School District

18.10 **Important Disclaimer**. Plan Benefits are provided according to this SPD. The terms of this SPD are superseded by applicable law.

EMPLOYER

By: ______________________________

Printed Name: ______________________________

Title: ______________________________

Date: ______________________________

Address: ______________________________

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Appendix A – Prescription Drug List

Appendix B – Additional Benefits

Mental Health/Chemical Dependency Benefit

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

If you have any questions regarding any aspect of these Benefits, please call the SelectHealth Behavioral Health Advocates[sm] weekdays, from 8:00 a.m. to 6:00 p.m. at 800-876-1989.

2. **Using Participating Mental Health Providers**. Mental health Services will be covered only when rendered by a Participating Provider unless otherwise noted on your Schedule of Benefits.

3. **Services requiring Preauthorization**. Preauthorization is required for the following mental health services:

- **a**. Inpatient psychiatric/detoxification admissions;
- **b**. Residential treatment (when indicated as a covered Benefit on your Schedule of Benefits;
- **c**. Day treatment;
- **d**. Partial hospitalization; and
- **e**. Intensive outpatient treatment.

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

4. **Exclusions**.

4.1 The following Services 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.** Family counseling and/or therapy;
- **e.** Long-term care;
- **f.** Marriage counseling and/or therapy;
- **g.** Methadone maintenance/therapy clinics or Services;
- **h.** Milieu therapy;
- **i.** Rest cures;
- **j.** Self-care or self-help training (nonmedical); and
- **k.** Surgical procedures to remedy a condition diagnosed as psychological, emotional, or mental.

4.2 In addition, Services for conduct disorder are not covered.

Chiropractic Benefits

1. **<u>Your Chiropractic Benefits</u>**. The Plan provides Chiropractic Benefits for the correction of nerve interference (by manual or mechanical means) resulting from or related to the distortion, misalignment, or partial dislocation in the vertebral column. These Benefits are subject to all other Plan provisions, Limitations, and Exclusions.
2. **<u>Exclusions</u>**. The following Services are not covered:
   - **a.** Chiropractic appliances;
   - **b.** Services related to the diagnosis and treatment of jaw problems such as temporomandibular joint (TMJ) syndrome or craniomandibular disorders;
   - **c.** Services for treatment of non-neuromusculoskeletal disorders;
   - **d.** Professional radiology services (reading of an X-ray);
   - **e.** Services for children ages six and under; and
   - **f.** Services for children ages seven through 12 unless:
     - **(i)** The child has a specific chronic neuromusculoskeletal diagnosis causing significant and persistent disability;
     - **(ii)** Other conservative therapies have been tried and have failed to relieve the patients symptoms; and
     - **(iii)** Improvement is documented within the initial two weeks of chiropractic care.