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WELCOME TO SELECTHEALTH

We want to make it simpler and easier for you to understand and access your healthcare benefits. This document provides you with important information and guidelines about your coverage.

Please contact the following SelectHealth departments if you have any questions about your insurance coverage. We look forward to serving you.

Questions about your benefits or claims

Member Services .... 801-442-5038 (Salt Lake area) or 800-538-5038

Weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m.

Member Services can help you understand how your insurance plan works or provide foreign language assistance.

Help choosing a doctor

SelectHealth Member Advocates® .... 801-442-4993 (Salt Lake area) or 800-515-2220

Weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m.

Member Advocates can help you find a doctor, help schedule an appointment right away, or give you information about a certain provider.

Preventive care questions

Preventive care hotline .... 801-442-6492 (Salt Lake area) or 800-374-4949

Weekdays from 8:00 a.m. to 5:00 p.m.

Preventive care includes services that promote wellness and prevent disease.

Prenatal care questions

SelectHealth Healthy Beginnings® .... 801-442-5052 (Salt Lake area) or 866-442-5052

Weekdays from 8:00 a.m. to 5:00 p.m.

SelectHealth's prenatal program can help you have a healthy pregnancy and baby.

Mental health questions

Behavioral Health Advocates℠ .... 801-442-1989 (Salt Lake area) or 800-876-1989

Weekdays from 8:00 a.m. to 6:00 p.m.

Behavioral Health Advocates can help you with questions about mental health and substance abuse.

Appeals

Appeals department 801-442-4684

Weekdays from 8:00 a.m. to 5:00 p.m.

The Appeals department can help if you want to appeal a decision about a claim or if you feel SelectHealth has discriminated against you in any way.

On the Internet

MyHealth **........ www.selecthealth.org/myhealth**

My Health is your online source for personalized health and plan option information.

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UNDERSTANDING YOUR MEMBER PAYMENT SUMMARY (MPS)

The Member Payment Summary (MPS) contains information specific to your health insurance benefits. The sample shown below outlines important information found on the MPS. If the MPS does not include one or more of the following definitions, it does not apply to your plan.

01/01/2009

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MEMBER PAYMENT SUMMARY	PARTICIPATING (In-Network) When using participating providers, you are responsible to pay the amounts in this column.	NONPARTICIPATING (Out-of-Network) When using nonparticipating providers, you are responsible to pay the amounts in this column.
CONDITIONS AND LIMITATIONS		
Lifetime Maximum Plan Payment - *Per Person*	$2,500,000	
Pre-Existing Conditions (PEC)	None	
Benefit Accumulator Period	calendar year	
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET	**PARTICIPATING**	**NONPARTICIPATING**
Deductible - Per Person/Family (per calendar year)	$500/$1000	$1000/$2000
Out-of-Pocket Maximum - Per Person/Family (per calendar year)	$2000/$4000 (Deductible Included)	$4000/$8000 (Deductible Included)
INPATIENT SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Medical, Surgical, Hospice, and Emergency Admissions	20% after deductible	40% after deductible with precert
Maternity and Adoption [1]	20% after deductible	40% after deductible with precert
Skilled Nursing Facility - Up to 60 days per calendar year	20% after deductible	40% after deductible with precert
Inpatient Rehab Therapy: Physical, Speech, Occupational Up to 40 days per calendar year for all therapy types combined	20% after deductible	40% after deductible with precert
PROFESSIONAL SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP) [2]	$25	40% after deductible
Secondary Care Provider (SCP) [2]	$35	40% after deductible
Preventive Care		
Primary Care Provider (PCP) [2]	$25	Not Covered
Secondary Care Provider (SCP) [2]	$35	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Not Covered
Elective Immunizations [3]	20%	Not Covered
Diagnostic Tests: Minor [3]	Covered 100%	Not Covered
Allergy Tests	See Office Visits Above	Not Covered
Allergy Treatment and Serum	20%	Not Covered
Major Office Surgery *(Surgical and Endoscopic Services Over $350)*	20%	40% after deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after deductible	40% after deductible with precert
OUTPATIENT SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Outpatient Facility and Ambulatory Surgical - *(all related services)*	20% after deductible	40% after deductible with precert
Ambulance (Air or Ground) - *Emergencies Only*	20% after deductible	See Participating Benefit
Emergency Room - *(Participating facility) - Includes all services rendered in conjunction with the ER*	$100 after deductible	See Participating Benefit
Emergency Room - *(Nonparticipating facility) - Includes all services rendered in conjunction with the ER*	$150 after deductible	See Participating Benefit
Intermountain InstaCare[SM] Facilities, Urgent Care Facilities	$35	40% after deductible
Intermountain KidsCare[SM] Facilities	$25	40% after deductible
Chemotherapy, Radiation and Dialysis	20% after deductible	40% after deductible
Diagnostic Tests: Minor [3]	Covered 100%	40% after deductible
Diagnostic Tests: Major [3]	20% after deductible	40% after deductible
Home Health, Hospice, Outpatient Private Nurse	20% after deductible	40% after deductible with precert
Outpatient Rehab Therapy: Physical, Speech, Occupational *Up to 20 visits per calendar year for each therapy type*	$35 after deductible	40% after deductible

1 LIFETIME MAXIMUM

The total amount the plan pays for each covered family member in his or her lifetime.

2 PRE-EXISTING CONDITIONS (PEC)

A condition that is present during the six-month period before your plan enrollment date for which medical advice, diagnosis, care, or treatment was either received from or recommended by a provider. This section tells you if you have a waiting period before coverage starts for a PEC.

3 BENEFIT ACCUMULATOR PERIOD

Refer to this line to determine if your benefits apply to a calendar or plan year. Benefits are calculated on a yearly basis. For calendar year plans, the out-of-pocket maximums and limited benefits start over on January 1. For plan year plans, the out-of-pocket maximums and limited benefits start over on your group renewal date.

4 ANNUAL OUT-OF-NETWORK MAXIMUM

The maximum dollar amount that your health plan will pay per member per calendar year for services from nonparticipating providers covered as a nonparticipating benefit. Dollar amounts applied to this maximum are also applied to the lifetime maximum benefit limit.

5 MEDICAL DEDUCTIBLE

A set dollar amount that you must pay for yourself and/or family members before your health plan begins to pay for covered medical services.

6 MEDICAL OUT-OF-POCKET MAXIMUM

The maximum dollar amount that you and/or your family pays each year for covered medical services in the form of deductibles, copays, and coinsurance.

7 PHARMACY DEDUCTIBLE

A set dollar amount that you must pay for yourself and/or family members before your health plan begins to pay for covered prescription drugs.

8 MENTAL HEALTH DEDUCTIBLE

A set dollar amount that you must pay for yourself and/or family members before your health plan begins to pay for covered mental health and chemical dependency services.

9 MENTAL HEALTH OUT-OF-POCKET MAXIMUM

The maximum dollar amount that you and/or your family pays each year for covered mental health and chemical dependency services in the form of deductibles, copays, and coinsurance.

COPAY

The specific dollar amount that you pay directly to a provider when you receive covered services.

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	MEMBER PAYMENT SUMMARY	
	PARTICIPATING *(In-Network)*	**NONPARTICIPATING** *(Out-of-Network)*
MISCELLANEOUS SERVICES	PARTICIPATING	NONPARTICIPATING
Durable Medical Equipment (DME) [4] .... *(Max Plan Payment $1,500/ calendar year)*	20% after deductible	40% after deductible with precert
Infertility - *Selected Services* .... *(Max Plan Payment $1,500/ calendar year; $5,000 lifetime)*	*50% after deductible	Not Covered
Miscellaneous Medical Supplies (MMS)	20% after deductible	40% after deductible
BENEFIT RIDERS	PARTICIPATING	NONPARTICIPATING
Catastrophic Mental Health and Chemical Dependency *(combined benefits)*		
Mental Health Deductible - Per Person/Family - (per calendar year)	8 $500/$1000	N/A
Mental Health Out-of-Pocket Maximum - Per Person/Family - (per calendar year)	9 $2000/$4000	N/A
Mental Health Office Visits	$[illegible] mental health deductible	Not Covered
Inpatient	50% after mental health deductible	Not Covered
Outpatient	50% after mental health deductible	Not Covered
Injectable Drugs and Specialty Medications +	20% after deductible	40% after deductible with precert
Prescription Drugs - *Up to 30 Day Supply of Covered Medications* +		
Tier 1	7 *$15	
Tier 2	*$30	
Tier 3	*$50	
Maintenance Drug Benefit-90 Day Supply (Medco by Mail or Retail90SM)-*selected drugs* +		
Tier 1	*$15	
Tier 2	*$60	
Tier 3	*$150	
Generic Substitution Required	Generic required or must pay copay plus cost difference between name brand and generic	

1 SelectHealth provides an allowable adoption amount of $4,000 as outlined by the state of Utah. Medical deductible and copay/coinsurance applies.
2 Refer to your SelectHealth Provider & Facility Directory to identify whether a provider is a primary or secondary care provider.
3 Refer to your Membership Guide for more information.
4 DME is limited to the cost of the item(s) up to the annual DME maximum. Certain DME items are excluded from the annual DME maximum and require prior notification or precertification for coverage. Refer to your Membership Guide, or contact SelectHealth Member Services for additional information.
5 Precertification is required for all the following: inpatient services; maternity stays longer than two days for a normal delivery or longer than four days for a cesarean; home health nursing services; and pain management/pain clinic services. If you fail to precertify, benefits are reduced to 50 percent and will not be applied to your out-of-pocket maximum.
6 Dollar amount applied to the Maximum Annual Out-Of-Network Payment is also applied to the Lifetime Maximum Benefit.
+ Preauthorization is required on certain injectable and prescription drugs. If you fail to preauthorize, the drug will not be covered. Please refer to your membership guide for more information.
* Not applied to Medical out-of-pocket maximum.

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

Select Care Plus participating benefits are administered and underwritten by SelectHealth. Select Care Plus nonparticipating benefits are administered by SelectHealth and underwritten by SelectHealth Benefit Assurance Company.

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COINSURANCE

The percentage of eligible charges that you pay directly to a provider when you receive covered services.

NONPARTICIPATING

Nonparticipating benefits allow you the flexibility to use nonparticipating providers and facilities at a lesser benefit.

PARTICIPATING

Participating benefits apply when you receive covered services from participating providers.

	MEMBER PAYMENT SUMMARY
	PARTICIPATING *(In-Network)* When using participating providers, you are responsible to pay the amounts in this column. Services from nonparticipating providers are not covered (except emergencies).
CONDITIONS AND LIMITATIONS	
Lifetime Maximum Plan Payment - *Per Person*	$2,500,000
Pre-Existing Conditions (PEC)	None
Benefit Accumulator Period	calendar year
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET	**PARTICIPATING**
Deductible - Per Person/Family (per calendar year)	$100/$200
Out-of-Pocket Maximum - Per Person/Family (per calendar year)	$2000/$4000 (Deductible Included)
INPATIENT SERVICES	**PARTICIPATING**
Medical, Surgical, Hospice, and Emergency Admissions	10% after deductible
Maternity and Adoption [1]	10% after deductible
Skilled Nursing Facility - Up to 60 days per calendar year	10% after deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational Up to 40 days per calendar year for all therapy types combined	10% after deductible
PROFESSIONAL SERVICES	**PARTICIPATING**
Office Visits & Minor Office Surgeries	
Primary Care Provider (PCP) [2]	10% after deductible
Secondary Care Provider (SCP) [2]	10% after deductible
Preventive Care	
Primary Care Provider (PCP) [2]	Covered 100%
Secondary Care Provider (SCP) [2]	Covered 100%
Adult and Pediatric Immunizations	Covered 100%
Elective Immunizations [3]	10%
Diagnostic Tests: Minor [3]	Covered 100%
Allergy Tests	See Office Visits Above
Allergy Treatment and Serum	10% after deductible
Major Office Surgery *(Surgical and Endoscopic Services Over $350)*	10% after deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	10% after deductible
OUTPATIENT SERVICES	**PARTICIPATING**
Outpatient Facility and Ambulatory Surgical - *(all related services)*	10% after deductible
Ambulance (Air or Ground) - *Emergencies Only*	10% after deductible
Emergency Room - *(Participating facility) - Includes all services rendered in conjunction with the ER*	10% after deductible
Emergency Room - *(Nonparticipating facility) - Includes all services rendered in conjunction with the ER*	10% after deductible
Intermountain InstaCare℠ Facilities, Urgent Care Facilities	10% after deductible
Intermountain KidsCare℠ Facilities	10% after deductible
Chemotherapy, Radiation and Dialysis	10% after deductible
Diagnostic Tests: Minor [3]	Covered 100% after deductible
Diagnostic Tests: Major [3]	10% after deductible
Home Health, Hospice, Outpatient Private Nurse	10% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational *Up to 20 visits per calendar year for each therapy type*	10% after deductible

See other side for additional benefits

	MEMBER PAYMENT SUMMARY **PARTICIPATING** *(In-Network)*
MISCELLANEOUS SERVICES	**PARTICIPATING**
Durable Medical Equipment (DME) [4]	10% after deductible
(Max Plan Payment $1,500/ calendar year)	
Infertility - *Selected Services*	*50% after deductible
(Max Plan Payment $1,500/ calendar year; $5,000 lifetime)	
Miscellaneous Medical Supplies (MMS)	10% after deductible
BENEFIT RIDERS	**PARTICIPATING**
Catastrophic Mental Health and Chemical Dependency *(combined benefits)*	
Mental Health Deductible - Per Person/Family - (per calendar year)	$100/$200
Mental Health Out-of-Pocket Maximum - Per Person/Family - (per calendar year)	$2000/$4000
Mental Health Office Visits	10% after mental health deductible
Inpatient	10% after mental health deductible
Outpatient	10% after mental health deductible
Chiropractic - up to 20 visits per calendar year 1-800-678-9133	*$10
Injectable Drugs and Specialty Medications +	10% after deductible
Pharmacy Deductible - Per Person per calendar year	*$50
Prescription Drugs - *Up to 30 Day Supply of Covered Medications* +	
Tier 1	^*$10
Tier 2	^*$25
Tier 3	^*$45
Maintenance Drug Benefit-90 Day Supply (Medco by Mail or Retail90[SM])-*selected drugs* +	
Tier 1	^*$10
Tier 2	^*$50
Tier 3	^*$135
Generic Substitution Required	Generic required or must pay copay plus cost difference between name brand and generic

1 SelectHealth provides an allowable adoption amount of $4,000 as outlined by the state of Utah. Medical deductible and copay/coinsurance applies.
2 Refer to your SelectHealth Provider & Facility Directory to identify whether a provider is a primary or secondary care provider.
3 Refer to your Membership Guide for more information.
4 DME is limited to the cost of the item(s) up to the annual DME maximum. Certain DME items are excluded from the annual DME maximum and require prior notification for coverage. Refer to your Membership Guide, or contact SelectHealth Member Services for additional information.
+ Preauthorization is required on certain injectable and prescription drugs. If you fail to preauthorize, the drug will not be covered. Please refer to your membership guide for more information.
* Not applied to Medical out-of-pocket maximum.
^ After Pharmacy Deductible.

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

MEMBER ALERT – 2009 MEDICAL BENEFIT CHANGES

The information* below outlines the significant enhancements and clarifications made for 2009 plans.

Mental Health

SelectHealth's mental health network has been simplified. Members are no longer limited to the managed mental health network and gateway referrals are no longer required. Beginning January 1, 2009, all members will have access to SelectHealth's full mental health network. A complete list of participating providers will be available in the 2009 Provider Directory.

Durable Medical Equipment (DME)

The new DME benefit is designed to provide members with greater choice and enhanced coverage. Fewer items will require prenotification, making it easier for members to obtain necessary DME.

The DME benefit is limited to the cost of the item(s) up to the annual DME maximum of $1500 per member. The following DME items are not subject to the annual DME maximum and require prenotification/precertification for coverage:

- Insulin pumps and accessories
- Equipment used to provide oxygen and CPAP therapy and associated accessories
- Prosthetics
- Motorized/customized wheelchairs and associated accessories

Note: Prenotification requirements for the new DME benefit will be effective January 1, 2009. The annual maximum will be effective for new groups January 1 and upon renewal for existing groups.

Temporomandibular Joint (TMJ)/Orthognathic Surgery

Since January 2008, services for the evaluation, diagnosis, or treatment of the temporomandibular joint (TMJ) and temporomandibular disorders (TMD) have been covered at the benefit levels listed below. Beginning January 1, 2009, orthognathic surgery will also apply to this benefit.

- Participating benefits for in-network providers
- No coverage for out-of-network providers
- 50 percent coinsurance after the deductible
- Lifetime maximum plan payment of $3,000
- Coinsurance and deductible amounts do not apply to the out-of-pocket maximum
- When applicable, PEC exclusions apply
- Prenotification is required

Note: This change will take place upon renewal for existing groups.

** This is not a legal document and the information has been summarized.*

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USING YOUR MEDICAL BENEFITS

This document is a summary only; it is not a Contract. Refer to the Master Group Contract (available from your employer) for a more complete description of your benefits.

MEMBER IDENTIFICATION CARD

Each year you will receive an updated SelectHealth ID Card. You will be asked to present this card each time you receive care. This information allows your provider to bill SelectHealth correctly.

GET CONNECTED WITH MY HEALTH

Log in to My Health and connect to your wellness and benefit plan information.

- Coverage and Claims: View your plan coverage, claims, and amounts paid year-to-date
- Pharmacy: Access prescription drug history, price comparisons, copay calculations, and drug interaction information
- Decision Support: Make informed healthcare decisions with Plan Cost Compare, Hospital Compare, and Treatment Cost Estimator tools
- Insurance Education: Learn more about your options and how you can affect your overall healthcare costs
- Health and Wellness: Personalize your health profile and link to WebMD's suite of health management tools

Have your ID Card ready and get connected at www.selecthealth.org/myhealth.

PROVIDER & FACILITY DIRECTORY

Refer to the Provider & Facility Directory for a listing of providers and facilities that participate with SelectHealth. You can use the printed directory to identify whether a provider is a Primary Care Provider (PCP) or a Secondary Care Provider (SCP).

The network of participating providers and facilities occasionally changes. The most current information can be found on our Web site.

SELECTHEALTH MEMBER ADVOCATES®

Member Advocates is a service provided by a team of representatives who are available to give you information about available doctors.

Member Advocates offers the following services:

- Help choosing a doctor who is accepting new patients;
- Help getting an appointment for annual exams, immunizations, and checkups;
- Information about your doctor, such as where he or she went to medical school;
- Help getting an appointment to see a specialist; and
- Help getting an appointment for urgent care when your doctor is unavailable.

To contact Member Advocates, call 801-442-4993 (Salt Lake area) or 800-515-2220 weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m.

PARTICIPATING PROVIDERS AND FACILITIES

We encourage you to maintain a relationship with a participating provider who focuses on primary care services (Primary Care Provider). Primary Care Providers are doctors who specialize in family practice, internal medicine, pediatrics, or obstetrics/gynecology. They can meet your general medical and preventive care needs, as well as help you decide if you need to see a Secondary Care Provider (a specialist).

To get care from a participating Primary Care Provider, Secondary Care Provider, or any other participating provider or facility, simply refer to the Provider & Facility Directory, call the provider or facility you would like to use, and make an appointment. When you arrive at the participating provider's office, please present your ID Card.

NONPARTICIPATING PROVIDERS AND FACILITIES

SelectHealth will pay for covered services from nonparticipating providers and facilities in the following instances:

- For urgent conditions outside the service area;
- For emergencies; or
- When SelectHealth determines that required services cannot be provided by a participating provider. You must call Member Services if you need to see a provider who is not in the Provider & Facility Directory.

Nonparticipating providers and facilities may charge more than SelectHealth's fee schedule for covered services. If this is the case, you will be responsible to pay for any charges that exceed

the amount that SelectHealth pays for covered services. These excess charges do not apply to your out-of-pocket maximum.

COVERAGE OUTSIDE OF UTAH

Whenever possible, use a Beech Street provider or facility for emergencies and urgent condition services rendered outside of Utah to avoid being billed for excess charges. You will not be responsible for excess charges when you use a Beech Street provider or facility.

Present your SelectHealth ID Card when visiting a Beech Street provider or facility. Your card has the Beech Street logo on the back, giving you access to the network.

To find a Beech Street provider or facility, call 800-937-2277 or visit their Web site at www.beechstreet.com.

URGENT CARE

If you have an illness or injury that is not life threatening but needs medical attention within 24 hours, call a participating provider. If the provider is unavailable, then you can do any of the following:

- Call Member Advocates. They can help you get an immediate appointment with another doctor; or
- Go to an Intermountain InstaCareSM facility; or
- Call an Intermountain KidsCareSM facility to schedule a same-day appointment; or
- If you are outside of the service area and need urgent care, go to any doctor or hospital.

Urgent Care Within the Service Area

For urgent conditions, the service area is defined as 40 miles from a participating provider or facility.

If you are within SelectHealth's service area, participating benefits apply for urgent condition services rendered by a participating provider or facility.

If you are within SelectHealth's service area, urgent condition services will not be covered when rendered by a nonparticipating provider or facility.

Urgent Care Outside the Service Area

If you are outside SelectHealth's service area (more than 40 miles away from a participating provider or facility), participating benefits apply to services for urgent conditions rendered in any doctor's office or any urgent care facility. Refer to the Member Payment Summary for specific urgent condition benefit information.

EMERGENCY CARE

If you experience an emergency, call 911 or go to the nearest hospital. Using a participating emergency room will cost you less than using a nonparticipating emergency room. Refer to your ID Card or Member Payment Summary for specific benefit information.

Regardless of where you are when you need to go to an emergency room, your emergency room benefits consist of two levels:

Participating Emergency Rooms

Emergency room services in participating facilities cost significantly less than nonparticipating facilities. Therefore, you will pay a lower copay at a participating emergency room. We encourage you to use participating facilities listed in the Provider & Facility Directory whenever possible.

Nonparticipating Emergency Rooms

Nonparticipating emergency rooms do not contract with SelectHealth as participating providers. As a result, you will pay a higher copay. You will also pay the difference between the amount SelectHealth will pay for services at a participating emergency room and what the nonparticipating emergency room charges. Refer to the Member Payment Summary for specific emergency room benefit information.

If hospitalized for an emergency in a nonparticipating facility, you (or someone on your behalf) must contact Member Services within two working days or as soon as possible. Once the emergency condition has been stabilized, SelectHealth may request you to be transferred (at SelectHealth's expense) to a participating facility for the remainder of your care in order for you to receive participating benefits. If you choose to remain at the nonparticipating facility after the emergency condition has been stabilized, additional related claims will not be covered. Services listed in the "General Limitations and Exclusions" section will not be covered even if you call to precertify.

SelectHealth reserves the right to review all emergency claims to determine whether such claims satisfy the requirements for emergency services/emergency care as outlined in this document.

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

EMERGENCY TRANSPORTATION

Emergency transportation services are covered only for transportation to the nearest facility expected to have appropriate services for the treatment of the emergency, injury, or illness involved, or when you cannot safely be transported by other means.

Air ambulance transportation is covered when ground ambulance transportation is not available, or in the opinion of the responding medical professional, the delay would jeopardize patient safety.

SelectHealth must approve any requests for coverage of transportation services in nonemergency situations.

AFTER-HOURS CARE

If you need nonemergency care after hours, contact a participating provider first. Some doctors offer extended office hours. If your doctor is not available after hours and the situation requires immediate attention, please go to one of the facilities listed below.

Intermountain InstaCare Facilities

After-hours care is provided for patients of all ages.

Intermountain KidsCare Facilities

After-hours care is provided for babies, children, and teenagers.

Intermountain ExpressCare℠ Facilities

Extended hours offered for patients age two and older. Refer to your Provider & Facility Directory for the location nearest you.

CLAIMS AND APPEALS INFORMATION

Please refer to the “Claims and Appeals” section.

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ELIGIBILITY

This section outlines who is eligible for coverage. It also discusses what to do if you have a change in your coverage due to termination of employment, waiver of coverage, etc.

SUBSCRIBER ELIGIBILITY

You are eligible for subscriber (employee) coverage if you satisfy the eligibility criteria agreed upon between your employer and SelectHealth, including any applicable waiting period. Refer to the Master Group Contract (available from your employer) for more information about these criteria and subscriber eligibility.

DEFINITION OF DEPENDENT

Eligible dependents for you, the employee, include any of the following:

- Your lawful spouse, including a person who qualifies as a common law spouse at the time of enrollment. A person must be established as a common law spouse by a court of law or valid administrative order obtained prior to enrollment. A copy of the order must be provided to SelectHealth at the time of enrollment. A person will not be retroactively enrolled as a spouse as the result of a court or administrative order professing to establish a common law marriage. In cases of court or administrative orders purporting to retroactively either establish or annul/declare void a marriage or divorce, SelectHealth will enroll the subscriber's lawful spouse on the date the court or administrative order was signed by the court or administrative agency or the date the order is received by SelectHealth, whichever date is later. Eligibility may not be established retroactively (nunc pro tunc order); or
- An unmarried child who is under age 26 and who relies on the subscriber or the subscriber's lawful spouse for more than half of their support (according to Internal Revenue Code 1.152-1). This child must also be either:
- The natural or legally adopted child of you or your lawful spouse;
- A child placed for purposes of adoption with you or your lawful spouse. A child will be considered to be "placed" for purposes of adoption if you or your lawful spouse has assumed a legal obligation for total or partial support of the child in anticipation of adopting the child;
- A child placed under legal guardianship of you or your lawful spouse either under a testamentary appointment or court order; or
- A child for whom either the employee or spouse has a court-ordered obligation to provide healthcare coverage as a dependent (refer to "Court-Ordered Dependent Coverage" in this section).

The age limit does not apply to an unmarried child who is incapable of self-sustaining employment because of mental or physical impairment, who became impaired before reaching the limiting age, and who has been continuously enrolled in some form of healthcare coverage since the date the child turned 26. SelectHealth may require reasonable proof of incapacity and dependency at the time of enrollment and annually thereafter.

Refer to the Master Group Contract (available from your employer) for more information on extending eligibility for dependents who are age 26 and older.

Foster children, dependent parents, and any other relatives not included above are not eligible.

COURT-ORDERED DEPENDENT COVERAGE

When you or your lawful spouse are required by a court or administrative order to provide health coverage for a child, SelectHealth will enroll the child—also known as an "alternate recipient"—under your family coverage according to SelectHealth's guidelines and only to the minimum extent required by applicable law.

The following information explains types of court or administrative orders that can be issued.

Qualified Medical Child Support Order (QMCSO)

A QMCSO can be issued by a court of law or by a state or local child welfare agency. In order for the medical child support order to be qualified, the order must meet the requirements of ERISA section 609(a) (29 U.S.C. sec. 1169) specifying the following information:

- The name and last known mailing address (if any) of the covered employee and the name and mailing address of each alternate recipient covered by the order;
- A reasonable description of the type of coverage to be provided or the manner in which the coverage will be determined; and

- The period to which the order applies.

National Medical Support Notice (NMSN)

This notice is a type of a QMCSO that is issued by a state or local child welfare agency. It allows an employer to withhold income from an eligible employee in order to contribute required funds to health insurance for an alternate recipient.

Employer Responsibility

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

If SelectHealth confirms that the order is qualified, the effective date of coverage for the applicable alternate recipient(s) will begin the later of the following:

- The start date indicated in the order;
- Your satisfaction of any applicable waiting period; or
- The date the order is received by SelectHealth.

When SelectHealth receives an order for termination of court-ordered dependent coverage, coverage will terminate the end of month in which SelectHealth receives the court order.

ENROLLMENT

Subject to certain exceptions described below, in order to be covered by SelectHealth under your employer's plan, you and your eligible dependents must enroll within 31 days of becoming eligible for coverage. If you meet eligibility criteria as outlined in the Master Group Contract, you enroll yourself and any desired dependents by completing and signing an enrollment form provided by your employer.

IF YOU WAIVE COVERAGE

If you do not enroll when initially eligible, you and your dependents may not enroll in SelectHealth coverage under your employer's plan until the next open enrollment period established by your employer and SelectHealth. There are exceptions for special enrollment rights as described below.

SPECIAL ENROLLMENT RIGHTS

SelectHealth provides special enrollment rights in the following three circumstances:

1) LOSS OF OTHER COVERAGE

If you and/or your dependents are eligible for but not enrolled in this coverage, you may enroll in coverage at a time other than open enrollment if each of the following conditions is met:

- You initially declined to enroll in this coverage due to the existence of other health plan coverage;
- You stated in writing at the time on the initial Enrollment Form that you declined to enroll in this coverage due to the existence of the other health plan coverage;
- The loss of other health plan coverage was involuntary. (This special enrollment right will not apply if you lose the other coverage due to nonpayment of premiums or misconduct.)
- Note: For members of a large employer health plan (51 or more eligible employees), if your eligible dependents voluntarily drop their coverage under another large employer health plan during that group's open enrollment, a special enrollment period will be permitted for your eligible dependents in order to avoid a gap in coverage.
- You and/or your dependents who lost the other coverage must enroll in this coverage within 31 days after the date the other coverage was lost; and
- Proof of loss of the other coverage (Certificate of Creditable Coverage) is submitted to SelectHealth as soon as reasonably possible.

In the absence of a Certificate of Creditable Coverage, SelectHealth will accept the following:

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

Coverage of any members properly enrolled under this special enrollment right will be effective on the date the other coverage was lost.

Proof of loss of coverage must be submitted to SelectHealth as soon as reasonably possible. Proof of loss of coverage must be submitted before any benefits will be paid on applicable members.

2) NEW DEPENDENTS

You may enroll new dependents in coverage if each of the following conditions is met:

- You are enrolled in this coverage (or are eligible to be covered but declined to enroll during a previous enrollment period); and
- You gain a dependent through marriage, birth, adoption, or placement for adoption. In these cases, you may enroll the dependent and yourself, if you are not otherwise enrolled, under this coverage. In the case of birth or 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 31 days of the marriage, birth, adoption, or placement for adoption. (There is an exception for enrolling a newborn or adopted child if enrolling the child does not change the premium as explained in the "Newborns, Adopted Children, and Children Placed for Adoption" section.)

Coverage of any members properly enrolled under this special enrollment right will be effective as indicated as the result of the following situations:

- Marriage - as of the date of the marriage;
- A dependent's birth - as of the date of the birth;
- A dependent's placement for adoption - if the child is LESS than 31-days-old as of the date of the placement for adoption coverage will begin on the date of birth. If the child is MORE than 31-days-old when placed for adoption, coverage will begin on the child's date of placement.

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

Annulment of a Dependent Child's Marriage

You may enroll as an eligible dependent a financially dependent child of yourself or your lawful spouse who is under age 26 and who becomes financially dependent as the result of a divorce or an annulment of the child's marriage. You must enroll any such children within 31 days after the signing by the court of the order granting the annulment or must wait until the next annual open enrollment period. Coverage for any children properly enrolled under this special enrollment right will be effective on the effective date of the annulment if that date is within six months of date of marriage. If the court signs the order granting the annulment more than six 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.

Legal Guardianship

The unmarried, financially dependent children (placed under the legal guardianship through testamentary appointment or court order) of you or your lawful spouse who are under age 26 may enroll as eligible dependents. You must enroll any such children within 31 days of receiving their legal guardianship. However, the effective date for coverage will be the later of either of the following:

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

Note: A child is not eligible to be added as a dependent as the result of a law that provides guardianship for school residency purposes. A child is not eligible to be added as an eligible dependent when the subscriber or the subscriber's spouse is designated as the child's temporary guardian.

3) NEWBORNS, ADOPTED CHILDREN, AND CHILDREN PLACED FOR ADOPTION

Enrollment Process for Newborns, Adopted Children, and Children Placed for Adoption

Claims for services for a newborn or a child placed for adoption will be denied until the child is properly enrolled. A newborn, adopted child, or child placed for adoption must be enrolled within the time frames listed below:

- If enrolling such child requires additional premium, you must enroll the newborn or adopted child within 31 days of the child's birth or placement for adoption;
- If enrolling such child does not change the premium, you must enroll the newborn or adopted child within 31 days from the date SelectHealth mails notification that a claim for services was received for the child. Such a claim will not be processed until the child is properly enrolled.

If the newborn, adopted child, or child placed for adoption is not enrolled within the applicable time frame, the child may only be enrolled during your employer's next annual open enrollment period.

If you lose eligibility for coverage before the end of the applicable time frame, you are still allowed to enroll the newborn or adopted child within that time frame. However, the child will only be covered from the moment of birth, adoption, or placement for adoption until the date that you lost eligibility for coverage.

LOSS OF ELIGIBILITY

Coverage for you under the Master Group Contract may be canceled, reformed, or rescinded by SelectHealth during the two-year period after you enroll or elect to continue coverage with SelectHealth. This is based on medical or other enrollment or eligibility information received that was fraudulent or an intentional material misrepresentation of material fact in connection with the coverage. Coverage for your dependents will also be canceled, reformed, or rescinded. PLEASE NOTE: If your coverage is rescinded as described in this section, the termination of coverage will relate back to the effective date of coverage. SelectHealth will return the premium paid by your employer to your employer minus an administrative fee. The amounts paid on all claims will also be recovered up to the time limits allowed by state and federal law. Therefore, both SelectHealth and you are returned to a financial position as if no coverage had ever been in force. SelectHealth may initiate this action in the event that there is fraud or intentional material misrepresentation of material fact in connection with the coverage.

FAMILY MEDICAL LEAVE ACT

You may or may not be eligible to take leave under the Family Medical Leave Act. It is your employer's responsibility to notify you of the terms and conditions for continuing coverage under the Family Medical Leave Act. SelectHealth will administer coverage for a subscriber on leave under the Family Medical Leave Act as follows:

- You, the employee, may with any enrolled dependents, continue to be covered by SelectHealth if your employer continues to pay the premium to SelectHealth;
- If your employer does not pay the premiums during your leave, coverage will be terminated. Upon your return to work, coverage for you and any previously enrolled dependents that are still eligible will be prospectively reinstated if the applicable premium is paid by your employer within 30 days of your return. SelectHealth will not be responsible for any claims incurred during this break in coverage;
- If premiums are not paid and coverage is terminated, you along with any previously enrolled dependents may be retroactively reinstated with no loss in coverage if all back premiums are paid within 30 days of your return to work.

Remember, it is up to you and your employer to decide if your premiums will continue to be paid during your leave under the Family Medical Leave Act.

Your employer should notify SelectHealth if a leave of absence is taken. A leave of absence is defined as any time an employee no longer works sufficient hours (once vacation and sick leave are exhausted) to meet the eligibility criteria as outlined in the Master Group Contract.

CHANGES IN COVERAGE

This section describes what you should do if you experience changes in coverage.

INFORM SELECTHEALTH IF YOU HAVE CHANGES

You and your dependents are required to notify SelectHealth through your employer within 31 days whenever there is a change in your situation or your dependent's situation that may affect your eligibility or their eligibility or enrollment. This entitles you or them to continuation coverage, or alters the duration of an existing period of continuation coverage (refer to the "Continuation and Conversion Coverage" section for more details), including, but not limited to, the following events:

- Adoption of a child, placement of a child for adoption, birth of a child, or gaining legal guardianship of a child
- Child loses dependent status (for example, marriage, turning age 26, or is no longer financially dependent)
- Death
- Divorce
- Marriage
- Involuntary loss of other coverage
- Being called to active military duty
- Receiving a Qualified Medical Child Support Order (QMCSO)
- You or your dependents obtain other health coverage

The occurrence of one of these events does not necessarily allow you to change your coverage elections. Some of these events—those related to gaining a new dependent or the loss of other coverage—may give rise to a Special Enrollment Right (refer to the "Special Enrollment Rights" subsection in the "Eligibility" section for further details). Others may require you or your dependent(s) to be terminated from coverage.

Note: If you or your dependents fail to notify SelectHealth through your employer within 31 days of an event that results in the loss of eligibility, SelectHealth may recover the amount of any benefits the member(s) received after losing eligibility. Both you and any applicable dependent(s) are responsible to promptly pay SelectHealth, upon request, the actual expenses incurred by SelectHealth for the services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment received by the member during the period between when the member lost eligibility and SelectHealth was properly notified. Failure to properly notify SelectHealth of one of the events listed above may also result in the forfeiture of continuation coverage.

Change Forms are available from your employer or at www.selecthealth.org. Change Forms must be submitted through your employer to notify SelectHealth of changes such as your name and/or marital status and to add or delete a dependent on your coverage. (Refer to the "Eligibility" section for guidelines on adding new dependents.)

Changes Regarding Dependents

You must notify SelectHealth through your employer within 31 days to remove a dependent from coverage when any of the following apply:

- The dependent turns age 26;
- The dependent marries; or
- The dependent is no longer financially dependent.

If your dependent needs to extend coverage, refer to the "Continuation and Conversion of Coverage" section for more information.

If you fail to remove an ineligible dependent from coverage, you will be responsible to reimburse the actual claims payments made by SelectHealth for any services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment received by the ineligible dependent after the loss of eligibility.

Changes Regarding a Spouse

A covered spouse may be removed from coverage in the following situations:

- During your employer's next annual open enrollment period;
- The occurrence of a divorce or annulment (when proof of legal divorce or annulment is presented to SelectHealth). If you are making a change because of a divorce, you must attach a copy of the divorce decree with the Change Form. The first page of the divorce decree, the signature page, and any other portion(s) of the decree that specifies responsibility for dependent coverage should be included with the Change Form; or
- Mutual consent given by the spouse by signing the Change Form if such is allowed by your employer's eligibility rules.

If you wish, you may discontinue your medical benefits with SelectHealth by submitting a Change Form. However, you may be required to stay with your current coverage until your

employer's next annual open enrollment period. See your employer to find out if this requirement applies to you.

If you wish, you may discontinue medical benefits for your spouse or other dependent if he or she is incarcerated in a prison, jail, or other correctional facility as the result of a criminal conviction. If a spouse or other dependent is incarcerated in a prison, jail, or other correctional facility, the incarcerated person may not be added as a dependent.

IF YOU OBTAIN OTHER HEALTHCARE COVERAGE

If you obtain other coverage, you must notify SelectHealth. When you call, a SelectHealth Member Services representative will need the following information from you:

- Name of the insured;
- Name, phone number, and policy number of the other insurance carrier; and
- Name of the policyholder.

CHANGES IN BENEFITS OR SERVICES

Should any changes be made in the benefits or services offered through SelectHealth, you will be notified of such changes through your employer. It will be your responsibility to notify your dependents of any such changes.

TERMINATION OF COVERAGE

SelectHealth may terminate coverage either individually or upon termination of your employer's Master Group Contract. Conditions under which termination of your coverage may be initiated include the following:

- Your failure to meet eligibility requirements;
- If any member allows a person who is not covered by their ID Card to use their card, the card will be revoked and all rights of the member will end. If a member uses an ID Card to receive services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment that he or she is not eligible for, then that person will be responsible to pay for those services;
- In connection with SelectHealth's termination of your employer's group coverage;
- Your repeated failure to make any required payroll deduction; or
- You no longer live, work, or reside in SelectHealth's service area.

SelectHealth will give appropriate written notice if your individual coverage is terminated for these reasons.

Retroactive Termination of a Member

If SelectHealth discovers that a member has been enrolled when no longer eligible under the Master Group Contract guidelines, SelectHealth may terminate the member retroactively back to the date the member was no longer eligible.

No Coverage after Loss of Eligibility

SelectHealth is never responsible for healthcare claims incurred after a member's loss of eligibility, even if SelectHealth is properly notified of the loss.

TERMINATION OF A PARTICIPATING PROVIDER OR CERTIFIED NURSE-MIDWIFE/CONTINUITY OF CARE

If a participating provider or certified nurse-midwife who recently treated you ceases to participate with SelectHealth, SelectHealth will notify you 30 days prior to the termination date.

If the participating provider or certified nurse-midwife ceases to participate with SelectHealth while you are under their care, SelectHealth will continue to arrange for services until the completion of the care (not to exceed 90 days) or until you are transferred to another participating provider or certified nurse-midwife, whichever occurs first. However, if you are receiving maternity care in the second or third trimester, you may continue such care through the first postpartum visit.

To continue care, the participating provider or certified nurse-midwife must not have been terminated by SelectHealth for quality reasons, must remain in the service area, and agree to all of the following:

- Accept SelectHealth's fee schedule as payment in full;
- Follow SelectHealth's Utilization Management policies and procedures;
- Continue treating you; and
- Share information with SelectHealth regarding your treatment plan.

TERMINATION OF ANY PARTICIPATING FACILITY

Should a participating facility cease to participate with SelectHealth, you will be notified by SelectHealth at least 30 days prior to the change or as soon as SelectHealth becomes aware of such a change.

CONTINUATION AND CONVERSION COVERAGE

Under certain conditions, you or your enrolled dependents may be able to continue group coverage. The following information explains continuation coverage generally, when it may become available to you and your family, and what you need to do to protect the right to receive it. For additional information about your rights and obligations under your employer's plan and under federal law, contact your employer.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT

Federal continuation coverage, known as "COBRA," may be available to you if you are employed by an employer group with 20 or more employees. Under federal law, it is your employer's—not SelectHealth's—obligation to provide COBRA continuation coverage. SelectHealth will assist your employer in providing this coverage, but only in the following instances:

- In accordance with the provisions of the Master Group Contract (available from your employer); and
- To the minimum extent required by applicable law.

COBRA continuation coverage may be available to you and/or your eligible dependents if your group coverage would otherwise end due to one of the following "qualifying events":

- Termination of your employment for any reason except gross misconduct; or
- A reduction in your hours; or
- Your death; or
- Your divorce or legal separation; or
- You become entitled to Medicare; or
- Your covered dependent child's loss of eligibility for coverage. Coverage may continue for that dependent.

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

NOTIFICATION REQUIREMENTS

Under the law, you or your applicable dependents have the responsibility to inform the plan administrator or its designated COBRA administrator in writing within 60 days of a divorce or legal separation or of a child losing dependent status under this coverage. Failure to provide this notification within 60 days will result in the loss of COBRA continuation coverage rights.

Your employer has the responsibility to notify the plan administrator or its designated COBRA 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 a qualifying event, the plan administrator or its designated COBRA administrator will promptly notify you and other qualifying individual(s) of your COBRA continuation coverage rights. You and any applicable dependents must elect COBRA continuation coverage within 60 days after your coverage would otherwise end, or, if later, within 60 days of the notice of COBRA continuation coverage rights. Failure to elect COBRA continuation coverage within this 60-day period will result in the loss of COBRA continuation coverage rights.

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 member 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 COBRA continuation coverage, COBRA continuation coverage for the qualifying member and any non-disabled dependents who are also entitled to COBRA continuation coverage may be extended to 29 months. The qualifying member or dependent, if applicable, must notify the plan administrator or its designated COBRA administrator during the original 18-month COBRA 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 member 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 member'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.

COST OF COBRA CONTINUATION COVERAGE

The cost of COBRA continuation coverage is determined by the employer and paid by the qualifying member to the employer. This cost cannot exceed 102 percent of premium for providing coverage to a similarly situated member to whom a qualifying event has not occurred or, during a period of extended COBRA continuation coverage due to a disability, 150 percent of the premium for providing coverage to a similarly situated member to whom a qualifying event has not occurred. Premium payments for COBRA continuation coverage for you or your dependent's "initial premium month(s)" are due by the 45th day after electing COBRA continuation coverage. The "initial premium month(s)" are any month that ends on or before the 45th day after you or the qualifying member elects COBRA continuation coverage. All other premiums are due on the first of the month for which coverage is sought, subject to a 30-day grace period. The cost of COBRA 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 31 days of the established due date will result in the permanent cancellation of COBRA continuation coverage.

WHEN COBRA CONTINUATION COVERAGE ENDS

COBRA continuation coverage ends on the earliest of any of the following:

- The date the maximum continuation coverage period expires; or
- The date your employer no longer offers any group health plan to its employees; or
- The first day for which timely payment is not made to SelectHealth; or
- The date on which the qualifying member first becomes, after the date of election, covered under another group health plan (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the qualifying member have been exhausted or satisfied); or
- The date the qualifying member becomes entitled to Medicare benefits (Part A, Part B, or both) after electing COBRA; or
- The last day of the month during which the qualifying member, who was entitled to a 29-month maximum continuation period, is subject to a final determination that he or she is no longer disabled under the Social Security Act.

CONVERSION OF COVERAGE

Under certain conditions, if you are no longer eligible for group coverage or continuation coverage, you may be eligible to obtain conversion coverage. If eligible, you must apply for conversion coverage within 60 days from the termination date of your group coverage or continuation coverage. Refer to the Master Group Contract (available from your employer) for details regarding conversion coverage.

Preventive Care Guidelines

CHILD & ADOLESCENT CARE

Birth to Age 17
Start a medical record history.
Check on the progress of your child's physical development.
Get physical exams
Check speech, social, and motor skills, as well as eyesight and metabolism
Get immunizations and other important shots
Learn more about nutrition, safety, and any special needs
Screen children for exposure to lead

Well-child visits
Take your child in for regular visits with the doctor at the following ages: Birth; 2 to 4 days; 2 to 4 weeks; 2, 4, and 6 months; 9, 12, 15 and 18 months; ages 2 to 6, 8, and 10; once a year from ages 11 to 18.

ADULT CARE

Ages 18 to 39	Ages 40 to 49	Ages 50 to 65
Height and weight: Yearly	Height and weight: Yearly	Height and weight: Yearly
Blood pressure: Every 2 years	Blood pressure: Every 2 years	Blood pressure: Every 2 years
Cholesterol: Every 5 years	Cholesterol: Every 5 years	Cholesterol: Every 5 years
Pap test: Yearly to age 30. After age 30, every 3 years after 3 normal exams	Colon screen: As advised by doctor	Colon screen: As advised by doctor
Mammogram: As advised by doctor	Pap test: Every 3 years after 3 normal exams	Pap test: Yearly
Chlamydia test: Yearly, ages 18 to 24	Mammogram: Yearly	Mammogram: Yearly
	Chlamydia test: As advised by doctor	Chlamydia test: As advised by doctor
	Prostate exam: Yearly	Prostate exam: As advised by doctor

IMMUNIZATIONS

Child Immunizations	Adolescent Immunizations
Diphtheria, tetanus, acellular pertussis (DTaP)	Hepatitis B
Haemophilus influenzae type b (Hib)	Human Papilloma Virus (HPV)
Hepatitis A	Measles, mumps, rubella (MMR)
Hepatitis B	Meningococcal
Influenza	Tetanus, diphtheria, and acellular pertussis (Tdap) booster
Measles, mumps, rubella (MMR)	Any immunizations not previously given
Polio	**Adult Immunizations**
Pneumococcal	Tetanus booster
Rotavirus	Human Papilloma Virus (HPV)
Varicella (chicken pox)	Influenza
	Pneumococcal

ADDITIONAL PREVENTIVE CARE TESTS

People with special risk factors may need more preventive care.

Risk Factors	Preventive Services
Diabetes	Eye and foot exams, urine and blood tests
Drug abuse/alcoholism	AIDS and TB tests, hepatitis and influenza immunizations
Overweight	Blood sugar test
Homeless, recent refugee, or immigrant	TB test
High-risk sexual behavior	AIDS test, syphilis test, gonorrhea test, chlamydia test

For more detailed information on preventive care, call **801-442-6492** (Salt Lake area) or **800-374-4949**, visit **www.selecthealth.org**, or consult your doctor.

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SELECTHEALTH WELLNESS

The SelectHealth wellness program is designed to help prevent unnecessary health problems and manage existing chronic conditions. We provide a number of resources ranging from discounts at local fitness centers to smoking cessation programs.

DISCOUNTS

We know you are more likely to embrace a healthy lifestyle when it costs less. The following table outlines discounts we offer to members through partnerships with numerous vendors:

To receive the discounts mentioned above, simply present your ID Card. For more detailed information about these discounts or to find participating locations, visit selecthealth.org/discounts.

Eyewear	Up to 35 percent off
LASIK Eye Surgery	Up to 10 percent off
Spas and Fitness Centers	Varied discounts
Vitamins and Nutritional Supplements	Up to 40 percent off
Chiropractic Services, Massage Therapy, Acupuncture Services	Up to 25 percent off
Hearing Aids	Up to 15 percent off
Drug education materials	Up to $80 off

DISEASE MANAGEMENT

Helping you maintain a healthy life is a top priority. We're especially concerned about members with chronic health conditions. With our disease management program, you have access to a care management nurse, educational classes, and newsletters mailed to your home. We want you to know you're not alone. The program covers the following areas:

- Allergies and Rhinitis
- Asthma
- Cancer
- Cholesterol
- Congestive Heart Failure
- Depression
- Diabetes
- Hepatitis C
- Hypertension
- High-risk Pregnancy
- Migraines

SELECTHEALTH HEALTHY BEGINNINGS®

Pregnancy is a special time. Our prenatal program provides support and resources for expectant mothers. The program includes a risk assessment screening and provides case management, as well as pregnancy education materials.

SMOKING CESSATION PROGRAM

Quitting smoking is one of the most significant things a person can do to improve overall health, and we offer a program to help you quit. Free & Clear® allows you to progress at your own pace from home. A counselor is available to talk with participants over the phone.

WORKSITE PROGRAMS

Keeping you healthy can improve your workplace productivity. Our programs, including Catch A Flight℠, Walk-A-Day℠, Walking Trails℠, Summer Slim Down℠, Holiday Weigh InSM, Weigh to Health®, and Get Fit℠, help members incorporate health awareness into their daily work routine. For more information, call our Health and Wellness department at 801-442-6759.

ADDITIONAL WELLNESS RESOURCES

We want you to have important health information at your fingertips. We provide online education centers, health newsletters, a health topic calendar, and several other resources. To access these materials, visit selecthealth.org.

Note: These benefits and services may not be available to all employer groups or regions. To confirm your benefits, call your human resource/benefit representative.

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COORDINATION OF BENEFITS

SelectHealth is committed to providing high-quality healthcare and service. As part of that service, we want to inform you about a process referred to as Coordination of Benefits or COB.

Coordination of Benefits is a process used when you have coverage with more than one insurance carrier. The purpose of coordinating benefits is to avoid duplication of insurance payments. It involves determining which insurer is required to pay benefits as the primary payer, which insurer pays as the secondary payer, and so on until all insurers are considered in the correct payment order.

If you have or obtain other healthcare coverage in addition to SelectHealth, please provide us with the following information:

- The name of the other health insurance company
- The policy number and policyholder information
- The family member(s) covered under this plan, date(s) of birth, and effective date(s)

If you have or obtain other healthcare coverage in addition to SelectHealth as the result of a divorce, please provide us with the following information:

- A copy of the first page of the divorce decree
- A copy of the section that shows who is responsible for dependent children's medical/health coverage
- A copy of the section, if any, of the decree that assigns custody
- A copy of the signature page

USING PARTICIPATING PROVIDERS

When SelectHealth is secondary to another health plan, we will coordinate benefits at your SelectHealth participating benefit level when you follow your primary insurance plan's guidelines, even if the provider is not participating with SelectHealth. If you have questions, please refer to the Master Group Contract (available from your employer) or contact Member Services.

NON-DUPLICATION OF COVERAGE

Coverage will be reduced or denied for any accident, disease, condition, treatment, service, care, or procedure which is or would have been covered if you had enrolled and maintained coverage in any one or more of the following:

Automobile Insurance

Utah and other states have laws that require motorists to carry automobile insurance that includes medical and pharmacy claims' payment for bodily injuries sustained in an accident. If a member does not carry the minimum automobile insurance where it is required by law, SelectHealth will deny related medical and pharmacy expenses up to the amount of coverage required by the state. The member will be responsible for the denied amount.

If you do have the minimum automobile insurance required, once the automobile insurance pays the maximum benefit on injuries, you will need to send SelectHealth a Personal Injury Protection (PIP) roster or denial from your automobile insurance. The PIP roster includes a list of providers, amounts, and dates of service(s) that were paid by the automobile insurance. The PIP roster allows SelectHealth to coordinate benefits appropriately.

Workers Compensation Fund

If a member is injured at work, the industrial carrier or workers' compensation may be liable. The Workers Compensation Fund does not cover injuries sustained while the employee was going to or leaving work. It is only effective while the member is duly engaged in work activities.

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MISCELLANEOUS INFORMATION

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, SelectHealth or issuer may pay for a shorter stay if the attending provider (e.g., your doctor, certified nurse-midwife), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, a plan or issuer may not under federal law require that a doctor or other healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain doctors or facilities or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

In accordance with the Women's Health and Cancer Rights Act (WHCRA), SelectHealth covers mastectomies for the treatment of breast cancer and reconstructive surgery after a mastectomy for the treatment of breast cancer. If you are receiving benefits in connection with a mastectomy, coverage will be provided according to SelectHealth's Utilization Management criteria and in a manner determined in consultation with the attending doctor and the patient for the following services:

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

Under WHCRA, coverage of mastectomies and breast reconstruction benefits are subject to deductible, copay, and coinsurance limitations consistent with those established for other benefits. Following the initial reconstruction, any additional modification or revision is covered only to the extent that it is not otherwise limited or not covered by this agreement. Refer, for example, to the "Corrective, Reconstructive, and Cosmetic Procedures" subsection of the "General Limitations and Exclusions" section of this document. Revisions requested as the result of the normal aging process are not covered under this exclusion.

UTILIZATION REVIEW AND PROCEDURES

SelectHealth's Utilization Management (UM), Case Management, and Quality Improvement departments work in concert with doctors to determine the best way to provide you with quality care and services. These departments help to reduce some of the medical burdens you might otherwise face.

Utilization Management and Case Management

The SelectHealth Utilization Management and Case Management departments were formed to help fulfill SelectHealth's vision for quality services at affordable prices. The teams in these departments are a resource for members with certain serious or chronic medical needs, such as spinal cord injuries, diabetes, asthma, or premature birth. They can help you get the care you need, while monitoring the quality of care given in Intermountain facilities. The UM and Case Management departments work closely with you and your family members, healthcare providers, and community resources to arrange for appropriate care in cost-effective, high-quality settings.

UM makes sure the services you receive match your medical condition. SelectHealth does not pay employees or doctors for the type of decisions they make. SelectHealth does not tell employees or doctors to deny care when the care is needed.

Quality Improvement

The Quality Improvement department measures and monitors medical services at facilities and clinics to make sure you are getting high-quality care. They also work hard to improve access to preventive care and health screenings.

Evaluation of Emerging Healthcare Technologies

One of SelectHealth's most important and difficult tasks is to make decisions about which medical technologies (i.e., procedures, devices, drugs, and biologics) to cover. SelectHealth regularly reviews and determines the effectiveness of new and existing medical technologies based on evidence and outcomes documented in medical literature.

Subrogation/Restitution

As a condition of receiving health benefits from SelectHealth, the member agrees that SelectHealth is automatically subrogated to, and has a right to receive equitable restitution from, any right of recovery that a member may have against any third party as the result of an accident, illness, injury, or other condition involving the third party that causes a member to obtain covered services of any type paid for or provided by SelectHealth. To the extent of all payments, costs, and expenses paid by SelectHealth, or payable in the future by SelectHealth, because of any such accident, illness, injury, or other condition, SelectHealth is entitled to receive as equitable restitution the proceeds of any judgment, settlement, or other payment paid or payable in satisfaction of any such claim or potential claim that a member has or could assert against the third party. Any funds recovered by a member (or member's agent or attorney) by way of settlement, judgment, or other award from a third party or from a member's own insurance due to an accident, illness, injury, or other condition involving a third party will be held by a member (or a member's agent or attorney) in a constructive trust for the benefit of SelectHealth until its equitable restitution interest has been satisfied. SelectHealth has the right to intervene in any lawsuit, threatened lawsuit, or settlement negotiation involving a third party for purposes of asserting and collecting SelectHealth's equitable restitution interest. SelectHealth has the right to bring a lawsuit against or assert a counterclaim or cross-claim against a member or a member's agent or attorney for purposes of collecting equitable restitution interest or to enforce the constructive trust.
Except for proceeds obtained from uninsured or underinsured motorist coverage, this contractual right of subrogation/restitution applies whether or not a member believes that he or she has 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).

Members are required to do the following:

- Promptly notify SelectHealth of all possible subrogation/restitution situations;
- Help SelectHealth or SelectHealth's designated agent to assert its subrogation/restitution interest;
- Not take any action that prejudices SelectHealth's right of subrogation/restitution, including settling a dispute with a third party without protecting SelectHealth's subrogation/restitution interest;
- Sign any papers required to enable SelectHealth to assert its subrogation/restitution interest;
- Grant to SelectHealth a first priority lien against the proceeds of any settlement, verdict, or other amounts received by the member; and
- Assign to SelectHealth any benefits the member may have under any other coverage, to the extent of SelectHealth's claim for restitution.

SelectHealth's right of subrogation/restitution exists to the full extent of any payments made, services provided, or expenses incurred on behalf of a member because of or reasonably related to the situation involving the third party. A member or a member's personal representative will be personally liable for the equitable restitution amount to the extent that SelectHealth does not recover that amount through the process described previously.

In addition to SelectHealth's subrogation/restitution right described in this part, if a member fails to fully cooperate with SelectHealth or SelectHealth's designated agent in asserting its subrogation/restitution right, then limited to the compensation received by the member for the member (or member's agent or attorney) from a third party, SelectHealth may reduce or deny coverage and offset against any future claims including, but not limited to, claims arising from the accident, illness, injury, or other condition involving the third party and any complications or extended or follow-up care or treatment. Further, SelectHealth may compromise with a member on any issue involving subrogation/restitution in a way that includes surrendering the right to receive further care or services for the illness, injury, or other condition from which the subrogation/restitution claim arose.

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

DEFINITIONS OF TERMS

This section includes definitions for commonly referenced terms found in the Membership Guide.

Adoption

Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation.

Accidental Injury

A bodily injury resulting from an unforeseen, unexpected event independent of disease, bodily infirmity, or any other cause. An injury resulting from normal body movement, such as stooping bending, twisting, lifting, or chewing is not an accidental injury under the Master Group Contract.

Activities of Daily Living

Activities of daily living include eating, personal hygiene, dressing, and activities that prepare an individual to participate in work or other usual activities. In the case of students, these activities or such prepare he or she for normal classroom or study activities. Activities of daily living do not include school-related, recreational, or professional sporting activities.

Covered Services

Those services, supplies, tests, treatment, appliances, drugs, devices, medications, procedures, or equipment for the treatment and diagnosis of conditions for which benefits apply. Covered services include services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, and equipment for which no payment is actually made by SelectHealth because of the application of deductible, copay, or coinsurance requirements.

Diagnostic Test, Major

A test is classified as major diagnostic based on several different considerations, including, but not limited to, the invasiveness and complexity of performing the test, the level of expertise required to interpret or perform the test, and the place of service where the test is commonly performed. Major diagnostic tests include, but are not limited to, imaging studies such as MRIs, CT scans, and PET scans; neurologic studies such as EMGs and nerve conduction studies; cardiovascular procedures such as coronary angiograms; gastrointestinal procedures such as EGDs, and ERCPs; and gene-base testing and genetic testing.

Tests involving new technologies will be categorized as major if they are similar to these tests in terms of invasiveness, complexity, level of expertise required, or place of service.

Diagnostic Test, Minor

Tests that do not meet the definition of major diagnostic are considered minor diagnostic tests. Examples of common minor diagnostic tests include routine blood and urine tests, simple X-rays such as chest and long bone X-rays, some EKGs, and echocardiograms.

Eligible Charges, Fee Schedule for Providers and Facilities

The maximum dollar amount allowed by SelectHealth for covered services rendered by providers and facilities. Deductibles and coinsurance amounts are calculated based on eligible charges and not billed charges. Participating providers and facilities accept this allowed amount as payment in full for covered services. Nonparticipating providers and facilities may not accept this amount as payment in full for covered services. (Refer to the "Excess Charges" definition.) Members are required to pay a share of eligible charges as copays, coinsurance, and/or deductibles when otherwise applicable.

Emergency Care

Emergency care is covered services that are provided for a condition of recent onset and sufficient severity. Some of these include, but are not limited to, severe pain that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in any of the following:

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

Conditions requiring immediate medical attention include, but are not limited to, the following examples:

- Breathing stops
- Heart attack (typically a heavy, crushing chest pain)
- Major bleeding
- Sudden, unexplained loss of consciousness

Employer's Plan

The group health plan sponsored by your employer and insured under the Master Group Contract with SelectHealth.

Excess Charges

Charges from providers and facilities that exceed SelectHealth's fee schedule 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.

Experimental and/or Investigational

Services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment (hereafter referred to as "intervention") are considered by SelectHealth to be "experimental" and/or "investigational" if the best available evidence fails to validate that the intervention is the "standard of care" within the appropriate medical specialty. Additionally, intervention is considered by SelectHealth to be "experimental" and/or "investigational" if their application is inconsistent with accepted standards of medical practice, even if approved by the U.S. Food and Drug Administration (FDA). This includes, but is not limited to, any service that is research in nature or not generally recognized by the U.S. medical community as conforming to accepted medical practice, and any service for which required government approval has not been granted at the time the service is provided. An intervention is considered experimental and/or investigational by SelectHealth if any one or more of the following apply:

- It cannot be lawfully marketed without the approval of the FDA, and such approval has not been granted at the time of its use or proposed use;
- It is the subject of a current investigational new drug or new device application on file with the FDA;
- 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;
- The peer-reviewed medical literature suggests there is no clear medical consensus among appropriate experts about the role and value of the intervention;
- It is being delivered or provided or should be delivered or provided subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the U.S. Department of Health and Human Services (HHS);
- The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research or investigational settings;
- If the predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, effectiveness, or effectiveness compared with conventional alternatives;
- While it is not experimental or investigational in itself pursuant to the above, it would not be medically necessary but for the provision of an intervention; or
- It is being delivered or provided due to psychological events or feelings. This does not exclude mental health benefits that are covered under other provisions within the Master Group Contract (available from your employer).

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

- Medical records;
- The protocol(s) pursuant to which the intervention is to be delivered;
- Any consent document you have executed or will be asked to execute in order to undergo or receive the services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment (or if the member is a child or a mentally impaired adult, the consent document that the parent or legal guardian has executed or will be asked to execute);
- The published peer-reviewed medical literature regarding the intervention as applied to similar clinical circumstances; and
- Regulations and other official actions and publications issued by the FDA and/or by HHS.

Home Healthcare and Treatment

Medical care and/or treatment ordered by a doctor for the purpose of caring for sick or injured members at their home. This care and/or treatment should be supplied by a nurse or other licensed healthcare provider who works for an organization that is licensed by the state wherein services are provided to render such care and/or treatment.

Hospice Care

Palliative and supportive care provided on an inpatient or outpatient basis to terminally ill patients who are not expected to live more than six months. This care may also be provided to the patient's immediate family at the family's expense.

Injectable Drugs and Specialty Medications

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

- Products produced through bio-engineering
- Require special training to administer
- Have special storage and handling requirements
- Are typically limited in their supply and distribution to patients or providers
- Often have additional monitoring requirements

Certain drugs used routinely in a provider's office to treat common acute medical conditions (such as injectable antibiotics) are not considered injectable drugs or specialty medications.

Master Group Contract

The insurance agreement between SelectHealth and the employer under which SelectHealth provides defined healthcare benefits to members. If there is a conflict between the Master Group Contract and any other member materials, including the Enrollment Guide, Membership Guide, or the Summary Plan Description for the employer's plan, the Master Group Contract will control.

Medical Necessity/Medically Necessary

Healthcare services or products 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 all of the following:

- In accordance with generally accepted standards of medical practice in the United States;
- Clinically appropriate in terms of type, frequency, extent, site, and duration;
- Not primarily for the convenience of the patient, doctor, or other healthcare provider; and
- Covered under this document.

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. It shall also consider potential benefits and harms to the member, and known efficacy. For interventions not yet in widespread use, the effectiveness shall be based on scientific evidence. For established interventions, the effectiveness shall be based on (1) scientific evidence; (2) professional standards; and (3) expert opinion.

Medical necessity is determined by the treating provider and by SelectHealth's medical director or another provider designated by SelectHealth. The fact that a provider, even a participating provider, may prescribe, order, recommend, or approve services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment does not make it medically necessary, even if it is not listed as an exclusion or limitation.

Member

An eligible person, including subscribers and dependents, who is properly enrolled in SelectHealth coverage. To become a member, a person must satisfy the eligibility requirements of the Master Group Contract and must apply and be accepted by SelectHealth as a member. Membership is also conditioned upon the timely payment of premiums by the employer. In situations requiring consent, payment, or some other action, references to "member" include the parent or guardian of a minor or disabled member on behalf of that member.

Mental Impairment

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

Nonparticipating Providers and Facility (out-of-network)

Healthcare providers, including pharmacies and facilities, that are not under contract with SelectHealth.

Participating Providers and Facilities (in-network)

Healthcare providers, including pharmacies and facilities, that are under contract with SelectHealth to accept eligible charges as payment in full for covered services provided to members.

Participating Benefits

Participating benefits apply when you receive covered services from participating providers.

PCP
Primary Care Physician or Primary Care Provider

A general practitioner who attends to your common medical problems and provides preventive care and health maintenance. SelectHealth has classified the following types of physicians and providers and their associated physician assistants and nurse practitioners as PCPs:

- Certified Nurse-Midwives
- Family Practice
- Geriatricians
- Internal Medicine
- Obstetrics and Gynecology (OB/GYN)
- Pediatricians

Pervasive Developmental Disorder (PDD/ Developmental Delay)
A state in which an individual, usually a child, has not reached certain developmental milestones normal for the individual's age, yet no obvious medical diagnosis or condition has been identified which could explain the cause of the delay. PDD includes, but is not limited to, five disorders characterized by delays in the development of multiple basic functions, including socialization and communication. The most commonly known PDD is autistic disorder. Others include Rett's disorder, childhood disintegrative disorder, Asperger's syndrome, and pervasive developmental disorder not otherwise specified (or PDDNOS).

Physical Impairment
Any physiological disorder, or condition, disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory organs, speech organs, cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, or endocrine.

Plan Administrator
If the Master Group Contract is part of an employee benefit plan subject to the Employee Retirement Income Security Act (ERISA) of 1974, the employer or its designated employee(s) will be the plan administrator and in that capacity has delegated to SelectHealth the following authority:

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

The reservation of discretion made under this provision only establishes the scope of review that a federal court will apply when a claimant seeks judicial review of SelectHealth's determination of eligibility for benefits, the payment of benefits, or interpretation of the terms and conditions applicable to the benefit plan.

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

If the Master Group Contract is not part of an employee benefit plan subject to ERISA, the above provision (in bold) does not apply and is not considered part of this document.

Plan Sponsor
Plan sponsor is defined in section 3(16) (B) of ERISA, 29 U.S.C. 1002(16) (B). In general, a plan sponsor is the employer or employers who maintain or establish a plan to provide healthcare benefits.

Preauthorization for Certain Drugs
Providers are required to obtain advance approval for certain drugs before the drugs are dispensed to the member. Providers must preauthorize these drugs, or they will not be covered.

Precertify/Precertification
Precertification consists of providing SelectHealth advance notice of specified kinds of procedures and providers and of obtaining from SelectHealth a conditional, preliminary approval for the procedure and the provider. Precertification is done by the member.

Prenotify/Prenotification
Prenotification consists of providing SelectHealth advance notice of specified kinds of procedures and providers and of obtaining from SelectHealth conditional, preliminary approval for the procedure and the provider. Prenotification is done by the provider.

Prescription Drug List

The Prescription Drug List is a brief list of many of the most commonly prescribed preferred brand-name and generic drugs. This list may change at anytime because of new drugs, new therapies, or other factors.

Preventive Care

Services, examinations, immunizations, certain screening laboratory and X-ray tests, and procedures commonly accepted by clinicians that, when performed periodically, can detect disease conditions.

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

If a disease state exists for which the treatment of a condition prevents a subsequent condition (e.g., treating high blood pressure, preventing a heart attack or stroke) and the purpose of the visit is to evaluate and manage this problem, it is NOT considered a preventive service.

Rural vs. Urban Designation

For the purposes of benefit determination in circumstances where the member's coverage responsibility is affected by the distance they travel to a particular provider, SelectHealth abides by the designation put forth in R590-237 Access to Health Care Providers in Rural Counties.

Additionally, for purposes of benefit determination, in circumstances where the patient resides in a county designated "rural" by R590-237, additional considerations are given to allow the member to seek care at a nonparticipating provider if the required distance to travel is greater than 40 miles for primary care services and greater than 100 miles for specialty care services.

Scientific Evidence

Studies from nationally recognized medical journals and research sponsored by the federal government. Scientific evidence does not include literature sponsored by a drug or medical device manufacturer, individuals with apparent vested interest in the results of a study, or single studies without other supporting studies.

SCP

Secondary Care Physician or Secondary Care Provider

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

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

SelectHealth

Refers to all coverage plans, including Select Choice℠ Premier plans, offered by SelectHealth Benefit Assurance Co., and administered by SelectHealth but does not include plans offered by other companies that contract to use any of the SelectHealth's panel of providers.

Service Area

The area in which SelectHealth arranges for covered services for you from participating providers.

The Select Care℠/Select Care Plus℠ service area includes the following counties: Beaver, Box Elder, Cache, Davis, Duchesne, Garfield, Iron, Juab, Kane, Millard, Morgan, Piute, Rich, Salt Lake, Sanpete, Sevier, Summit, Tooele, Uintah, Utah, Wasatch, Washington, Wayne, and Weber. However, not all ZIP codes within these counties are included. As of January 2007, the following ZIP codes are NOT part of the Select Care/Select Care Plus service area: 84313, 84329, 84034, and 84083.

The Select Med℠/Select Med Plus℠ service area includes the following counties: Beaver, Box Elder, Cache, Davis, Duchesne, Garfield, Iron, Juab, Millard, Morgan, Piute, Salt Lake, Sanpete, Sevier, Summit, Tooele, Uintah, Utah, Wasatch, Washington, Wayne, and Weber. However, not all ZIP codes within these counties are included. As of January 2007, the following ZIP codes are NOT part of the Select Med/Select Med Plus service area: 84313, 84329, 84712, 84716, 84717, 84718, 84726, 84736, 84759, 84764, 84776, 84723, 84034, 84083, 84008, 84035, 84078, 84079, and 84734.

The Select Value℠ service area includes the following counties: Davis, Salt Lake, Summit, Utah, and Weber. However, not all ZIP codes within these counties are included. As of January 2007, the following ZIP codes are NOT part of the Select Value service area: 84017, 84024, 84033, 84036, 84055, 84061, 84013, 84626, 84633, 84651, 84653, 84655, and 84660.

Skilled Nursing Services

Services that improve rather than maintain a member's health condition and which require the skills of a licensed nurse in order to be provided safely and effectively.

Subscriber

The individual with employment or another defined relationship to the employer through whom dependents may be enrolled with SelectHealth. Subscribers are also members.

Urgent Conditions

An urgent condition is an acute health condition with a sudden, unexpected onset, which is not life-threatening but which poses a danger to the health of the member if not attended by a doctor within 24 hours. Urgent conditions include, but are not limited to, the following:

- Headaches
- Sore throats
- Sprains/strains
- Upper or lower respiratory conditions

Types of conditions that would never be considered urgent include, but are not limited to, the following examples:

- Chemotherapy, radiation, dialysis
- Elective care
- Extended follow-up care
- Ongoing treatment
- Preventive care
- Therapy (e.g., physical, occupational, speech, chronic pain management)

GENERAL LIMITATIONS AND EXCLUSIONS

SelectHealth strictly enforces the limits on payments and coverage available to you. This is done according to the terms, conditions, limitations, and exclusions contained in this document and the Master Group Contract (available from your employer).

You should not expect that any services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment will be covered or otherwise provided or paid for by SelectHealth in excess of the kinds and amounts specified in the Master Group Contract and on the Member Payment Summary. You are always free to personally obtain and pay for services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment outside of the coverage provided by SelectHealth. When required by federal law, exclusions will not apply to injuries resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

Unless otherwise noted in the Member Payment Summary, the following general limitations and exclusions apply.

ABORTION/TERMINATION OF PREGNANCY

Abortions are not covered except under the following conditions:

- When determined by SelectHealth to be medically necessary to save the life or good health of the mother;
- Where the pregnancy was caused by a rape or by incest if evidence of the rape or incest is presented either from medical records or through the review of a police report or the filing of charges that a crime has been committed; or
- When there is evidence of grave fetal defects that are inconsistent with sustaining life.

Medical complications resulting from an abortion are covered.

Treatment of miscarriage/spontaneous abortion (occurring from natural causes) is covered.

ACCEPTED MEDICAL PRACTICE

Services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment determined by SelectHealth to be inconsistent with accepted medical practice are not covered. This includes any service, supplies, tests, treatments, appliances, drug, devices, medications, procedures, or equipment that is not generally recognized by the U.S. medical community as conforming to accepted medical practice, including services which are investigational, experimental, or research in nature, or for which there is insufficient evidence to determine their likely effects on patients' health outcomes, or required government approval has not been granted at the time. (Refer to the "Definitions of Terms" section for a complete definition of "Experimental and/or Investigational.")

ACUPUNCTURE/ACUPRESSURE/DRY NEEDLING

Acupuncture, acupressure services, and dry needling procedures are not covered.

ADMINISTRATIVE CHARGES

Provider charges are not covered when submitted for the following: completing insurance forms, duplication services, interest (except where required by UAC Rule R590-192), finance charges, late fees, missed appointments, and other administrative charges.

ADMINISTRATIVE EXAMS AND SERVICES

Examinations and services are not covered when SelectHealth determines that they are not medically necessary or when obtained for administrative purposes, whether or not illness or injury is involved. Such administrative purposes include, but are not limited to, immunizations, supplies, accommodations, treatment, care, reports, or appearances obtained for or pursuant to legal proceedings, court orders, employment, continuing or obtaining insurance coverage, governmental licensure, home health recertification, travel, military service, school, or institutional requirements.

ADOPTION INDEMNITY BENEFIT

If you adopt a child while you are covered under the Master Group Contract, SelectHealth will provide an indemnity benefit payable to you, as required by Utah Code 31A-22-610.1, if the child is placed for adoption with you within 90 days of the child's birth. You have one year from the date of placement to submit a claim for this benefit or as soon as reasonably possible. This benefit is outlined on the Member Payment Summary and is subject to the deductibles, copays,

and coinsurance listed under the maternity benefit. Only one indemnity benefit is payable to you for adopting more than one child from the same birth (adopting twins, triplets, etc.). SelectHealth will pay its pro rata share of the adoption indemnity benefit if each adoptive parent has coverage for maternity benefits with a different insurer, and each adoptive parent makes a claim for the adoption indemnity benefit described in this section.

ALLERGY TESTS, TREATMENT, OR SERUM

Allergy testing, treatment, and serum are covered except those tests and treatments specifically listed as not covered. Covered allergy tests, treatments, and serum must be received from a participating board certified allergist, immunologist, otolaryngologist, or participating facility. Oral food challenge testing is only covered when received by a provider who is board certified in allergy/immunology and when this service is performed in a participating facility.

The following allergy tests are not covered:

- Cytotoxic test (Bryan's Test);
- Leukocyte histamine release test;
- Mediator release test (MRT);
- Passive cutaneous transfer test (P-K test);
- Provocative conjunctival test;
- Provocative nasal test;
- Rebuck skin window test;
- Rinkel test;
- Subcutaneous provocative food and chemical test; and
- Sublingual provocative food and chemical test.

The following allergy treatments are not covered:

- Allergoids;
- Autogenous urine immunization;
- LEAP therapy;
- Medical devices (filtering air cleaner, electrostatic air cleaner, air conditioners, etc.);
- Neutralization therapy;
- Oral desensitization therapy;
- Photoinactivated extracts; and
- Polymerized extracts.

AMBULANCE

Refer to the "Transportation Services" subsection of this section.

APPOINTMENTS NOT KEPT

Provider charges for appointments scheduled and not kept are not covered.

ATTENTION DEFICIT DISORDER/ADD/ADHD

Cognitive or behavioral therapies for the treatment of these disorders are not covered. Medical management for the adjustment of medication and to assess the efficacy/safety of medical therapy is covered.

BARIATRIC SURGERY

Gastric or intestinal bypass services and complications related to such services are not covered unless otherwise listed on the Member Payment Summary. Gastric or intestinal bypass services including lap banding, gastric stapling, and other similar procedures to facilitate weight loss; the reversal, or revision of such procedures are not covered. Services required for the treatment of complications from such procedures are not covered. Refer to the exclusion under the "Obesity" subsection of this section.

BIOFEEDBACK/NEUROFEEDBACK

Biofeedback/neurofeedback is not covered.

BIRTHING CENTERS AND HOME CHILDBIRTH

Childbirth in any place other than a hospital, including, but not limited to, a birthing center, a standalone birthing center, or a home, is not covered. This includes all provider and/or facility charges related to the delivery.

CANCER THERAPY

The evaluation and treatment of cancer is a covered benefit unless the diagnostic test or the treatment meets the definition of experimental and/or investigational as outlined in the "Definitions of Terms" section.

In addition, the following treatments are not covered as they have been found to have no better therapeutic outcomes for the disease being treated and are less cost effective than other therapies. The treatments that are not covered include, but are not limited to, the following:

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

CHIROPRACTIC SERVICES

Chiropractic services are defined as correction (by manual or mechanical means) of nerve interference resulting from or related to the distortion, misalignment, or partial dislocation in the vertebral column. Chiropractic services are generally provided by a licensed chiropractor. Chiropractic services are not covered unless the Chiropractic Benefit Rider or the chiropractic nonparticipating benefit is listed on the Member Payment Summary.

The following are not covered when rendered by a chiropractor:

- Chiropractic appliances;
- Services for treatment of non-neuromusculoskeletal disorders;
- Professional radiology services (reading of an X-ray);
- Services for children younger than age seven;
- Physical therapy services; and
- Services for children ages seven through 12 are not covered unless the following apply:
  - The child has a specific, chronic neuromusculoskeletal diagnosis causing significant and persistent disability;
  - Other conservative therapies have been tried and have failed to relieve the patient's symptoms; and
  - Improvement is documented within the initial two weeks of chiropractic care.

If the chiropractic rider is listed on the Member Payment Summary, refer to the "Using your Chiropractic Benefits" section.

CLAIMS AFTER ONE YEAR

Claims are denied if submitted to SelectHealth more than one year after services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment were provided unless you show that notice was given or proof of loss was filed as soon as reasonably possible. Adjustments or corrections to claims are denied if submitted to SelectHealth more than one year after claims were first processed unless you show that the additional claim information was filed as soon as reasonably possible. Where SelectHealth is secondary coverage, Coordination of Benefits claims will be denied if submitted more than one year after the claim was first processed by the primary carrier unless you show that notice was given or proof of loss was filed as soon as reasonably possible. If it is discovered that SelectHealth is primary when they were believed to be secondary and claims were submitted within the filing deadline to the other carrier first, SelectHealth will consider claims up to three years from the date of service.

COCHLEAR IMPLANTS

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

- Such cochlear implantation must be preapproved by SelectHealth in writing.
- Such cochlear implantation must be provided by a participating provider in an Intermountain facility.
- Bilateral cochlear implantation is not a covered benefit.
- Auditory brain implantation or similar devices are not a covered benefit.
- Batteries for cochlear implants are not covered.

Aural rehabilitation related to an approved cochlear implantation is subject to the speech therapy benefit limitations. Refer to the "Rehabilitation Therapy Services" subsection of this section.

COMPLICATIONS

Unless otherwise stated in this document all services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment provided or ordered to treat complications of a noncovered illness, injury, condition, situation, procedure, or treatment are not covered. This includes, but is not limited to, complications resulting from any illness, injury, condition, situation, procedure, or treatment occurring prior to coverage under the Master Group Contract if such earlier illness, injury, condition, situation, procedure, or treatment would not have been covered under the Master Group Contract.

COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM)

CAM or similar non-traditional services are not covered. Such services may include, but are not limited to, acupuncture (refer to the "Acupuncture" subsection in this section), homeopathy, homeopathic drugs, massage therapies, aroma therapies, yoga, hypnosis, rolfing, thermography, etc.

CORRECTIVE, RECONSTRUCTIVE, AND COSMETIC PROCEDURES

Any care, treatment, or procedure performed primarily for cosmetic purposes is not covered. Any care, treatment, or procedure primarily intended to improve appearance

or correct a deformity, whether congenital or acquired, without restoring physical bodily function is not covered. Reconstruction or corrective procedures done primarily for the purposes of restoring “normal” body form or appearance are not covered. (This restriction includes reconstructive or corrective procedures to restore or correct congenital anomalies that do not impair or risk impairing function. It does not apply when reconstructive or corrective procedures are to improve or correct an impairment or loss of bodily function.) Psychological factors, such as but not limited to, poor self-image or difficult peer or social relations, are not relevant to this exclusion, even though a doctor may indicate that such factors constitute “medical necessity.”

Cosmetic surgery and other care or procedures required as the result of an accidental injury, illness, or therapeutic intervention are not covered unless the services are rendered within 12 months of the cause or onset of the injury, illness, or therapeutic intervention.

Surgery to revise a scar whether acquired through injury or surgery is not a covered benefit at any time except when the primary purpose of the scar revision surgery is to improve or correct a functional impairment.

The reversal, revision, repair, or treatment for a noncovered, corrective, reconstructive, or cosmetic procedure is not covered. The treatment of complications resulting directly or indirectly from a noncovered, corrective, reconstructive, or cosmetic procedure is not covered.

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

- Abdominoplasty;
- Acne (except routine office visits and drug therapy);
- Alopecia;
- Body piercing, including ear piercing and any immediate or remote complications of the procedure;
- Breast augmentation (except when related to reconstructive surgery following treatment for breast cancer);
- Breast reduction (except according to SelectHealth’s criteria);
- Congenital cleft lip except for treatment rendered (or a planned, staged series of services as specifically documented in your medical record are initiated) within 12 months of birth; or when congenital cleft lip surgery is performed as part of a cleft palate repair;
- Face lift;
- Genioplasty;
- Helmet therapy for congenital cranial defects, post cranial surgery and in children 12 months of age or older with positional plagiocephaly is covered. For patients younger than 12 months of age with positional plagiocephaly, helmet therapy is only covered after a 3 month course of conservative therapy has failed;
- Idiopathic short stature;
- Implantation of a breast implant (except following a mastectomy for breast cancer);
- Laser hair removal;
- Liposuction of the face, neck, chest, abdomen, flanks, buttocks, arms, legs (except covered breast surgery or surgery related to the treatment of breast cancer);
- Otoplasty;
- Port wine stain treatment (except according to SelectHealth’s criteria);
- Rhinoplasty;
- Scar revision (except to correct a functional problem);
- Sclerotherapy of superficial varicose veins (spider veins);
- Skin resurfacing procedures (e.g., dermabrasion, chemical peels, and laser treatments);
- Tattoos or their removal (except when related to reconstructive surgery following treatment for breast cancer); and
- Vitiligo.

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

CUSTODIAL CARE, LONG-TERM CARE

Custodial care and/or long-term care are not covered when provided primarily to maintain rather than improve a patient’s condition. Examples are personal hygiene, assistance in daily activities, and controlling or changing the patient’s environment, including, but not limited to, care which could be rendered by non-licensed persons for the purpose of meeting personal needs, domiciliary, or convalescent care, rest cures, nursing home services, etc.

DENTAL, MOUTH, AND JAW

Tooth-related dental services and mouth and jaw services are not a covered benefit unless otherwise noted in this document. Dental services are defined as care rendered to the teeth, the tooth pulp, the gums, or the bony structure supporting the teeth. This includes all diagnostic procedures, care, treatment, therapy,

or surgery for treatment of tooth-related dental, mouth, and jaw. This includes, but is not limited to, the following:

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

Except where noted in the list above, diagnostic procedures, care, treatment, therapy, or surgery necessary to treat medical complications of a dental procedure are covered only if administered under the direction of a medical provider whose primary practice is not dentistry or oral surgery. The following may be covered if SelectHealth determines such treatment(s) to be medically necessary:

- Maxillary and/or mandibular osteotomy and orthognathic procedures; and
- Upper/lower jaw augmentation or reduction procedures, including developmental corrections or altering of vertical dimension.

Repairs are covered for physical damage to natural teeth, crowns, and the supporting structures surrounding teeth (not including damage resulting from biting or chewing) only in the following circumstances:

- When such damage is a direct result of an accident independent of disease or bodily infirmity or any other cause; and
- When medical advice, diagnosis, care, or treatment was recommended or received for the injury at the time of the accident; and
- When such repairs are initiated within one year of the date of the accident.

Please notify SelectHealth to determine coverage of repairs related to dental accidents. Orthodontia and the replacement/repair of artificial/manufactured dental appliances are not covered even after an accident. Repairs for physical damage resulting from biting or chewing are not covered. Bleaching of teeth to restore the cosmetic pre-injury appearance of the injured tooth/teeth is covered to a maximum allowed cost established by SelectHealth.

The removal of cysts involving the jaw when distant from the teeth or supporting structures of the teeth are covered when found to be medically necessary to treat other medical conditions or to avoid further injury or illness to the member.

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

- The patient is younger than age five;
- Proposed dental work involves three or more teeth;
- The diagnosis is nursing bottle mouth syndrome or extreme enamel hypoplasia;
- The proposed procedures are restoration or extraction for rampant decay; and
- The anesthesia is administered at a participating hospital or participating surgical center.

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

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

DIETARY PRODUCTS

Dietary products (a medical food or low protein modified food product) are only covered in the following instances:

In the cases of hereditary metabolic disorders:

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

In all other situations:

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

Refer to the "Food Supplements" subsection of this section.

DIETETIC CONSULTATION

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

- The consultation must be prescribed by a participating provider as part of a structured program to treat a specific condition;
- In the case of anorexia nervosa and bulimia, the participating behavioral health provider must obtain a prenotification;
- The services must be provided by a registered dietitian working at an Intermountain-owned facility.

There is a maximum benefit limit for dietetic consultation and nutrition training. Please contact Member Services for more information.

DRUGS, MEDICATIONS, AND INJECTIONS

Prescription drugs, medications, and injections are only covered to the extent indicated in the Member Payment Summary. Generic medications are generally covered at a different level than name brand medications. Medications may also be grouped into payment tiers with different levels of coverage. Even when there is a prescription drug benefit, the following types of drugs, medications, and injections are never covered or coverage is limited as indicated below:

- Appetite suppressants and weight loss medications;
- Certain off-label drug usage, either alone or in combination with other FDA-approved drugs, unless the use has been approved by either a SelectHealth medical director or by a SelectHealth pharmacologist;
- Compounded drugs when alternative products are available commercially;
- Cosmetics, health or beauty aids, or prescription drugs used for cosmetic purposes, including tretinoin (Retin-A) for non-acne therapy;
- Drugs purchased from nonparticipating providers over the Internet;
- Drugs that may be FDA approved but have not proven to be better than other standard therapies in medical literature;
- Drug use that is not medically necessary;
- Experimental drugs, medications labeled "Caution, Limited by Federal Law to Investigational Use," drugs not approved by the FDA, or FDA approved drugs used for treatment not recognized by SelectHealth. (Refer to the "Definitions of Terms" section of this document for a complete definition of "Experimental and/or Investigational");
- Flu symptom medication (e.g., Tamiflu, Relenza);
- Foreign medications- drugs and medications purchased through a foreign pharmacy. However, please call Pharmacy Services if you have a special need (for example, an emergency while traveling out of the country) for medications from a foreign pharmacy;
- Human growth hormone for the treatment of idiopathic short stature;
- Infertility medications;
- Minerals, fluoride, vitamins other than prenatal. Vitamins are covered only when determined to be medically necessary to treat a specifically diagnosed disease.
- Naturopathic vitamins, minerals, and similar medications;
- Nicotine and smoking cessation medications. Exception: These may be covered depending upon your particular prescription drug benefits and participation in a SelectHealth-sponsored smoking cessation program;
- Medications for noncovered medical conditions (e.g., topical minoxidil, Nystatin powder);
- Over-the-Counter (OTC) medications are not covered by SelectHealth except when all of the following conditions are met:
- The OTC medication is listed on the SelectHealth formulary as a covered medication;

- The SelectHealth Pharmacy & Therapeutics Committee has approved the OTC medication as a medically appropriate substitution of a prescription drug or medication;
- The OTC medication is medically necessary to treat a condition that is covered by SelectHealth; and
- The member has obtained a prescription for the OTC medication from a participating licensed provider and filled the prescription at a participating pharmacy.
- Prescriptions received under workers' compensation or reimbursable under local, state, or federal programs or other insurance plans;
- Prescriptions written by a licensed dentist unless used for the prevention of infection or pain in conjunction with a dental procedure;
- Replacements of lost, stolen, or damaged drugs and medications;
- Sexual dysfunction medications unless the Sexual Dysfunction Rider is listed as a Benefit Rider on the Member Payment Summary;
- Travel-related medication, including preventive medication for the purpose of travel to other countries. Refer to the "Immunizations" subsection of this section; and
- Vitamin injections are covered only when determined by SelectHealth to be medically necessary for members with specifically diagnosed diseases.

For covered injectable drugs, refer to the "Prescription Drug Benefits" section.

DRUG TESTING

Urine or blood testing performed for illegal drugs when there are no clinical conditions present establishing medical necessity are not covered for the following:

- Administrative purposes related to work or recreational activities;
- To monitor an individual's compliance with a legal order;
- Other work-related testing; or
- For personal screening.

DURABLE MEDICAL EQUIPMENT (DME)

Coverage of DME is limited to those items necessary for activities of daily living and intended for the sole use of the member. SelectHealth does not cover duplication or replacement of lost, damaged, or stolen DME, or replacement of DME more often than SelectHealth considers medically necessary. Home fitness equipment, spas, hot tubs, or similar equipment is not covered.

DME is limited to the cost of the item(s) up to the annual DME maximum. The following DME items are excluded from the annual DME maximum and require prenotification/precertification for coverage:

- Insulin pumps and accessories
- Equipment used to provide oxygen and CPAP therapy and associated accessories
- Prosthetics
- Motorized/customized wheelchair and associated accessories

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

EDUCATIONAL AND NUTRITION TRAINING

Educational and nutrition training is covered only in the following circumstances:

- Diabetic and asthma education is covered only in connection with the treatment of diabetes or asthma and only when referred by a participating provider to a certified educator or registered dietitian provided at a participating facility.
- Educational and nutrition training for bulimia, anorexia nervosa, obesity, and morbid obesity is covered only when referred by a participating provider to a certified educator or registered dietitian affiliated with an Intermountain facility. Please contact Member Service for more information on the requirements and benefit limit.

Excess Charges

Charges from providers and facilities that exceed SelectHealth's fee schedule for covered services are not covered. You are responsible for charges from nonparticipating providers and facilities that exceed SelectHealth's fee schedule for covered services.

For services received outside the state of Utah, use a Beech Street provider or facility whenever possible to avoid being billed for excess charges. Refer to the "Use Beech Street Providers and Facilities When Outside Utah" subsection in the "Using Your Medical Benefits" section of this document to find a Beech Street provider or facility.

EXPERIMENTAL AND/OR INVESTIGATIONAL SERVICES

Services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment that are considered to be experimental and/or investigational are not covered. Refer to the "Definitions of Terms" section for a complete definition of "Experimental and/or Investigational."

EYE SURGERY, REFRACTIVE

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

FELONY, RIOT, OR INSURRECTION

Care or treatment of an illness, injury, or connected disability is not covered if the member was a voluntary participant in, caused, or contributed to a felony, riot, insurrection, rebellion, or similar acts.

FITNESS TRAINING

Fitness training or conditioning is not covered when conducted as a preventive measure. Exercise equipment as well as membership fees to a spa or health club are also not covered.

FOOD SUPPLEMENTS

Food supplements, food substitutes, medical foods, and formulas (except when related to treatment of inborn errors of amino acids or urea cycle metabolism) are not covered. Refer to the "Dietary Products" subsection in this section.

GENE THERAPY

Gene therapy or gene-based therapies are not covered. These are any treatments which try to replace a portion of a person's DNA code with material from an external source with the purpose of correcting a genetic defect related to a specific disease or to treat a specific condition. The external DNA can be in the form of intact genes, portions of genes, or the building blocks of gene-nucleic acids.

GENERAL ANESTHESIA

General anesthesia administered in a doctor's office is not covered.

GENETIC TESTING

Genetic testing is only covered in the following circumstances:

- As prenatal testing when performed as part of an amniocentesis to assess specific chromosomal abnormalities in women at high risk for conditions such as Down syndrome or other inheritable conditions that can lead to significant immediate and/or long-term health consequences to the child after birth;
- As neonatal testing to look for specific inheritable metabolic conditions such as PKU; or
- In selected cases, when the patient being tested has a more than five percent probability of having an inheritable genetic condition and has presented signs or symptoms suggestive of a specific condition or has a strong family history of the condition (defined as two or more first degree relatives with the condition), and the results of the testing will directly affect the patient's treatment.

Additionally, genetic testing is specifically not covered when done as part of in vitro fertilization or as part of pre-implantation genetic testing. This coverage is only for individuals who are currently members of a SelectHealth plan. Genetic testing is not covered for relatives who are not covered by SelectHealth.

HABILITATION THERAPY SERVICES

Habilitation therapy services designed to create or establish function that was not previously present are not covered.

HEARING AIDS

The purchase, fitting, or ongoing evaluation of hearing aids, appliances, or related procedures are not covered, including, but not limited to, hearing aids, bone-anchored hearing aids, auditory brain stem implants and similar devices to achieve a similar function, other hearing appliances, and any other procedure or device intended to establish or improve hearing or sound recognition.

HOME HEALTH AIDE SERVICES

All home health aide services such as bathing, dressing, nail care, feeding, etc. are not covered.

ILLEGAL ACTIVITIES

Care, services, treatments, drugs, medications, supplies, or equipment for an illness, condition, accident, or injury are not covered if the illness, condition, accident, or injury occurred as a result of any of the following:

- While the member was a voluntary participant in the commission of a felony;

- While the member was a voluntary participant in disorderly conduct, riot, or other breach of the peace;
- While the member was engaged in any conduct involving the illegal use or misuse of a firearm or other deadly weapon;
- While the member was driving or otherwise in physical control of a car, truck, motorcycle, scooter, off-road vehicle, boat, or other motor driven vehicle if the member either:
- had sufficient alcohol in his or her body that a subsequent test shows that he or she has either a blood or breath alcohol concentration of .08 grams or greater at the time of the test; or
- had any illegal drug or other illegal substance in his or her body to a degree that it affected his or her ability to drive or operate the vehicle safely;
- While the member was driving or otherwise in physical control of a car, truck, motorcycle, scooter, off-road vehicle, boat, or other motor driven vehicle either without a valid drivers permit or license, if required under the circumstances, or without the permission of the owner of the vehicle; or
- As a complication of, or as the result of, or as follow-up care for any illness, condition, accident, or injury that is not covered as the result of this exclusion.

IMMUNIZATIONS

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

INFERTILITY SERVICES

Infertility counseling, diagnostic testing, and treatment are covered only when rendered by participating providers and only to the extent stated on the Member Payment Summary. The infertility benefit may not be used for any infertility-related service that is listed as not covered.

The following infertility services are not covered:

- Artificial insemination, sperm washings, sperm banking or storage;
- Donor costs;
- Experimental or investigational treatment (Refer to the “Definitions of Terms” section for a complete definition of “Experimental and/or Investigational”);
- Gamete Intrafallopian Transfer (GIFT);
- Hamster egg penetration tests;
- In Vitro Fertilization (IVF);
- In vitro genetic testing;
- Medications for infertility and ultrasounds associated with infertility medication therapy;
- Nonparticipating provider or facility services for infertility;
- Pre-implantation genetic testing;
- Sterilization, reversal including tuboplasty (except in cases of ectopic pregnancies), tubotubal anastomosis, vasovasostomy, vasovasorrhaphy, etc.; and
- Zygote Intrafallopian Transfer (ZIFT).

LIMITED BENEFITS

Normally covered services that exceed benefit limits specified on the Member Payment Summary (e.g., dollars, days, visits) are not covered and not applied to out-of-pocket maximums, including, but not limited to, services exceeding benefit limits for skilled nursing facilities, rehabilitation therapy, psychiatric services, etc.

LONG-TERM CARE

Refer to the “Custodial Care, Long-Term” subsection in this section.

MATERNITY SERVICES – SMALL EMPLOYER PLANS

Note: For members of a small employer health plan (50 or less eligible employees):

Maternity services for dependent children are not covered. If you have a separate maternity deductible, all covered maternity and adoption services (including prenatal, labor, delivery, and postpartum care) are subject to the applicable maternity deductible. This deductible is per pregnancy and does not apply toward the out-of-pocket maximum. Complications of pregnancy apply to your regular medical benefits and are not subject to the maternity deductible. Your Member Payment Summary will indicate if you have a separate maternity deductible.

MEDICAL NECESSITY

Services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment that are not medically necessary are not covered. Refer to the “Definitions of Terms” section.

MENTAL HEALTH

Inpatient mental health and chemical dependency rehabilitation services and outpatient mental health and chemical dependency rehabilitation services are not covered. If the Catastrophic Mental Health and Chemical Dependency Benefit Rider is listed on the Member Payment Summary, mental health and chemical dependency rehabilitation will be covered but only to the extent specified in the "Using Your Mental Health Benefits" section.

METHADONE CLINICS

Methadone maintenance/therapy clinics or services are not covered.

MISCELLANEOUS MEDICAL SUPPLIES

Miscellaneous Medical Supplies (MMS) are not covered when they are not prescribed by a doctor or where determined by SelectHealth to be medically unnecessary, non-therapeutic, or generally usable in the absence of an illness or injury.

NEUROPSYCHOLOGICAL TESTING

Neuropsychological testing provided by behavioral health specialists is considered under the mental health benefits except in the following listed circumstances. When performed for any indication other than those listed below, coverage for testing is limited to once in a member's lifetime.

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

- Testing performed as part of the preoperative evaluation for patients undergoing any of the following:
- Seizure surgery,
- Solid organ transplantation,
- CNS malignancy;
- Patients being evaluated for dementia/Alzheimer's Disease;
- Post-stroke patients undergoing formal rehabilitation; and
- Post traumatic brain injury patients;

All other conditions are considered under the mental health benefit.

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

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

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

NON-ASSIGNABILITY

Neither the benefits under the Master Group Contract nor the right to receive reimbursement or payment from SelectHealth under the Master Group Contract may be transferred or assigned by the employer, subscribers, or members.

NONCOVERED SERVICES AND COMPLICATIONS

Except as set forth in the "Abortion/Termination of Pregnancy" exclusion, all services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment related to noncovered services are not covered, including complications resulting directly from a noncovered service. When a noncovered procedure is performed as part of the same operation or process as a covered service, then only eligible charges relating to the covered service will be eligible for benefits. Charges that are related to noncovered services are not covered.

NONPARTICIPATING PROVIDERS AND FACILITIES

Except for emergencies, out-of-area urgent conditions, and exceptions approved by SelectHealth, nonparticipating benefits apply to any services rendered, ordered, or prescribed by nonparticipating providers or in a nonparticipating facility. If your plan does not include coverage for nonparticipating providers and facilities, your claims will not be covered. (Refer to the Member Payment Summary for specific nonparticipating benefits.)

NO PRESUMPTION OF COVERAGE

There is no presumption of coverage. Services not specified as covered are not covered.

NO VESTED RIGHTS

No member has any vested right or interest in the Master

Group Contract or in the benefits available under the Master Group Contract. Benefits may change or terminate as the Master Group Contract is renewed, modified, or terminated from year to year.

OBESITY

The medical management of obesity is covered only for medical nutrition therapy; however, such therapy has a maximum benefit limit and must be referred by a participating provider to a dietitian employed at an Intermountain facility. Please contact Member Services for more information on dollar limits and other requirements.

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

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

Surgical treatment or other management of all types of obesity regardless of the nature of the surgery is not covered. The reversal of any operations whose intent is to treat overweight/obese conditions and any complications from such operations or treatments are also not covered, regardless of when the operation or treatment occurred.

Medical or surgical complications which can be reasonably attributed to a bariatric procedure that was not covered by SelectHealth are not covered if they arise within ten years from the date of the procedure. If the surgery was originally covered by SelectHealth pursuant to a Bariatric Surgery Rider, then complications arising from that surgery are not subject to this exclusion.

ORGAN TRANSPLANTS/IMPLANTS

All organ transplant/implant services require advance written authorization by SelectHealth’s medical director and are not covered when rendered by nonparticipating providers or facilities. Services for crossmatching and/or harvesting organs from live or deceased donors are not covered for all noncovered transplant/implant services and whenever the organ recipient is not a member. Services for both the donor and the recipient are only covered under the recipient’s coverage, even if both are members of a SelectHealth plan. Donor-related services are limited to $40,000 per transplant. All organ transplant/implant services that are experimental and/or investigational in nature are not covered. (Refer to the “Definitions of Terms” section for a complete definition of “Experimental and/or Investigational.”) Only the following organ transplant/implant services are covered:

- Bone marrow whether from a donor or from the member but only as treatment for conditions listed in SelectHealth’s “Bone Marrow Transplant Criteria” in effect at the time authorization for the transplant is sought;
- Combined heart/lung;
- Single or double lung;
- Combined pancreas/kidney;
- Cornea;
- Heart;
- Kidney (but only to the extent not covered by a government program);
- Pancreas After Kidney (PAK); and
- Liver.

Small bowel transplantation is not covered.

OSTEOPOROSIS SCREENING

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

PAIN MANAGEMENT SERVICES

In general, services for the treatment of acute and chronic pain are a covered benefit. However, some therapies/services are never covered. These noncovered therapies/services include, but are not limited, to the following:

- Prolotherapy;
- Radiofrequency ablation of dorsal root ganglion;
- Radiofrequency of the sacroiliac joint;
- Acupuncture; and
- IV pamidronate therapy for the treatment of reflex sympathetic dystrophy (RSD).

Additionally, the following pain management services are only covered when either the patient or provider receives authorization from SelectHealth prior to their completion:

- Radiofrequency ablation of facet joints;
- Spinal cord stimulators;
- Intrathecal pain pumps; and
- Sacral nerve stimulation.

PERVASIVE DEVELOPMENTAL DISORDER (PDD)/DEVELOPMENTAL DELAY

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

PRE-EXISTING CONDITIONS (PEC)

If a pre-existing condition waiting period is specified on the Member Payment Summary, refer to the "Pre-Existing Conditions" section.

PRESCRIPTION DRUGS AND MEDICATIONS

Refer to the "Drugs, Medications, and Injections" subsection in this section.

PREVENTIVE CARE

The following preventive care services are not covered:

- Nonparticipating provider or facility services for preventive care except when specified on the Member Payment Summary;
- More than one preventive examination and related screening tests per year (except for well-baby visits during the first 24 months of life); and
- Injections, immunizations, and medications related to employment or travel, anthrax, typhoid, yellow fever, cholera, plague, and BCG immunizations.

PROVIDER HOUSEHOLD SERVICES

Services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment are not covered when rendered to you by a healthcare provider who ordinarily resides in the same household as you.

PSYCHIATRIC

Refer to the "Mental Health" subsection in this section.

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 the Member Payment Summary for benefit limitations.

Rehabilitation services are not covered when used to assist a member in establishing skills not previously possessed, regardless of the etiology or age of the individual.

Additionally, the following rehabilitation therapy services are not covered:

- Functional nervous disorders, pervasive developmental disorder/developmental delay, or problems of a similar nature or an impairment otherwise not attributable to a specific accident or illness;
- Vision rehabilitation therapy services;
- Speech therapy for developmental speech delay associated with chronic otitis media/effusions without hearing loss; and
- Physical/occupational therapy specifically intended for the individual to participate or resume recreational, curricular/extracurricular, or professional sports-related activities.

RESEARCH

Refer to the "Accepted Medical Practice" subsection in this section.

RESPITE CARE

Care provided principally for relief, delay, respite, or "rest" from caretaking responsibilities is not covered.

ROBOTIC-ASSISTED SURGERY

The direct costs related to the use of robotic assistance in performing any surgery are not covered. These costs include, but are not limited to, any disposable or reusable items or surcharges applied to any surgery performed using robotic operating devices.

SelectHealth will only cover the cost for the base procedure performed using robotic assistance when that base procedure has been determined to be medically necessary. Currently only the following procedure is considered medically necessary, and the cost of the base procedure will be covered:

- Laparoscopic radical prostatectomy for prostate cancer

SEXUAL DYSFUNCTION

Unless the Sexual Dysfunction Rider is listed as a benefit rider on the Member Payment Summary, all services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment related to sexual dysfunction are not covered.

When listed as a benefit rider on the Member Payment Summary, sexual dysfunction benefits only apply when sexual dysfunction is a result of the following:

- Physical trauma (meaning a specific, physically traumatic event);
- Organic disease (e.g., prostate cancer, diabetes mellitus, arterial sclerosis);
- Effects of surgery;
- Radiation therapy; or
- Drug therapy.

Psychotherapy and counseling, as well as coverage for sexual deviations, are not covered.

Services covered under this Rider include all FDA-approved drugs (up to SelectHealth's limit of eight standard doses per month), implants, and devices/appliances. All benefits covered require a provider's statement (e.g., medical chart/documentation) and diagnoses consistent with the sexual dysfunction definition and criteria stated above.

SHIPPING AND HANDLING

All finance, interest, postage, shipping, and handling fees charged by a provider are not covered.

SPECIALTY SERVICES

In the interest of providing the highest quality care for members, coverage for specific specialty services may be restricted to only those providers who document expertise through board certification or other formal training documentation that is considered a standard part of their training experience.

TELEPHONE/E-MAIL CONSULTATIONS

Charges for provider telephone and/or e-mail consultations are not covered.

TEMPOROMANDIBULAR JOINT (TMJ)/ ORTHOGNATHIC SURGERY

Dental and/or medical services for the evaluation, diagnosis, or treatment of the temporomandibular joint (TMJ), temporomandibular joint disorders (TMD), or occlusive deformities treated by means of orthagnathic surgery are covered at 50 percent of the allowed charges after the deductible (if applicable) to a lifetime maximum established by SelectHealth.

TERRORISM OR NUCLEAR RELEASE

Care or treatment of an illness, injury, or connected disability is not covered when caused by or arising out of an act of international or domestic terrorism. Care or treatment is also not covered as a result of an accidental, negligent, or intentional release of nuclear material or nuclear byproduct material.

TRANSPORTATION SERVICES

Emergency transportation services (ambulance) are not covered beyond the nearest facility expected to have appropriate services for the treatment of the emergency, injury, or illness involved or when you could be transported safely by other means. Air ambulance transportation is not covered when ground ambulance transportation is available, or in the opinion of the responding medical professional, the delay would not jeopardize patient safety.

Costs associated with travel to a local or distant medical provider, including accommodation and meal costs, are not covered. Any requests for coverage of transportation services in non-emergency situations must be approved in advance by SelectHealth.

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

UNPROVEN INTERVENTIONS AND THERAPIES

Certain services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment are not covered. These are not covered as they do not provide better outcomes than covered procedures, have not demonstrated an improvement in the health outcomes, and may lack strong evidence of their efficacy. SelectHealth's review of these treatments includes the benefits and risks, quality of the evidence supporting the outcomes, availability of alternative

treatments, and costs. These noncovered treatments include, but are not limited to, the following:

- Anodyne infrared device for any indication;
- Balloon kyphoplasty;
- Chronic intermittent IV insulin therapy;
- Coblation therapy of the soft tissues of the mouth, nose, throat, or tongue;
- Computer-assisted interpretation of X-ray (except mammograms);
- Cryoablation therapy for plantar fasciitis and Morton's neuroma;
- Extracorporeal shock wave therapy for musculoskeletal indications;
- Freestanding/home cervical traction;
- Home anticoagulation or hemoglobin A1c testing;
- Intimal Media Thickness (IMT) testing to assess risk of coronary disease;
- Lovaas therapy;
- Magnetic Source Imaging (MSI);
- Microprocessor controlled, computerized lower extremity limb prostheses;
- Mole mapping;
- Nonsurgical spinal decompression therapy (e.g., VAX-D or DRS therapy);
- Nucleoplasty or other forms of percutaneous disc decompression;
- Platelet-rich plasma for orthopedic indications
- Pressure Specified Sensory Device (PSSD) for neuropathy testing;
- Prolotherapy;
- Radiofrequency ablation for lateral epicondylitis;
- Radiofrequency ablation of the dorsal root ganglion;
- Radiofrequency of sacroiliac joints;
- Secretin infusion therapy for the treatment of autism;
- Virtual colonoscopy;
- Whole body scanning; and
- Wireless capsule endoscopy of the esophagus (PillCAM ESO).

URGENT CONDITIONS

Refer to the "Urgent Care" subsection of the "Using Your Medical Benefits" section.

UTILIZATION MANAGEMENT REQUIREMENTS

Services, supplies, tests, treatments, appliances, drugs, devices, medications, procedures, or equipment obtained in a manner that does not comply with SelectHealth's utilization management requirements are not covered or are limited in the extent of coverage stated on the Member Payment Summary. Utilization management requirements include, but are not limited to, prenotification/precertification and length-of-stay (hospital) limits.

VERTEBRAL COLUMN MANIPULATION

Refer to the "Chiropractic Services" subsection in this section.

VISION AIDS

The purchase, fitting, or ongoing evaluation of vision aids, appliances, or procedures is not covered, including, but not limited to, contact lenses and eyeglasses. Contacts are covered for members diagnosed with keratoconus, congenital cataracts, or when used as a bandage after eye trauma or injury. Prescribed eyeglasses are covered for members following covered cataract surgery. In such cases, coverage is limited to a lifetime maximum of $100.

Monofocal intraocular lenses after cataract surgery are covered. However, accommodating or multifocal intraocular lenses to correct vision after cataract surgery are not covered.

WAR

Care or treatment of an illness or injury or connected disability is not covered when caused by or arising out of a war or an act of war (whether or not declared) or service in the armed services of any county.

USING YOUR PRESCRIPTION DRUG BENEFITS

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

ONLINE PHARMACY TOOLS

Visit www.selecthealth.org/pharmacy for 24-hour access to your personal prescription drug information. You can find information about the following topics:

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

IS MY PRESCRIPTION DRUG COVERED?

For the most current information regarding drug coverage, use the drug look-up tool available at www.selecthealth.org and www.selecthealth.org/pharmacy. The tool can tell you whether on not your drug is covered and its tier level. For more information on tier levels, see the "Prescription Drug Benefit" section below. You may also call Member Services or refer to the Prescription Drug List included in this document. Please note, the Prescription Drug List is not a complete list of all drugs and may change due to new drugs, new therapies, or other factors.

USE PARTICIPATING PHARMACIES

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

If you are on the Select Med®, Select CareSM, or Select Choice network, you may use a nonparticipating pharmacy. When you do, you must pay full price for the drug, and then submit a Prescription Reimbursement Form with your pharmacy receipt to SelectHealth. Please be sure to send the itemized pharmacy receipt and not the receipt from the cash register. If covered, you will be reimbursed the discounted amount that would have been paid to a participating pharmacy for the drug, minus your copay and/or deductible.

There are three ways to find out which pharmacies participate with SelectHealth both nationally and within Utah.

- Refer to the pharmacy tools on www.selecthealth.org
- Refer to your Provider & Facility Directory
- Call Member Services

PRESCRIPTION DRUG BENEFIT

The prescription drug benefit has three tiers. These tiers, listed on your ID Card and Member Payment Summary, tell you how much you pay when you go to the pharmacy.

Tier 1: Lowest Copay

You will pay the lowest copay for Tier 1 drugs.

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

Tier 2: Middle Copay

You will pay a middle copay for Tier 2 drugs.

Tier 2 drugs include select brand-name drugs and select generic drugs.

Tier 3: Highest Copay

You will pay the highest copay for Tier 3 drugs.

Tier 3 drugs are generally brand-name medications that have an alternate drug in a lower tier.

Your doctor can determine whether a lower tier drug is right for you.

Any covered medication not listed in Tier 1 or Tier 2 is considered a Tier 3 drug.

To determine which tier applies to each prescription drug, use the drug look-up tool available at www.selecthealth.org or www.selecthealth.org/pharmacy. If your doctor prescribes a Tier 2 or Tier 3 drug, you can speak with him or her to determine if there is an appropriate Tier 1 drug available.

Please note, injectable drugs and specialty medications are not covered under your prescription drug benefits. Instead they are covered under your medical benefits. Please see the "Injectable Drugs and Specialty Medications" section of your Membership Guide or contract.

PHARMACY DEDUCTIBLE

Your prescription drug benefit includes a pharmacy deductible. A pharmacy deductible is the amount you pay directly to the pharmacy for covered prescription drugs each calendar year before SelectHealth will begin to provide any prescription drug benefits.

PHARMACY OUT-OF-POCKET MAXIMUM

Your pharmacy benefit includes a pharmacy out-of-pocket maximum. This is the maximum dollar amount per year of eligible pharmacy charges you pay directly to the pharmacy as deductibles, copays, and coinsurance. The pharmacy out-of-pocket maximum is specified on the Member Payment Summary. Except where otherwise noted on the Member Payment Summary, SelectHealth will pay 100 percent of eligible pharmacy charges during the remainder of the year once the pharmacy out-of-pocket maximum is satisfied. Member payments for noncovered services or excess charges are not applied to the out-of-pocket maximum.

DRUGS WITH SPECIAL REQUIREMENTS

Certain drugs require preauthorization or step therapy before they are covered. Please note that these drugs may change due to new drugs, new therapies, or other factors. As a result, there may be other drugs not on the Prescription Drug List that may require preauthorization or step therapy. For the most current list of drugs with special requirements, use the pharmacy tools at www.selecthealth.org/pharmacy or call Pharmacy Services.

PREAUTHORIZATION OF PRESCRIPTION DRUGS

There are certain drugs that require your doctor to call SelectHealth before you purchase them. This is called "preauthorization." Preauthorization is not required when SelectHealth is the secondary insurance, unless Medicare is your primary insurance carrier. Prescription drugs that require preauthorization are identified by the letters (PA) in the online pharmacy tools and on the Prescription Drug List. Preauthorization is also required if the medication is in excess of the plan limits (quantity, duration of use, maximum dose, etc.).

Your doctor must preauthorize these drugs, or SelectHealth will not cover them. To get preauthorization for these drugs, please have your doctor call SelectHealth Pharmacy Services at 801-442-4912 (Salt Lake area) or 800-442-3129 weekdays, from 7:00 a.m. to 8:00 p.m., or Saturdays, from 9:00 a.m. to 3:00 p.m.

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

DRUGS THAT REQUIRE STEP THERAPY

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

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

Prescription drugs that require step therapy are identified by the letters (ST) in the online pharmacy tools and on the Prescription Drug List.

LIMITATIONS

The following limitations apply to your pharmacy benefits:

Eligibility

If you are not eligible for coverage at the time your prescription is filled, then your prescription will not be covered, even if the prescription was written while you were eligible.

Copay/Coinsurance

At participating retail pharmacies, you will be charged one copay/coinsurance per covered prescription up to a 30-day supply.

Day Supply and Quantity Qimitations

Prescriptions are subject to SelectHealth quantity and days-supply limitations. For example, Schedule II drugs are limited to a 30-day supply per prescription. Schedule II drugs include, but are not limited to, controlled substances such as pain medications and stimulants. For certain drugs, a 90-day supply may be obtained. For more information, see the “Maintenance Drug Benefit” section.

Dose Limit

If your doctor prescribes a dose of a medication that is not available, you will be charged a copay for each strength of the medication.

Refills

Refills are allowed after 80 percent of the last refill has been used. Some exceptions may apply; contact Member Services for more information.

Excluded Drugs

Some drugs are excluded from coverage, including but not limited to, flu symptom medication, over-the-counter drugs, and cosmetics. Please see the “General Limitations and Exclusions” section of your Membership Guide or contract for a list of excluded drugs.

COORDINATION OF BENEFITS

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

GENERICSAMPLE℠

GenericSample is a great way to try a generic drug for FREE. The program eliminates your copay/coinsurance for the first 30-day fill of select generic prescriptions. GenericSample is only available through participating retail pharmacies. It is not available under the 90-day maintenance drug benefit.

Eligible drugs have certain strengths and quantity limits. The eliminated copay will not be applied to your deductible if you have one. Eligible drugs are identified by the letters (GS) in the online pharmacy tools and on the Prescription Drug List.

IF YOU ABUSE THE DRUG BENEFIT

SelectHealth may limit the availability and filling of any prescription for a controlled substance or other prescription drug that is susceptible to abuse. If SelectHealth suspects you may be abusing the drug benefit, a care manager may rely on any of the following protocol:

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

If you abuse the healthcare delivery system to obtain drugs in amounts in excess of what is medically necessary, such as making repeated emergency room visits to obtain drugs for conditions that are not considered emergencies, SelectHealth may deny coverage of any medication susceptible to abuse or misuse. SelectHealth may also deny coverage for any particular medication susceptible to abuse or misuse beyond the amount considered medically necessary according to accepted medical practice and may deny amounts requested or needed to support any drug dependence, addiction, or abuse.

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

Inappropriate Prescription Practices

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

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

These medications are not covered when they are prescribed in the following situations:

- Outside the usual standard of care for the practitioner prescribing the medication;
- In a manner inconsistent with accepted medical practice; and
- For unproven indications as defined by the experimental/investigational definition in the "Definitions of Terms" section of this Membership Guide.

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

GENERIC SUBSTITUTION REQUIRED

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

MAINTENANCE DRUG BENEFIT

When listed on your Member Payment Summary, this benefit is available for prescriptions you use on a continuous, ongoing basis. These are called maintenance drugs. Eligible drug categories are listed below. Maintenance drugs are identified by the letter (M) on the online pharmacy tools and on the Prescription Drug List. The maintenance drug benefit is only available for drugs that you have been taking for one month

MAINTENANCE MEDICATION OPTIONS		
	Retail90℠	Medco By Mail
Description	90-day supply available through participating retail pharmacies.	90-day supply available through mail order.
New Prescriptions	You must have filled one month's supply of the medication using your SelectHealth prescription drug benefit in one of the following ways: • at least once at any participating retail pharmacy within the previous six months; or • at least once through Medco by Mail within the previous six months. Please give the pharmacy two to three days notice before you pick up your new Retail90 prescription.	Ask your doctor for two prescriptions. The first prescription should be for a one-month supply to be filled at a participating retail pharmacy. The second prescription must be for a 90-day or three-month supply (refills up to a year) to be filled through Medco By Mail. Submit the second prescription either by mail or fax together with the Medco Order Form.
Refills	Refills are picked up at the pharmacy where you will pay a new copay. Please order your refill two to three days before you plan to pick it up.	Visit www.selecthealth.org/pharmacy to find instructions for medication refills.
Delivery of Medication	You will pick up your medication at the pharmacy.	Medications are usually sent to you by U.S. mail or UPS. Please allow two weeks for processing.
Paying for Medication	You will pay the applicable copay at the pharmacy before you pick up your medication.	You may pay by check, money order, or most major credit cards.

and expect to continue using for the next year. Visit www.selecthealth.org/pharmacy or call Pharmacy Services to verify if your medication is considered a maintenance drug and is eligible for the maintenance drug benefit.

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

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

OPTIONS WHEN FILLING MAINTENANCE MEDICATIONS

You have two options when filling prescriptions under the maintenance drug benefit. Detailed instructions and an order form for Medco By Mail are included in this section.

PRESCRIPTION DRUG LIST-ALPHABETIZED

A categorized prescription drug list is available at **www.selecthealth.org**

This alphabetized list contains the most commonly prescribed drugs in their most common strengths and formulations. This is not a complete list of all drugs and may change due to new drugs, therapies, or other factors. The tier referenced on this Prescription Drug List is based on the most frequently prescribed strength and dosage formulations. The tier level listed for each drug determines the amount you are responsible to pay. This amount can be found on your ID card or on your Member Payment Summary (MPS) or Schedule of Benefits. This list does not include injectable drug benefits. Please refer to your member materials or contact Member Services at the number below for injectable drug information.

If you have any questions about your prescription drug benefits, please call Member Services at 801-442-5038 (Salt Lake area) or 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m. **For the most current information regarding drug coverage, use the drug look-up tool available at www.selecthealth.org/myhealth.**

Drug	Tier
ABILIFY (QL) (M)	Tier 2
ACCOLATE (M)	Tier 2
ACCUPRIL [QUINAPRIL] (M)	Tier 3
ACCUTANE [ISOTRETINOIN]	Tier 3
ACEON (M)	Tier 3
ACIPHEX (QL) (ST) (M)	Tier 2
ACTIQ [FENTANYL] (QL) (PA)	Tier 3
ACTIVELLA (M)	Tier 2
ACTONEL (QL) (M) (ST)	Tier 2
ACTOPLUS MET (M)	Tier 2
ACTOS (QL) (M)	Tier 2
ACYCLOVIR *(Zovirax)*	Tier 1
ADDERALL XR (QL)	Tier 2
ADDERALL [AMPHETAMINE SALTS]	Tier 3
ADVAIR (M)	Tier 2
ADVICOR (QL) (M)	Tier 3
AGGRENOX (M)	Tier 2
ALBUTEROL [VENTOLIN] (M)	Tier 1
ALDARA	Tier 2
ALDOMET [METHYLDOPA]	Tier 3
ALENDRONATE *(Fosamax)* (QL) (M) (GS)	Tier 1
ALINIA (QL)	Tier 3
ALLEGRA [FEXOFENADINE]	Tier 3
ALLEGRA-D	Tier 3
ALOCRIL (M)	Tier 2
ALPRAZOLAM *(Xanax)*	Tier 1
ALPRAZOLAM ER *(Xanax XR)* (QL)	Tier 1
ALTABAX	Tier 3
ALTACE [RAMIPRIL] (M)	Tier 3
AMARYL [GLIMEPIRIDE] (M)	Tier 3
AMBIEN CR (QL) (ST)	Tier 3
AMBIEN [ZOLIPIDEM] (QL) (ST)	Tier 3
AMERGE (QL)	Tier 2
AMITIZA (QL)	Tier 2
AMITRIPTYLINE *(Elavil)* (M)	Tier 1
AMLODIPINE *(Norvasc)* (M) (GS)	Tier 1
AMLODIPINE/BENAZEPRIL *(Lotrel)* (M)	Tier 1
AMNESTEEM *(Accutane)*	Tier 1
AMOX TR-K CLAV *(Augmentin)*	Tier 1
AMOXICILLIN (GS)	Tier 1
AMOXIL	Tier 1
AMPHETAMINE SALT *(Adderall)*	Tier 1
AMPICILLIN	Tier 1
AMRIX (QL) (PA)	Tier 3
ANDRODERM (ST) (M)	Tier 2
ANDROGEL (M)	Tier 2
ANZEMET (QL)	Tier 3
APAP W/ BUTALBITAL *(Phrenilin)* (QL)	Tier 1
APIDRA (M)	Tier 3
APRI *(Desgen and Ortho-Cept)* (M)	Tier 1
ARAVA [LEFLUNOMIDE] (M)	Tier 3
ARICEPT (M)	Tier 2
ARIMIDEX (QL) (M)	Tier 2
ARMOUR THYROID [THYROID] (M)	Tier 3
AROMASIN (QL) (M)	Tier 2
ARTHROTEC (M)	Tier 3
ASACOL (M)	Tier 2
ASMANEX (M) (QL)	Tier 2
ASTELIN (M)	Tier 2
ATACAND HCT (ST) (M)	Tier 3
ATACAND (ST) (M)	Tier 3
ATENOLOL *(Tenormin)* (M)	Tier 1
ATIVAN [LORAZEPAM]	Tier 3
ATROVENT HFA (M)	Tier 3
ATROVENT [IPRATROPIUM] (M)	Tier 3
AUGMENTIN XR	Tier 2
AUGMENTIN *(Amox Tr-K Clav)*	Tier 3
AVALIDE (ST) (M)	Tier 3
AVANDAMET (M)	Tier 2
AVANDARYL (M)	Tier 2
AVANDIA (M)	Tier 2
AVAPRO (ST) (M)	Tier 3
AVELOX	Tier 3
AVINZA (QL)	Tier 2
AVODART (M)	Tier 3
AXERT (QL)	Tier 3
AZATHIOPRINE *(Imuran)* (M)	Tier 1
AZELEX	Tier 3
AZITHROMYCIN *(Zithromax)* (QL)	Tier 1
AZMACORT (M)	Tier 3
BACLOFEN	Tier 1
BACTRIM [SMZ-TMP]	Tier 3
BACTROBAN [MUPIROCIN]	Tier 2
BECONASE AQ (M)	Tier 3
BENAZEPRIL *(Lotensin)* (M) (GS)	Tier 1
BENAZEPRIL HCTZ *(Lotensin HCT)* (M)	Tier 1
BENICAR HCT (ST) (M)	Tier 3
BENICAR (ST) (M)	Tier 3
BENZACLIN	Tier 2
BENZAMYCIN [ERYTH/BP]	Tier 3
BENZOYL PEROXIDE *(Benzac)*	Tier 1
BETAMETHASONE *(Diprolene)*	Tier 1
BETAPACE AF [SOTALOL/AF] (M)	Tier 3

TIER 1 INCLUDES GENERIC DRUGS

TIER 2 INCLUDES PREFERRED BRAND-NAME DRUGS

TIER 3 INCLUDES NON-PREFERRED BRAND-NAME DRUGS

(PA) Preauthorization – Coverage of certain drugs is based on medical necessity. For these drugs, you will need preauthorization from SelectHealth; otherwise, you will be responsible to pay the drug's full retail price.

(ST) Step Therapy – Drugs that require step therapy are covered by SelectHealth only after you have tried the alternative therapy, and it didn't work (the therapy failed).

(QL) Quantity Limits – Quantity limitations apply to certain drugs (maximum number of tablets/capsules, etc. per prescription). Preauthorization is required if the medication exceeds the plan limits.

(GS) GenericSample℠ – The Rx copay will be eliminated for the first fill of certain strengths at the pharmacy.

(M) Maintenance Drug – Available for 90-day maintenance drug benefit.

[GENERIC NAME] – Drug names in brackets, such as [QUINAPRIL], indicate a generic equivalent to the brand-name drug listed is available. Not all generic drugs will be listed.

***(Brand name)* –** Drug names italicized in parentheses, such as *(Nizoral)*, indicate a brand-name equivalent to the generic drug listed.

†Drugs that are not covered can be obtained through an exception process. SelectHealth will cover these drugs after you have tried alternative, covered medications in the same therapeutic category that have failed to meet your medical needs. All approved exceptions will be priced as Tier 3 drugs.

BIAXIN XL [CLARITHROMYCIN ER] Tier 3
BIAXIN [CLARITHROMYCIN] Tier 3
BISOPROLOL *(Zebeta)* (M) Tier 1
BISOPROLOL HCTZ *(Ziac)* (M) Tier 1
BONIVA (QL) (M) (PA) Tier 3
BREVOXYL (QL) Tier 3
BROVANA (QL) (M) Tier 3
BUPROPION HCL *(Zyban)* (QL) Tier 1
BUPROPION, SR,XL*(Wellbutrin,SR, XL)*(QL)(M)(GS) Tier 1
BUSPAR [BUSPIRONE] Tier 3
BUSPIRONE *(Buspar)* Tier 1
BUTALBITAL-APAP-CAFFEINE *(Esgic)* Tier 1
BUTALBITAL-ASA-CAFFEINE *(Fiorinal)* Tier 1
BUTALBITAL-CAFF-APAP-COD *(Fioricet w/ Cod)* Tier 1
BUTORPHANOL *(Stadol)* (QL) Tier 1
BYETTA (QL) (ST) (M) Tier 2
BYSTOLIC Tier 3
CADUET (ST) (M) Tier 3
CAFERGOT [ERGOTAMINE/CAFF.] Tier 3
CALAN [VERAPAMIL] (M) Tier 3
CAPOTEN [CAPTOPRIL] (M) Tier 3
CAPOZIDE [CAPTOPRIL/HCTZ] (M) Tier 3
CAPTOPRIL *(Capoten)* (M) Tier 1
CAPTOPRIL HCTZ *(Capozide)* (M) Tier 1
CARAC Tier 2
CARBAMAZEPINE *(Tegretol)* (M) Tier 1
CARBATROL (M) Tier 2
CARDIZEM CD/LA [DILTIAZEM] (M) Tier 3
CARDURA [DOXAZOSIN] (M) Tier 3
CARISOPRODOL CMP/CODEINE Tier 1
CARISOPRODOL/ CMP *(Soma/ CMP)* (QL) Tier 1
CARVEDILOL *(Coreg)* Tier 1
CATAPRES TTS (M) Tier 2
CATAPRES [CLONIDINE] (M) Tier 3
CEDAX Tier 3
CEFACLOR *(Ceclor)* Tier 1
CEFADROXIL *(Duricef)* Tier 1
CEFDINIR *(Omnicef)* Tier 1
CEFPROZIL *(Cefzil)* Tier 1
CEFUROXIME *(Ceftin)* Tier 1
CEFZIL [CEFPROZIL] Tier 3
CELEBREX (QL) (M) Tier 3
CELEXA [CITALOPRAM] (QL) (ST) (M) Tier 3
CELLCEPT (M) Tier 2
CENESTIN (M) Tier 2
CEPHALEXIN *(Keflex)* Tier 1
CESIA *(Cyclessa)* (M) Tier 1
CHANTIX (QL) Tier 2
CHOLESTYRAMINE *(Questran)* (M) Tier 1
CHROMAGEN (PA) Tier 3
CICLOPIROX *(Loprox/Penlac)* Tier 1
CILOXAN [CIPROFLOXACIN] Tier 3
CIMETIDINE *(Tagamet)* (M) Tier 1
CIPRO HC Tier 2
CIPRO XR [CIPROFLOXACIN ER] Tier 3
CIPRO [CIPROFLOXACIN] Tier 3
CIPRODEX Tier 2
CIPROFLOXACIN *(Cipro)* Tier 1
CIPROFLOXACIN ER *(Cipro XR)* Tier 1
CITALOPRAM *(Celexa)* (QL) (M) (GS) Tier 1
CLARAVIS *(Accutane)* Tier 1
CLARINEX Tier 3
CLARINEX-D Tier 3
CLARITHROMYCIN *(Biaxin)* Tier 1
CLARITHROMYCIN ER *(Biaxin XL)* Tier 1
CLIMARA [ESTRADIOL] (M) Tier 2
CLINDAMYCIN *(Cleocin)* Tier 1
CLOBETASOL *(Temovate)* Tier 1
CLONAZEPAM *(Klonopin)* (M) Tier 1

CLONIDINE *(Catapres)* (M) Tier 1
CLOTRIMAZOLE *(Mycelex)* Tier 1
CLOTRIMAZOLE-BETAMETH *(Lotrisone)* Tier 1
CLOZAPINE *(Clozaril)* (M) Tier 1
COMBIGAN (M) (QL) Tier 2
COMBIVENT (M) Tier 3
CONCERTA (QL) Tier 2
COREG CR (M) Tier 2
COREG *(Carvedilol)* (M) Tier 3
COSOPT(M) Tier 2
COUMADIN [WARFARIN] (M) Tier 2
COZAAR(M) Tier 2
CRESTOR 10/20/40mg (QL) (M) Tier 2
CRESTOR 5mg (QL) (ST) (M) Tier 2
CRINONE (minimum age) Tier 3
CROMOLYN *(Crolom) (Intal)* (M) Tier 1
CYCLESSA [CESIA & VELIVET] (M) Tier 3
CYCLOBENZAPRINE *(Flexeril)* Tier 1
CYCLOSPORINE *(Sandimmune and Neoral)* (M) Tier 1
CYMBALTA (ST) (M) (QL) Tier 2
CYTOMEL (M) Tier 2
DAYPRO [OXAPROZIN] (M) Tier 3
DAYTRANA (QL) Tier 3
DDAVP [DESMOPRESSIN] (PA) Tier 3
DEMULEN (M) Tier 3
DEPAKOTE [DIVALPROEX] (M) Tier 2
DERMATOP [PREDNICARBATE] Tier 3
DESMOPRESSIN *(DDAVP)* (PA) Tier 1
DESOGEN Tier 3
DESONIDE *(Desowen)* Tier 1
DESYREL [TRAZODONE] (M) Tier 3
DETROL LA (M) Tier 3
DETROL (M) Tier 3
DEXEDRINE CR [DEXTROAM SR] (QL) Tier 3
DEXEDRINE [DEXTROAM] (QL) Tier 3
DEXTROAM *(Dexedrine)* (QL) Tier 1
DEXTROAM SR *(Dexedrine CR)* (QL) Tier 1
DIAZEPAM (Valium) Tier 1
DICLOFENAC *(Voltaren)* (M) (GS) Tier 1
DIFFERIN (age limit) Tier 2
DIFLUCAN [FLUCONAZOLE] Tier 3
DIFLUCAN 150mg [FLUCONAZOLE 150mg](QL) Tier 3
DIGOXIN *(Lanoxin)* (M) Tier 1
DILANTIN [PHENYTOIN] (M) Tier 2
DILTIAZEM *(Tiazac)* (M) Tier 1
DILTIAZEM ER *(Cardizem CD)* (M) Tier 1
DIOVAN HCT (M) Tier 2
DIOVAN (M) Tier 2
DIPHENOXYLATE-ATROPINE *(Lomotil)* Tier 1
DITROPAN XL [OXYBUTININ ER] Tier 3
DITROPAN [OXYBUTIN] (M) Tier 3
DIVALPROEX [DEPAKOTE] (M) Tier 1
DOVONEX Tier 3
DOXAZOSIN *(Cardura)* (M) (GS) Tier 1
DOXYCYCLINE *(Vibramycin)* (GS) Tier 1
DUAC/CS Tier 2
DUETACT (M) Tier 2
DURAGESIC [FENTANYL] (QL) Tier 3
E.E.S. Tier 1
EFFEXOR XR (QL) (ST) (M) Tier 2
EFFEXOR [VENLAFAXINE] (ST) (M) Tier 3
EFUDEX [FLUOROURACIL] Tier 2
ELESTAT Tier 2
ELIDEL (ST) Tier 2
ELOCON [MOMETASONE] Tier 3
EMEND (QL) Tier 3
EMSAM (QL) (ST) (M) Tier 3
ENABLEX (M) Tier 3
ENALAPRIL *(Vasotec)* (M) (GS) Tier 1

ENALAPRIL HCTZ *(Vaseretic)* (M) Tier 1
ENJUVIA (M) Tier 2
ENTOCORT EC Tier 3
EPLERENONE *(Inspra)* (ST) (M) Tier 1
ERY-TAB Tier 2
ERYTH-BP *(Benzamycin)* Tier 1
ERYTHROMYCIN *(Ery-Tab)* Tier 1
ESTRADERM (M) Tier 2
ESTRADIOL *(Estrace)* (M) Tier 1
ESTRADIOL PATCH *(Climara)* (M) Tier 1
ESTRATEST [SYNTEST] (M) Tier 2
ESTRING Tier 2
ESTROGEL (M) Tier 2
ESTROPIPATE *(Ogen)* (M) Tier 1
EVISTA (QL) (M) Tier 2
EXELON (M) Tier 3
EXFORGE (M) Tier 2
FAMCICLOVIR *(Famvir)* Tier 1
FAMOTIDINE *(Pepcid)* (QL) (M) Free
FAMVIR [FAMCICLOVIR] Tier 3
FELDENE [PIROXICAM] (M) Tier 3
FEMHRT (M) Tier 3
FEMTRACE (M) Tier 3
FENOFIBRATE *(Lofibra)* (QL) (M) Tier 1
FENTANYL *(Actiq)* (QL) (PA) Tier 1
FENTANYL *(Duragesic)* (QL) Tier 1
FENTORA (QL) (PA) Tier 3
FEXOFENADINE *(Allegra)* Tier 1
FINASTERIDE *(Proscar)* (ST) (M) Tier 1
FIORICET [BUTALBITAL/APAP/CAFF.] Tier 3
FLEXERIL *(Cyclobenzaprine)* Tier 3
FLOMAX (M) Tier 2
FLONASE [FLUTICASONE] (M) Tier 3
FLOVENT HFA (M) Tier 2
FLOXIN [OFLOXACIN] Tier 3
FLUCONAZOLE *(Diflucan)* Tier 1
FLUCONAZOLE 150mg *(Diflucan 150mg)* (QL) Tier 1
FLUNISOLIDE *(Nasarel)* (M) Tier 1
FLUOROURACIL *(Efudex)* Tier 1
FLUOXETINE *(Prozac)* (M) (GS) Tier 1
FLURAZEPAM *(Dalmane)* Tier 1
FLUTICASONE *(Flonase)* (M) (GS) Tier 1
FOCALIN XR (QL) Tier 3
FORADIL (M) Tier 3
FOSAMAX *(Alendronate)* (QL) (M) (ST) Tier 3
FOSAMAX D (QL) (M) Tier 2
FOSINOPRIL *(Monopril)* (M) Tier 1
FOSINOPRIL HCTZ *(Monopril HCT)* (M) Tier 1
FREESTYLE TEST STRIPS (QL) (M) Tier 2
FROVA (QL) Tier 3
FUROSEMIDE *(Lasix)* (M) Tier 1
GABAPENTIN *(Neurontin)* (QL) (M) Tier 1
GABITRIL (QL) (M) Tier 2
GEMFIBROZIL *(Lopid)* (QL) (M) Tier 1
GENGRAF *(Neoral)* (M) Tier 1
GENTAMICIN Tier 1
GEODON (QL) (M) Tier 2
GLEEVEC (PA) Tier 2
GLIMEPIRIDE *(Amaryl)* (M) Tier 1
GLIPIZIDE *(Glucotrol)* (M) Tier 1
GLIPIZIDE XL *(Glucotrol XL)* (M) Tier 1
GLIPIZIDE-MET *(Metaglip)* (M) Tier 1
GLUCAGON Tier 2
GLUCOPHAGE XR [METFORMIN] (M) Tier 3
GLUCOPHAGE [METFORMIN] (M) Tier 3
GLUCOTROL XL [GLIPIZIDE ER] (M) Tier 3
GLUCOTROL [GLIPIZIDE] (M) Tier 3
GLUCOVANCE [GLYBURIDE/MET] (M) Tier 3
GLYBURIDE *(Diabeta/Micronase)* (M) Tier 1

TIER 1 INCLUDES GENERIC DRUGS

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TIER 3 INCLUDES NON-PREFERRED BRAND-NAME DRUGS

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[GENERIC NAME] – Drug names in brackets, such as [QUINAPRIL], indicate a generic equivalent to the brand-name drug listed is available. Not all generic drugs will be listed.

***(Brand name)* –** Drug names italicized in parentheses, such as *(Nizoral)*, indicate a brand-name equivalent to the generic drug listed.

†Drugs that are not covered can be obtained through an exception process. SelectHealth will cover these drugs after you have tried alternative, covered medications in the same therapeutic category that have failed to meet your medical needs. All approved exceptions will be priced as Tier 3 drugs.

Drug	Tier
GLYBURIDE/MET *(Glucovance)* (M)	Tier 1
GRANISETRON (QL) *(Kytril)*	Tier 1
HALOPERIDOL (M)	Tier 1
HUMALOG 50/50 and 75/25 (M)	Tier 2
HUMALOG (PA) (M)	Tier 3
HUMULIN (PA) (M)	Tier 3
HYDROCHLOROTHIAZIDE (HCTZ) (M) (GS)	Tier 1
HYDROCODONE W/APAP *(Lortab/Vicodin)* (QL)	Tier 1
HYDROCORTISONE *(Cortef) (Hytone)* (M)	Tier 1
HYDROXYZINE *(Vistaril)*	Tier 1
HYOSCYAMINE *(Cystospaz)* (M)	Tier 1
HYOSCYAMINE *(Levsin)* (M)	Tier 1
HYTRIN [TERAZOSIN] (M)	Tier 3
HYZAAR (M)	Tier 2
IBUPROFEN *(Motrin)* (M) (GS)	Tier 1
IMDUR [ISOSORBIDE MONONITRATE] (M)	Tier 3
IMIPRAMINE *(Tofranil)* (M)	Tier 1
IMITREX (QL)	Tier 2
IMURAN [AZATHIOPRINE] (M)	Tier 3
INDERAL LA [PROPRANOLOL ER] (M)	Tier 3
INDOMETHACIN *(Indocin)* (M)	Tier 1
INNOPRAN XL (M)	Tier 2
INSPRA [EPLERENONE] (ST) (M)	Tier 3
INVEGA (QL) (PA) (M)	Tier 3
IPRATROPIUM *(Atrovent)* (M)	Tier 1
IRESSA (PA)	Tier 2
ISORDIL [ISOSORBIDE DINITRATE] (M)	Tier 3
ISOSORBIDE DINITRATE *(Isordil)* (M)	Tier 1
ISOSORBIDE MONONITRATE *(Imdur)*(M)	Tier 1
ISOTRETINOIN *(Accutane)*	Tier 1
ITRACONAZOLE *(Sporanox)* (QL) (PA)	Tier 1
JANUMET (QL) (M)	Tier 2
JANUVIA (QL) (M)	Tier 2
KADIAN (QL)	Tier 2
KARIVA *(Mircette)* (M)	Tier 1
KEFLEX [CEPHALEXIN]	Tier 3
KENALOG [TRIAMCINOLONE]	Tier 3
KEPPRA (QL) (M)	Tier 2
KETEK	Tier 3
KETOCONAZOLE *(Nizoral)*	Tier 1
KETOROLAC *(Toradol)* (QL)	Tier 1
KUVAN (PA)	Tier 3
KYTRIL [GRANISETRON] (QL)	Tier 3
LABETALOL *(Trandate)* (M)	Tier 1
LAMICTAL [LAMOTRIGINE] (QL) (M)	Tier 2
LAMISIL [TERBINAFINE] (QL)	Tier 3
LAMOTRIGINE *(Lamictal)* (QL) (M)	Tier 1
LANOXIN [DIGOXIN] (M)	Tier 2
LANTUS (M)	Tier 2
LEFLUNOMIDE *(Arava)* (M)	Tier 1
LESCOL (QL) (M)	Tier 3
LETAIRIS (PA)	Tier 3
LEVAQUIN	Tier 3
LEVEMIR (M)	Tier 2
LEVORA *(Nordette)* (M)	Tier 1
LEVOTHROID (M)	Tier 2
LEVOXL (M)	Tier 2
LEXAPRO (QL) (ST)	Tier 3
LIALDA (QL) (M)	Tier 2
LIDEX [FLUOCINONIDE]	Tier 3
LIPITOR (QL) (ST) (M)	Tier 3
LISINOPRIL *(Prinivil/Zestril)* (M)	Tier 1
LISINOPRIL HCTZ *(Prinzide)* (M) (GS)	Tier 1
LOESTRIN FE *(Microgestin)* (M)	Tier 3
LORAZEPAM *(Ativan)*	Tier 1
LORCET [HYDROCODONE-APAP] (QL)	Tier 3
LORTAB [HYDROCODONE/APAP] (QL)	Tier 3
LOTENSIN HCT [BENAZEPRIL-HCTZ] (M)	Tier 3
LOTREL [AMLODIPINE/BENAZEPRIL] (M)	Tier 3
LOTRONEX (QL) (PA) (M)	Tier 3
LOVASTATIN *(Mevacor)* (QL) (M) (GS)	Tier 1
LUMIGAN (M)	Tier 2
LUNESTA (QL) (ST)	Tier 3
LYBREL (M)	Tier 2
LYRICA (QL) (M)	Tier 3
MACROBID [NITROFURANTOIN]	Tier 3
MAVIK [TRANDOLAPRIL] (M)	Tier 3
MAXAIR (M)	Tier 2
MAXALT/ MLT (QL)	Tier 2
MAXZIDE [TRIAMTERENE-HCTZ] (M)	Tier 3
MEDROL [METHYLPREDNISOLONE]	Tier 3
MEDROXYPROGESTERONE *(Provera)* (M)	Tier 1
MELOXICAM *(Mobic)* (M)	Tier 1
METADATE CD	Tier 3
METADATE ER [METHYLIN ER]	Tier 3
METAGLIP [GLIPIZIDE-METFORMIN] (M)	Tier 3
METFORMIN *(Glucophage)* (M) (GS)	Tier 1
METFORMIN ER *(Glucophage XR)* (M) (GS)	Tier 1
METHOCARBAMOL *(Robaxin)*	Tier 1
METHYLDOPA *(Aldomet)* (M)	Tier 1
METHYLIN	Tier 3
METHYLPHENIDATE *(Ritalin)*	Tier 1
METHYLPREDNISOLONE *(Medrol)*	Tier 1
METOCLOPRAMIDE HCL *(Reglan)* (M)	Tier 1
METOPROLOL SUCCINATE *(Toprol XL)* (M)	Tier 1
METROCREAM [METRONIDAZOLE]	Tier 3
METROGEL	Tier 3
METROLOTION [METRONIDAZOLE]	Tier 2
METRONIDAZOLE *(Metrolotion)*	Tier 1
METRONIDAZOLE *(Flagyl)*	Tier 1
MIACALCIN [CALCITONIN] (M)	Tier 2
MICARDIS HCT (ST) (M)	Tier 3
MICARDIS (ST) (M)	Tier 3
MICROGESTIN/FE *(Loestrin)* (M)	Tier 1
MINIRIN (PA)	Tier 1
MINOCYCLINE *(Dynacin/Minocin)*	Tier 1
MIRCETTE [KARIVA] (M)	Tier 3
MIRTAZAPINE *(Remeron)* (QL) (M)	Tier 1
MOBIC [MELOXICAM] (M)	Tier 3
MOMETASONE *(Elocon)*	Tier 1
MORPHINE SULFATE *(MS Contin/Oramorph)*	Tier 1
MOTRIN [IBUPROFEN] (M)	Tier 3
MS CONTIN [MORPHINE SULFATE]	Tier 3
MUPIROCIN *(Bactroban)*	Tier 1
MYCELEX [CLOTRIMAZOLE]	Tier 3
MYFORTIC (M)	Tier 3
NABUMETONE *(Relafen)* (M)	Tier 1
NAMENDA (M)	Tier 2
NAPROXEN *(Naprosyn)* (M) (GS)	Tier 1
NASACORT AQ (M)	Tier 3
NASAREL [FLUNISOLIDE] (M)	Tier 3
NASONEX (M)	Tier 2
NECON *(Ortho-Novum)* (M)	Tier 1
NEORAL *(Cyclosporin)* (M)	Tier 2
NEURONTIN [GABAPENTIN] (QL) (M)	Tier 3
NEXAVAR (PA)	Tier 2
NEXIUM (QL) (ST)(M)	Tier 3
NIASPAN (QL) (M)	Tier 2
NICARDIPINE *(Cardene)* (M)	Tier 1
NIFEDIPINE *(Adalat and Procardia)* (M)	Tier 1
NIFEDIPINE ER *(Procardia XL)* (M)	Tier 1
NITRO-DUR [NITROGLYCERIN] (M)	Tier 2
NITROFURANTOIN *(Macrobid)*	Tier 1
NIZORAL [KETOCONAZOLE]	Tier 3
NORETHINDRONE *(Aygestin)* (M)	Tier 1
NORTREL *(Ortho-Novum)* (M)	Tier 1
NORTRIPTYLINE *(Pamelor)* (M)	Tier 1
NORVASC [AMLODIPINE] (M)	Tier 3
NOVOLIN	Tier 2
NOVOLOG (M)	Tier 2
NUVARING (QL) (M)	Tier 2
NYSTATIN	Tier 1
OCELLA *(Yasmin 28)* (M)	Tier 1
OCUFLOX [OFLOXACIN]	Tier 2
OFLOXACIN *(Floxin)*	Tier 1
OFLOXACIN *(Ocuflox)*	Tier 1
OLUX	Tier 3
OMEPRAZOLE *(Prilosec)* (QL) (M) (GS)	Tier 1
OMNARIS	Tier 3
OMNICEF [CEFDINIR]	Tier 3
ONDANSETRON *(Zofran)* (QL)	Tier 1
ONDANSETRON ODT *(Zofran ODT)* (QL)	Tier 1
OPANA/ER (QL) (PA)	Tier 3
OPTIVAR	Tier 2
ORACEA (ST)	Tier 3
ORAPRED [PREDNISOLONE SOD PHOSPHATE]	Tier 3
ORTHO EVRA (QL) (M)	Tier 3
ORTHO MICRONOR (M)	Tier 3
ORTHO TRI-CYCLEN LO (M)	Tier 3
ORTHO-CEPT (M)	Tier 3
ORTHO-CYCLEN (M)	Tier 3
ORTHO-NOVUM (M)	Tier 3
OVCON (M)	Tier 3
OXAPROZIN *(Daypro)* (M)	Tier 1
OXYBUTYNIN ER *(Ditropan)* (M)	Tier 1
OXYCODONE-APAP *(Percocet)*	Tier 1
OXYCODONE-ASPIRIN *(Percodan)*	Tier 1
OXYCONTIN (QL) (ST)	Tier 3
OXYTROL (M)	Tier 3
PAMELOR [NORTRIPTYLINE] (M)	Tier 3
PANTOPRAZOLE *(Protonix)* (QL) (ST) (M)	Tier 1
PAROXETINE *(Paxil)* (QL) (M) (GS)	Tier 1
PATADAY (M)	Tier 3
PATANOL	Tier 2
PAXIL CR (QL) (ST) (M)	Tier 2
PAXIL [PAROXETINE] (QL) (ST) (M)	Tier 3
PENICILLIN	Tier 1
PENLAC *(Ciclopirox)* (QL)	Tier 3
PENTASA (M)	Tier 2
PERCOCET [OXYCODONE/APAP]	Tier 3
PERIOSTAT [DOXYCYCLINE] (ST)	Tier 3
PEXEVA (QL) (ST) (M)	Tier 3
PHENERGAN [PROMETHAZINE]	Tier 3
PHENYTOIN *(Dilantin)* (M)	Tier 1
PIROXICAM *(Feldene)* (M)	Tier 1
PLAVIX (M)	Tier 2
PRANDIN (M)	Tier 2
PRAVACHOL [PRAVASTATIN] (QL) (M)	Tier 3
PRAVASTATIN *(Pravachol)* (QL) (M) (GS)	Tier 1
PRAZOSIN *(Minipress)* (M)	Tier 1
PRECISION TEST STRIPS (QL) (M)	Tier 2
PRECOSE (M)	Tier 2
PREDNICARBATE *(Dermatop)*	Tier 1
PREDNISOLONE *(Prelone)*	Tier 1
PREDNISOLONE SOD PHOS *(Orapred)*	Tier 1
PREDNISONE *(Sterapred)* (M)	Tier 1
PRELONE [PREDNISOLONE] (M)	Tier 3
PREMARIN (M)	Tier 2
PREMPHASE (M)	Tier 2
PREMPRO (M)	Tier 2
Prenatal Vitamins- Brand (M)	Tier 3
Prenatal Vitamins- Generic (M)	Tier 1
PREVACID NAPRAPAC (M)	Tier 2
PREVACID (QL) (ST) (M)	Tier 2
PREVIFEM *(Ortho-Cyclen)* (M)	Tier 1
PREVPAC (QL) (M)	Tier 2
PRILOSEC [OMEPRAZOLE] (QL) (ST) (M)	Tier 3

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Drug	Tier
PRINIVIL [LISINOPRIL] (M)	Tier 3
PRISTIQ (QL) (PA) (M)	Tier 3
PROAIR HFA (M)	Tier 2
PROGESTERONE (PA)	Tier 3
PROGRAF (M)	Tier 2
PROMETHAZINE *(Phenergan)*	Tier 1
PROMETRIUM (minimum age) (M)	Tier 2
PROPOXYPHENE *(Darvon)*	Tier 1
PROPOXYPHENE-APAP *(Darvocet)*	Tier 1
PROPRANOLOL *(Inderal)* (M)	Tier 1
PROPRANOLOL ER *(Inderal LA)* (M)	Tier 1
PROSCAR [FINASTERIDE] (ST) (M)	Tier 3
PROTONIX [PANTOPRAZOLE] (QL) (ST) (M)	Tier 3
PROTOPIC (ST)	Tier 2
PROVENTIL HFA (M)	Tier 2
PROVENTIL [ALBUTEROL] (M)	Tier 3
PROVERA [MEDROXYPROGESTERONE] (M)	Tier 3
PROVIGIL (QL)	Tier 3
PROZAC [FLUOXETINE] (QL) (ST) (M)	Tier 3
PULMICORT (M)	Tier 2
PYLERA (M)	Tier 3
QUASENSE *(Seasonale)* (QL) (M)	Tier 1
QUESTRAN [CHOLESTYRAMINE] (M)	Tier 3
QUINAPRIL *(Accupril)* (M) (GS)	Tier 1
QUINARETIC *(Accuretic)* (M)	Tier 1
QVAR (M)	Tier 2
RAMIPRIL *(Altace)* (M)	Tier 1
RANEXA (ST) (M)	Tier 2
RANITIDINE HCL *(Zantac)* (QL) (M)	Free
RAPAMUNE (M)	Tier 2
RAPIFLUX [FLUOXETINE] (ST)	Tier 3
RAZADYNE ER (M)	Tier 3
RAZADYNE (M)	Tier 3
REGRANEX (QL) (PA)	Tier 3
RELPAX (QL)	Tier 3
REMERON [MIRTAZAPINE] (ST) (M)	Tier 3
RESTASIS	Tier 3
RETIN-A (age limit) [TRETINOIN]	Tier 3
RETIN-A MICRO (age limit)	Tier 2
REVATIO (PA)	Tier 3
REVLIMID (QL) (PA)	Tier 2
RHINOCORT AQUA (M)	Tier 3
RISPERDAL [RISPERIDONE] (QL) (M)	Tier 3
RITALIN LA (QL)	Tier 3
RITALIN SR [METHYLPHENIDATE] (QL)	Tier 3
RITALIN [METHYLPHENIDATE]	Tier 3
ROBAXIN [METHOCARBAMOL]	Tier 3
ROZEREM (QL)	Tier 2
SANDIMMUNE [CYCLOSPORINE] (M)	Tier 2
SARAFEM (ST) (M)	Tier 3
SEASONALE (QL) (M)	Tier 3
SEASONIQUE [QUASENSE] (QL) (M)	Tier 3
SEREVENT (M)	Tier 2
SEROQUEL, XR (QL) (M)	Tier 2
SERTRALINE *(Zoloft)* (QL) (M) (GS)	Tier 1
SIMCOR (ST) (QL)	Tier 3
SIMVASTATIN *(Zocor)* (QL) (M) (GS)	Tier 1
SINGULAIR (ST) (M)	Tier 2
SKELAXIN	Tier 3
SMZ-TMP *(Bactrim/Septra)*	Tier 1
SOLIA *(Desogen and Ortho-Cept)* (M)	Tier 1
SOLODYN (ST)	Tier 3
SOLTAMOX (M)	Tier 2
SOMA /CMP [CARISOPRODO/ CMP] (QL)	Tier 3
SOMA 250 mg (PA)	Tier 3
SONATA [ZALEPON] (QL) (ST)	Tier 3
SORIATANE	Tier 3
SOTALOL/AF *(Betapace/AF)* (M)	Tier 1
SOTRET *(Accutane)*	Tier 1
SPIRIVA (QL) (M)	Tier 2
SPIRONOLACTONE *(Aldactone)* (M)	Tier 1
SPORANOX [ITRACONAZOLE] (QL)(PA)	Tier 3
SPRINTEC *(Ortho-Cyclen)* (M)	Tier 1
SPRYCEL (QL) (PA)	Tier 2
STIMATE	Tier 3
STRATTERA (QL)	Tier 3
SUPRAX	Tier 3
SUTENT (PA)	Tier 2
SYMBICORT (M)	Tier 2
SYMBYAX (M)	Tier 3
SYMLIN (QL) (ST) (M)	Tier 2
SYMLIN PEN (QL) (ST) (M)	Tier 2
SYNTEST *(Estratest)*	Tier 1
SYNTHROID (M)	Tier 1
TAMOXIFEN (M)	Tier 1
TARCEVA (PA)	Tier 2
TARGRETIN (QL)	Tier 2
TARKA (M)	Tier 2
TASIGNA (PA)	Tier 2
TAZORAC	Tier 2
TEGRETOL [CARBAMAZEPINE] (M)	Tier 2
TEKTURNA (ST) (M)	Tier 3
TEMAZEPAM *(Restoril)*	Tier 1
TEMOVATE [CLOBETASOL]	Tier 3
TERAZOSIN *(Hytrin)* (M)	Tier 1
TERBINAFINE *(Lamisil)* (QL)	Tier 1
TESTIM (ST) (M)	Tier 3
TETRACYCLINE *(Sumycin)*	Tier 1
TEVETEN HCT (ST) (M)	Tier 3
TEVETEN (ST) (M)	Tier 3
THEOPHYLLINE (M)	Tier 1
TIMOLOL *(Timoptic)* (M)	Tier 1
TIZANIDINE *(Zanaflex)*	Tier 1
TOBRAMYCIN	Tier 1
TOPAMAX (QL) (M)	Tier 2
TOPROL XL [METOPROLOL SUCCINATE] (M)	Tier 3
TRACLEER (PA)	Tier 3
TRAMADOL *(Ultram)* (QL)	Tier 1
TRAMADOL-APAP *(Ultracet)* (QL)	Tier 1
TRANDOLAPRIL *(Mavik)* (M)	Tier 1
TRAZODONE *(Desyrel)* (M)	Tier 1
TRETINOIN (age limit) *(Retin-A)*	Tier 1
TREXIMET (QL)	Tier 3
TRIAMCINOLONE ACETONIDE *(Kenalog)*	Tier 1
TRIAMTERENE-HCTZ *(Maxzide)* (M)	Tier 1
TRICOR (QL) (M)	Tier 2
TRILEPTAL (QL) (M)	Tier 3
TRIMOX	Tier 1
TRINESSA *(Ortho Tri-Cyclen)* (M)	Tier 1
TRIPHASIL 28 (M)	Tier 1
TRI-PREVIFEM *(Ortho Tri-Cyclen)* (M)	Tier 1
TRUSOPT (M)	Tier 2
TYKERB (QL) (PA)	Tier 2
ULTRACET [TRAMADOL/APAP] (QL)	Tier 3
ULTRAM [TRAMADOL/APAP] (QL)	Tier 3
ULTRAM ER (QL)	Tier 3
UNIPHYL (M)	Tier 2
UNITHROID (M)	Tier 2
UROXATRAL (M)	Tier 3
VAGIFEM (M)	Tier 2
VALTREX	Tier 2
VELIVET *(Cyclessa)* (M)	Tier 1
VENLAFAXINE *(Effexor)* (M)	Tier 1
VENTOLIN HFA (M)	Tier 3
VERAMYST (M)	Tier 3
VERAPAMIL *(Calan/Verelan/Isoptin)* (M)	Tier 1
VERELAN [VERAPAMIL] (M)	Tier 3
VESICARE (M)	Tier 3
VFEND (QL)	Tier 3
VICODIN [HYDROCODONE-APAP] (QL)	Tier 3
VICOPROFEN [HYDROCODONE-IBU] (QL)	Tier 3
VIGAMOX	Tier 3
VIVELLE (M)	Tier 2
VIVELLE-DOT (M)	Tier 2
VYTORIN 10/10 mg (QL) (ST) (M)	Tier 2
VYTORIN 10/20, 10/40, 10/80 mg (QL) (M)	Tier 2
VYVANSE (QL)	Tier 2
WARFARIN *(Coumadin)* (M)	Tier 1
WELCHOL (M)	Tier 2
WELLBUTRIN SR [BUPROPION SR](QL)(ST)(M)	Tier 3
WELLBUTRIN XL [BUPROPRION XL](QL)(ST)(M)	Tier 3
WELLBUTRIN [BUPROPION] (QL) (ST) (M)	Tier 3
WESTCORT [HYDROCORTISONE]	Tier 3
XALATAN (M)	Tier 2
XANAX XR [ALPRAZOLAM ER] (QL)	Tier 3
XANAX [ALPRAZOLAM]	Tier 3
XELODA	Tier 2
XIFAXAN (QL)	Tier 3
XOPENEX HFA (M)	Tier 3
XOPENEX (M)	Tier 3
XYREM (PA)	Tier 3
YASMIN 28 [OCELLA] (M)	Tier 3
YAZ (M)	Tier 2
ZALEPON [SONATA] (QL)	Tier 1
ZANAFLEX [TIZANIDINE]	Tier 3
ZANTAC [RANITIDINE] (QL) (M)	Tier 3
ZEGERID (QL) (ST) (M)	Tier 3
ZETIA (QL) (M)	Tier 2
ZIANA (age limit)	Tier 3
ZITHROMAX [AZITHROMYCIN] (QL)	Tier 3
ZMAX (QL)	Tier 3
ZOCOR [SIMVASTATIN] (QL) (M)	Tier 3
ZOFRAN ODT [ONDANSETRON ODT] (QL)	Tier 3
ZOFRAN [ONDANSETRON] (QL)	Tier 3
ZOLINZA (QL) (PA)	Tier 2
ZOLIPIDEM *(Ambien)* (QL)	Tier 1
ZOLOFT [SERTRALINE] (QL) (ST) (M)	Tier 3
ZOMIG ZMT (QL)	Tier 3
ZOMIG (QL)	Tier 3
ZONEGRAN [ZONISAMIDE] (QL) (M)	Tier 3
ZONISAMIDE *(Zonegran)* (QL) (M)	Tier 1
ZOVIA 1/50E *(Demulen)* (M)	Tier 1
ZOVIRAX [ACYCLOVIR]	Tier 3
ZYBAN [BUPROPION] (QL)	Tier 2
ZYFLO CR (ST) (M)	Tier 3
ZYMAR	Tier 3
ZYPREXA ZYDIS (QL) (M)	Tier 2
ZYPREXA (QL) (M)	Tier 2
ZYVOX	Tier 3

TIER 1 INCLUDES GENERIC DRUGS

TIER 2 INCLUDES PREFERRED BRAND-NAME DRUGS

TIER 3 INCLUDES NON-PREFERRED BRAND-NAME DRUGS

(PA) Preauthorization – Coverage of certain drugs is based on medical necessity. For these drugs, you will need preauthorization from SelectHealth; otherwise, you will be responsible to pay the drug's full retail price.

(ST) Step Therapy – Drugs that require step therapy are covered by SelectHealth only after you have tried the alternative therapy, and it didn't work (the therapy failed).

(QL) Quantity Limits – Quantity limitations apply to certain drugs (maximum number of tablets/capsules, etc. per prescription). Preauthorization is required if the medication exceeds the plan limits.

(GS) GenericSample℠ – The Rx copay will be eliminated for the first fill of certain strengths at the pharmacy.

(M) Maintenance Drug – Available for 90-day maintenance drug benefit.

[GENERIC NAME] – Drug names in brackets, such as [QUINAPRIL], indicate a generic equivalent to the brand-name drug listed is available. Not all generic drugs will be listed.

***(Brand name)* –** Drug names italicized in parentheses, such as *(Nizoral)*, indicate a brand-name equivalent to the generic drug listed.

†Drugs that are not covered can be obtained through an exception process. SelectHealth will cover these drugs after you have tried alternative, covered medications in the same therapeutic category that have failed to meet your medical needs. All approved exceptions will be priced as Tier 3 drugs.

USING YOUR INJECTABLE DRUG AND SPECIALTY MEDICATION BENEFITS

This section contains important information about how to use your injectable drug and specialty medications benefits, including certain requirements and limitations you should know.

INJECTABLE DRUGS AND SPECIALTY MEDICATIONS

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

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

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

Injectable drugs and specialty medications are covered under your medical benefits. This benefit can be found by locating the "Injectable Drugs and Specialty Medications" line on the Member Payment Summary. You will pay a coinsurance for these drugs after your medical deductible, if applicable. You can receive up to a 30-day supply of injectable drugs and specialty medications; however, exceptions can be made for travel purposes. Contact Pharmacy Services for more information. Some injectable drugs and specialty medications are not covered. Please refer to the "General Limitations and Exclusions" section.

Coverage of injectable drugs and specialty medications may change periodically because of new drugs, new therapies, or other factors. For the most current list of covered drugs and requirements, call Pharmacy Services or visit www.selecthealth.org/pharmacy.

OBTAINING INJECTABLE DRUGS AND SPECIALTY MEDICATIONS

In general, your provider will coordinate the process for obtaining these drugs. 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. If this is the case, contact Member Services to obtain information on participating drug vendors.

PREAUTHORIZATION OF INJECTABLE DRUGS AND SPECIALTY MEDICATIONS

Injectable drugs and specialty medications that require preauthorization are listed on the Injectable Drugs and Specialty Medications List. Preauthorization is also required if the medication is in excess of the plan limits (quantity, duration of use, maximum dose, etc.).

To request preauthorization for these drugs, please have your provider call SelectHealth Pharmacy Services at 801-442-4912 (Salt Lake area) or 800-442-3129, weekdays from 7:00 a.m. to 8:00 p.m., or Saturdays, from 9:00 a.m. to 3:00 p.m. Documentation supporting the medical necessity of the drug will be requested from your provider. To request preauthorization for a drug not listed, your provider can call Pharmacy Services at the number referenced above.

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

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

PHARMACY INJECTABLE DRUGS AND SPECIALTY MEDICATIONS

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

- Heparin
- Low-molecular-weight Heparin (Lovenox®)
- Glucagon
- Insulins
- Epinephrine (Epipen®)
- Sumatriptan (Imitrex®)

INJECTABLE DRUGS AND SPECIALTY MEDICATIONS LIST Coverage of the injectable drugs on this list is based on medical necessity. **For these drugs, you will need preauthorization from SelectHealth**. This is not a complete list of all injectable drugs and may change due to new drugs, therapies, or other factors.

If you have any questions about your injectable drug and speciality medication benefits, please call Member Services, weekdays, between 7:00 a.m. and 8:00 p.m. at 801-442-5038 (Salt Lake area) or 800-538-5038. Most SelectHealth prescription drug information is also available at www.myselecthealth.org and www.selecthealth.org/pharmacy.

Actimmune®
Apokyn®
Araclyst™
Avastin®
Betaseron
Boniva™
Botox®
Cimzia®
Erbitux™
Euflexxa
Fabrazyme®
Flolan®
Forteo®
Genotropin®
Humatrope®
Hyalgan®
Hyaluronate
Immune Globulin
Increlex™
Iplex™
Ixempra™
Kineret®
Mecasermin
MyoBloc®
Norditropin®
Nplate™
Nutropin AQ®
Nutropin Depot®
Nutropin®
Orencia
Orthovisc
Pegasys®
PEG-Intron®
Pregnyl®
Prialt®
Profasi®
Progesterone
Protropin™
Reclast™
Relistor™
Remodulin®
Saizen®
Soliris™
Somatrem™
Somatropin
Somatropin (rDNA origin)
Somavert®
Supartz™
Synagis®
Synvisc®
Tev-Tropin™
Torisel™
Tysabri
Vectibix™
Velcade®
Ventavis
Xolair®
Zorbtive™

SelectHealth identifies many of the drugs on this list by their respective trademarks, but SelectHealth does not own those 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.

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USING YOUR MENTAL HEALTH BENEFITS

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

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

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

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

USE PARTICIPATING MENTAL HEALTH PROVIDERS

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

DEFINITIONS OF TERMS

The following terms are in addition to the "Definitions of Terms" section of this document and the Master Group Contract:

Mental Health Deductible

The portion of eligible mental health charges payable by you each year directly to providers for covered mental health services before SelectHealth provides mental health benefits. If the mental health deductible applies to your plan, it will be specified on the Member Payment Summary. This deductible is separate from any other deductible that may apply.

Mental Health Disorder or Alcohol/Chemical Dependency

An emotional condition or chemical dependency listed as a mental disorder in the Diagnostic and Statistical Manual, as periodically revised, and which requires professional intervention for as long as mental health services are considered medically necessary.

Mental Health Out-of-Pocket Maximum

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

Mental Health Provider

A licensed and qualified mental health provider.

Mental Health Service

Treatment for a mental health disorder or alcohol/ chemical dependency.

Nonparticipating Mental Health Provider

A mental health provider who has not been accepted on the mental health network.

Participating Mental Health Provider

A licensed and qualified mental health provider who has been accepted to participate on the mental health network and who has signed a written provider agreement with SelectHealth that is in effect at the time the service is rendered.

Refer to the Provider & Facility Directory for a listing of providers and facilities that participate with SelectHealth. The network of participating providers and facilities occasionally changes. The most current information can be found on our Web site.

Exclusions

The mental health services that are covered are limited in scope and extent. Mental health services are not covered unless SelectHealth determines that evaluation and intervention on a crisis or short-term basis will improve the condition. The

following are not covered: long-term care and noncovered conditions, treatments, and situations.

The following psychiatric procedures and diagnoses are not covered:

Procedures

- Behavior modification;
- Biofeedback;
- Counseling with a patient's family, friend(s), employer, school authorities, or others (except for approved, medically necessary collateral visits, with or without the patient present, in connection with otherwise covered treatment of the patient's mental illness);
- Education or training;
- Electrosleep or electronarcosis therapy;
- Family counseling and/or therapy;
- Marriage counseling and/or therapy;
- Methadone maintenance/therapy clinics or services;
- Milieu therapy;
- Psychotherapy or psychoanalysis credited toward earning a degree or furthering your education or training;
- Residential treatment, day treatment, partial hospitalization, and intensive outpatient treatment when rendered by nonparticipating providers;
- Rest cures;
- Self-care or self-help training (nonmedical);
- Sensitivity training;
- Surgical procedures to remedy a condition diagnosed as psychological, emotional, or mental, including, but not limited to, transsexual or sex change treatment; and
- Psychological or neuropsychological testing by nonparticipating providers or facilities and any testing or mental examinations in the absence of symptoms of mental illness.

Diagnoses (except where secondary to a covered primary diagnosis)

- Adjustment disorder;
- Chronic organic brain syndrome not specified as a dementia;
- Conduct disorder;
- Marital or family problems;
- Mental retardation;
- Personality disorder;
- Psychosexual disorder, such as, but not limited to, transsexualism, psychosexual identity disorder, psychosexual dysfunction, or gender dysphoria;
- Social, occupational, religious, or other social maladjustment;
- Specific developmental disorders or learning disabilities, such as, but not limited to, autism, Attention Deficit Disorder (ADD)/hyperactivity, and pervasive developmental disorder;
- Diagnoses that refer to someone else's illness, such as family history of psychiatric condition, family history of mental retardation, family disruption, and/or alcoholism in the family;
- Difficult life circumstance not part of treatment for a formal mental illness;
- Screening exams;
- Separation anxiety; and
- Problems with gambling, theft, or fire setting.

USING YOUR CHIROPRACTIC BENEFITS

Chiropractic benefits for SelectHealth are administered by American Specialty Health Networks, Inc. (ASH). If you have any questions, concerns, or complaints about your chiropractic benefits, please call the ASH Member Services department at 800-678-9133 or write to the following address:

American Specialty Health Networks, Inc.
Attn: Member Services Department
P.O. Box 509002
San Diego, CA 92150-9002

USING YOUR CHIROPRACTIC BENEFITS

Using your chiropractic benefit is easy. Simply use a participating chiropractic provider listed in the Chiropractic Provider Directory.

You may receive covered chiropractic services from any participating chiropractic provider. Except for medically necessary emergency chiropractic services, ASH will not pay for services received from any out-of-network chiropractic provider.

PREAUTHORIZATION

After the initial examination, the participating chiropractic provider must obtain preauthorization for any additional covered services that you receive. The participating chiropractic provider will be responsible for filing all claims with ASH.

EMERGENCY CHIROPRACTIC SERVICES

You may receive emergency chiropractic services from any chiropractor, including an out-of-network chiropractic provider if the delay caused by seeking immediate chiropractic attention from a participating chiropractic provider could decrease the likelihood of maximum recovery. ASH will pay the out-of-network chiropractic provider for the emergency chiropractic service to the extent they are covered chiropractic services.

TYPES OF COVERED CHIROPRACTIC SERVICES

Each office visit to a participating chiropractor, as described below, requires a copay by you. A maximum number of visits per calendar year will apply to you as specified on the Member Payment Summary.

- A new patient examination is performed by a participating chiropractor to determine the nature of your problem. If covered chiropractic services appear warranted, a clinical treatment form of services is prepared by the participating chiropractor. A new patient examination is provided for each new patient. A copay is required.
- An established patient examination may be performed by the participating chiropractor to assess the need to continue, extend, or change a clinical treatment form approved by ASH. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a copay is required.
- Subsequent office visits, as set forth in a clinical treatment form approved by ASH, may involve an adjustment, a brief re-examination, and other services in various combinations. A copay will be required for each visit to the office.
- Adjunctive therapy, as set forth in a clinical treatment form approved by ASH, may involve modalities, such as ultrasound, hot packs, cold packs, electric muscle stimulation, and other therapies.
- X-rays and lab tests are payable in full when prescribed by a participating chiropractor and authorized by ASH. Radiological consultations are a covered benefit when authorized by ASH as medically necessary services and provided by a licensed chiropractic radiologist, medical radiologist, radiology group, or hospital that has contracted with ASH to provide those services.
- Chiropractic appliances are payable up to a maximum of $50.00 per year when prescribed by a participating chiropractor and approved by ASH.

DEFINITIONS

The following are in addition to the “Definitions” section found in this document and the Master Group Contract (available from your employer).

Administrative Appeal

Administrative appeals may result from adverse benefit determinations that are based on issues that arise from administrative procedures.

Examples of administrative appeals may include the following scenarios:

- Treatment plan was denied for not meeting authorization and/or claim time frame requirements; or
- Necessary information was not received from provider according to ASH timeliness.

ASH's Quality Management and Improvement (QI) Program

The QI program encompasses those standards, protocols, policies, and procedures adopted by ASH to monitor and improve the quality of clinical care and quality of services provided to you.

ASH Service Area

The ASH service area is the geographic area in which ASH arranges chiropractic services in Utah.

ASH Utilization Management (UM) Program

The UM program includes those standards, protocols, policies, and procedures adopted by ASH regarding the management, review, and approval of the provision of covered chiropractic services to you.

Chiropractic Appliances

Chiropractic appliances are support-type devices prescribed by a participating chiropractor. Following are the only items that could be covered; all others are not covered: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, support/lumbar braces/supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units (cervical or lumbar), ankle braces, knee braces, rib supports, and wrist braces.

Chiropractic Services

Chiropractic Services are the services rendered or made available to you by a chiropractor for treatment or diagnosis of neuromuscular skeletal disorders.

Clinical Appeals

Clinical appeals may result from adverse benefit determinations that are based on medical necessity, experimental and/or investigational treatment, or similar exclusions or limits.

Examples of clinical appeals may include the following scenarios:

- Treatment plan was denied or modified due to lack of medical necessity; or
- The number of visits requested by the provider did not meet clinical criteria.

COVERED CHIROPRACTIC SERVICES

Chiropractic covered services are the chiropractic services which are benefits, as limited under this section, that ASH determines to be medically/clinically necessary chiropractic services.

Emergency Chiropractic Services

Emergency chiropractic services are provided to manage an injury or condition with a sudden and unexpected onset, which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate clinical attention to result in any of the following:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- Decreasing the likelihood of maximum recovery.

Medically/Clinically Necessary Services

Medically/clinically necessary chiropractic services are chiropractic services that are all of the following:

- Necessary, appropriate, safe, effective, and rendered in accordance with professionally recognized, valid, evidence-based standards and guidelines that have been adopted by ASH for its use in determining whether chiropractic services are appropriate for reimbursement;
- Directly applicable to the diagnosis and treatment of a covered condition;
- Verified by ASH as being rendered for the purpose of reaching a defined and appropriate functional outcome or maximum therapeutic benefit (defined as your return to pre-illness/pre-injury daily functional status and activity);
- Rendered in a manner that appropriately assesses and manages your response to the clinical intervention;
- Rendered for the diagnosis and treatment of a covered condition;
- Rendered in accordance with the Clinical Services Management Program and Clinical Performance Management Program standards as published in ASH's Chiropractic Provider Operations Manual;
- Appropriate for the severity and complexity of symptoms and consistent with the covered condition (diagnosis) and appropriate for your response to care; and
- Not considered to be an elective chiropractic service or a chiropractic service for any condition that is not

a covered condition. Examples of elective services are outlined below:

- Preventive maintenance;
- Wellness;
- Services not necessary to return you to pre-illness/pre-injury functional status and activity; and
- Services provided after you have reached maximum therapeutic benefit.

Neuromuscular Skeletal Disorders

Neuromuscular skeletal disorders are conditions with associated signs and symptoms related to the nervous, muscular, and/or skeletal systems. Neuromuscular skeletal disorders are conditions typically categorized as structural, degenerative, or inflammatory disorders, biomechanical dysfunction of the joints of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs, and synovial structures), or related neurological manifestations or conditions.

Out-of-Area Services

Out-of-area services are those emergency chiropractic services provided while you are outside the ASH service area, that would have been the financial responsibility of ASH had the services been provided within the ASH service area. Covered chiropractic services, which are to be provided outside of the ASH service area and are arranged by ASH for assigned members, are not considered out-of-area services.

Participating Chiropractor

A participating chiropractor is a chiropractor who is duly licensed to practice chiropractic in Utah and who has entered into an agreement with ASH to provide covered chiropractic services to you.

CHIROPRACTIC EXCLUSIONS AND LIMITATIONS

ASH will not pay for or otherwise cover the following:

- Any services or treatments not authorized by ASH, except for a new patient examination and emergency chiropractic services;
- Any services or treatments not delivered by participating chiropractic providers for the delivery of chiropractic care to you, except for emergency chiropractic services;
- Services for examinations and/or treatments for conditions other than those related to neuromuscular skeletal disorders;
- Hypnotherapy, behavior training, sleep therapy, and weight programs;
- Thermography;
- Services, lab tests, X-rays, and other treatments not documented as medically/clinically necessary, as appropriate, or classified as experimental or investigational and/or as being in the research stage, as determined in accordance with professionally recognized standards of practice;
- Services and/or treatments which are not documented as medically/clinically necessary chiropractic services;
- Magnetic resonance imaging, CT scans, and any types of diagnostic radiology;
- Transportation costs including local ambulance charges;
- Educational programs, non-medical self-care, self-help or any self-help physical exercise training, or any related diagnostic testing;
- Services or treatments for pre-employment physicals or vocational rehabilitation;
- Any services or treatments caused by or arising out of the course of employment or covered under any public liability insurance;
- Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices or appliances;
- All chiropractic appliances or durable medical equipment, except as specified herein;
- Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order;
- Services provided by a chiropractor practicing outside of Utah, except for emergency chiropractic services;
- Hospitalization, anesthesia, manipulation under anesthesia, or other related services;
- All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids;
- Adjunctive therapy not associated with spinal, muscle, or joint manipulation; and
- Vitamins, minerals, nutritional supplements, or other similar products.

GENERAL PROVISIONS

Master Group Contract and This Document

This section is subject to all provisions, limitations, exclusions, and agreements of the Master Group Contract (available from your employer) and this document.

Claims and Appeals

This section contains the claims and appeals procedures and requirements applicable for new claims and appeals filed on or after July 1, 2004. ASH will follow administrative processes and safeguards designed to ensure and verify that benefit claim determinations are made in accordance with the provisions of this chiropractic benefit plan administered by ASH and that, where appropriate, the provisions have been applied consistently with respect to similarly situated claimants.

This claims and appeals section uses the following additional defined terms:

Adverse Benefit Determination

The term adverse benefit determination means any of the following: a denial, reduction, or termination of a claim for benefits, or a failure to provide or make payment for such a claim, including determinations related to a claimant's eligibility, the application of a review under ASH' utilization management program, and determinations that particular care or treatment is experimental and/or investigational or not medically/clinically necessary.

Authorized Representative

An authorized representative is 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 ASH Member Services department or ASH's Grievance and Appeals department. However, where an urgent care 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.

Benefit Determination

A benefit determination is the decision by ASH regarding the acceptance or denial of a claim for benefits under this chiropractic benefit plan.

Claimant

A claimant is any subscriber or member making a claim for benefits. Claimants may file claims themselves or may act through an authorized representative. In this section, the words "you" and "your" are used interchangeably with claimant.

Post-Service Claim

A post-service claim is any claim related to care or treatment that has already been received by the member.

Pre-Service Claim

A pre-service claim is any claim related to care or treatment that has not been received by the member.

Urgent Care Claim

An urgent care claim is any pre-service claim which, if subject to the normal time frames for determination, could seriously jeopardize your life, health, or ability to regain maximum function or which, in the opinion of your treating chiropractor, would subject you to severe pain that could not be adequately managed without the requested care or treatment. Whether a claim is an urgent care claim will be determined by an individual acting on behalf of ASH applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that your treating chiropractor determines is an urgent care claim will be treated as an urgent care claim.

How to Make a Pre-Service Inquiry

Pre-service inquiries should be directed to the ASH Member Services department at 800-678-9133.

How to File a Claim for Benefits

You or an authorized representative are responsible for submitting all pre-service, urgent service, and post-service claims to ASH. Under certain circumstances provided by federal law, if proper claims' procedures for filing a claim are not followed, ASH will provide notice of the failure and describe the proper procedure to be followed. This notification will be provided as soon as reasonably possible but not later than five days after receipt of the claim. It may be verbal unless you specifically request it in writing.

Timing of Benefit Determinations

ASH will make benefit determinations and notify your provider and you or your authorized representative as follows:

Urgent Care Claims

Notice of a benefit determination will be provided as soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of the claim. However, if ASH gives you notice of an incomplete claim, the notice

will include a time period of not less than 48 hours for you to respond with the requested, specified information. ASH will then provide you with the notice of benefit determination within 48 hours after the earlier of 1) receipt of the specified information; or 2) the end of the period of time given you to provide the information. If the benefit determination is provided verbally, it will be followed in writing no later than three days after the verbal notice.

Other Pre-Service Claims

Notice of a benefit determination will be provided in writing within a reasonable period appropriate to the medical circumstances but not later than 15 days after receipt of the claim. However, this period may be extended one time by ASH for up to an additional 15 days if ASH both determines that 1) 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 ASH expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe specifically the required information, and you will be given at least 45 days from your receipt of the notice to provide the specified information.

Post-Service Claims

Notice of a benefit determination will be provided in writing within a reasonable period of time but not later than 30 days after receipt of the claim. However, this period may be extended one time by ASH for up to an additional 15 days if ASH both determines that 1) 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 ASH 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 specifically the required information, and you will be given at least 45 days from your receipt of the notice to provide the specified information.

The applicable time period for the benefit determination begins when your claim is filed in accordance with the reasonable procedures of ASH, even if you haven't submitted all the information necessary to make a benefit determination. However, if the time period for the benefit determination is extended due to your failure to submit information necessary to decide a claim, the time period for making the benefit determination will be suspended until the earlier of 1) the date on which you respond to the request for additional information or 2) the date established by ASH for the furnishing of the requested information (at least 45 days).

Notice of Adverse Benefit Determinations

If your claim is subject to an adverse benefit determination, you will receive a notification that includes the following information:

- The specific reason(s) for the adverse benefit determination;
- Reference to the specific provision(s) on which the adverse benefit determination was based;
- A description of any additional information or material needed from you to complete the claim, and an explanation of why it is necessary;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline protocol, or other similar criterion was relied upon in the adverse benefit determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
- If the adverse benefit determination was based on a medical/clinical necessity, experimental and/or investigational, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the chiropractic benefit plan to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
- If an urgent care claim was denied, a description of the expedited review process applicable to the claim; and
- A description of ASH's review or appeal procedures, including applicable time limits, and a statement of your right to bring suit under ERISA §502(a) with respect to any claim denied after an appeal.

PROBLEM SOLVING

ASH is committed to making sure that all of your concerns or problems are investigated and resolved as soon as possible. Most situations can be resolved informally by contacting the ASH Member Services department at 800-678-9133.

Formal Appeals

If you are not satisfied with the result of working with ASH Member Services, your provider and you or your authorized

representative may request a formal appeal either verbally or in writing of any adverse benefit determination. Written, formal appeals should be sent to the ASH Appeal and Grievance department. As the delegated claims review fiduciary, ASH will conduct a full and fair review of your appeal and has final discretionary authority and responsibility for deciding all matters regarding eligibility and coverage under this chiropractic benefit plan.

General Rules and Procedures

You will, upon request and free of charge, be given reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. You will also have the opportunity to submit written comments, documents, records, and other information relating to your appeal. ASH will consider this information regardless of whether it was considered in the adverse benefit determination.

At each level in the appeals process, decisions will be made by ASH personnel 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 treatments, drugs, or other services are experimental and/or investigational or not medically/clinically necessary, ASH personnel at each applicable level will consult with a medical professional with appropriate training and experience in the appropriate field of medicine 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 ASH in connection with the adverse benefit determination, whether or not the advice was relied upon in making the determination.

Form and Timing

All requests for a formal appeal of an adverse benefit determination (other than those involving an Urgent Care Claim) should include any pertinent information that you wish ASH to review in conjunction with your appeal. Send all information to the ASH appeals coordinator at the following address:

ASH Appeals Coordinator
P.O. Box 509001
San Diego, CA 92150-9002

You may also verbally request a formal appeal of an adverse benefit determination by calling ASH Member Services at 800-678-9133.

If the request is made verbally, ASH will send written confirmation acknowledging the receipt of your request within 24 hours. All necessary information, including ASH's determination on review, will be transmitted between ASH and you by telephone, facsimile, or other available similarly expeditious methods.

You or your authorized representative must file any formal appeal within 180 days from the date you received notification of the adverse benefit determination or made the pre-service inquiry, as applicable.

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

Standard and Voluntary Appeal Levels

As described below, the formal appeals process differs for Clinical and Administrative pre-service claims and post-service claims. In each case, there are both standard and voluntary levels of review.

You must exhaust all standard levels of review before you may pursue civil action under Section 502(a) of ERISA. It is your choice, however, whether or not to seek voluntary levels of review, and you are not required to do so before pursuing civil action under section 502 (a) of ERISA. ASH agrees that any statute of limitations or other legal defense based on timeliness is suspended during the time that any voluntary appeal level is pending. Your decision whether or not to seek voluntary levels of review will have no affect on your rights to any other benefits under this chiropractic benefit plan. ASH will provide you, upon request, sufficient information to enable you to make an informed judgment about whether or not to engage in a voluntary level of review.

ASH resolves each level of appeal for Pre-Service Claims (both clinical and administrative) within 15 calendar days from receipt of the appeal request. ASH resolves each level of appeal for Post-Service Claims (both clinical and administrative) within 30 calendar days from receipt of the appeal request. ASH resolves the standard appeal review levels for urgent care claims (both clinical and administrative) within 72 hours from receipt of the appeal request.

The Appeals Process for Clinical Appeals

The formal process for appealing a clinical adverse benefit determination consists of two standard review levels, two voluntary review levels, and the right to pursue civil action under Section 502(a) of ERISA.

Standard Review—Level 1

Upon receipt of your appeal request, a senior clinical services manager and at least one consumer representative conducts the first standard level of appeal for clinical appeals. If more information is needed, a letter is sent to the treating provider requesting additional information. If you are dissatisfied with the decision, you may request a second level standard appeal. You have 45 days from the date of the decision to file an additional appeal request.

Standard Review—Level 2

If you are dissatisfied with the outcome of the first standard level of appeal, the ASH director or senior clinician in the like specialty of the treating providers and at least one consumer representative conduct the second standard level of appeal for clinical appeals. If the director or senior clinician denies the appeal, the director or senior clinician will consult with a participating chiropractor.

If you are dissatisfied with the decision, you have the option to pursue the following levels of voluntary appeals.

Voluntary Review—Level 1: Independent Review Organization (IRO)

If you are dissatisfied with the outcome of the second standard level of appeal, you may request a voluntary level of appeal through an IRO. An IRO is an independent external review organization that is not connected in any way with ASH. The IRO engages healthcare professionals with the appropriate level and type of clinical knowledge and experience to properly judge an appeal. There is no cost to you for a voluntary IRO appeal.

Voluntary Review—Level 2: Voluntary, Binding Arbitration

If you are dissatisfied with the outcome of the first voluntary level of appeal, you may request a second voluntary level of appeal consisting of binding arbitration through the American Arbitration Association (AAA). To initiate the arbitration process, you may contact AAA at 800-778-7879. You will not be responsible for any charges or fees associated with voluntary dispute resolution options.

Any matter in dispute between you and the company may be subject to arbitration as an alternative to court action pursuant to the rules of the AAA or another recognized arbitrator. A copy of the rule is available upon request from the company. Any decision reached by arbitration shall be binding upon both you and the company. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction.

Civil Action—At any point after the standard review process, you may choose to pursue civil action under section 502(a) of ERISA. Failure to properly pursue the standard appeals process may result in a waiver of the right to challenge ASH's original decision.

The Appeals Process for Administrative Appeals

The formal process for appealing an administrative adverse benefit determination consists of two standard review levels, two voluntary review levels, and the right to pursue civil action under section 502(a) of ERISA.

Standard Review—Level 1: Administrative Appeals Committee (AAC)

Upon receipt of your appeal request, the ASH AAC, which consists of ASH managers and at least one consumer representative, conducts the first standard level of appeal for administrative appeals. The AAC evaluates the appeal and renders a decision regarding the appeal and may make recommendations for resolution of member issues. If you are dissatisfied with the decision of the AAC, you may request a second level standard appeal. You have 45 days from the date of the decision to file an additional appeal request.

Standard Review—Level 2: Administrative Review Committee (ARC)

If you are dissatisfied with the outcome of the first standard level of appeal, the ASH ARC, which consists of ASH officers, directors, employees, and at least one consumer representative, conducts the second standard level of appeal for administrative appeals. The ARC evaluates the appeal and renders a decision. They may also make recommendations for resolution of member issues. You have 45 days from the date of the decision to file an additional appeal request.

If you are dissatisfied with the decision, you have the option to pursue the following levels of voluntary appeals:

Voluntary Review—Level 1: Executive Review Committee (ERC)

If you are dissatisfied with the outcome of the second standard level of appeal, you may request a voluntary level of appeal by

the ASH ERC, which consists of ASH senior officers and one contracted chiropractor. The ERC evaluates the appeal and renders a decision. There is no cost to you for a voluntary ERC appeal.

Voluntary Review—Level 2: Voluntary, Binding Arbitration
If you are dissatisfied with the outcome of the first voluntary level of appeal, you may request a second voluntary level of appeal consisting of binding arbitration through the AAA. To initiate the arbitration process, you may contact AAA at 800-778-7879. You will not be responsible for any charges or fees associated with voluntary dispute resolution options.

Any matter in dispute between you and the company may be subject to arbitration as an alternative to court action pursuant to the rules of the AAA or another recognized arbitrator. A copy of the rule is available upon request from the company. Any decision reached by arbitration shall be binding upon both you and the company. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction.

Civil Action—At any point after ASH's standard review process, you may choose to pursue civil action under section 502(a) of ERISA. Failure to properly pursue the standard appeals process may result in a waiver of the right to challenge ASH's original decision.

Notification of Appeal Decisions

At each applicable level of the appeals process previously described, if your appeal is denied, ASH's written notification will include the following:

- The specific reason(s) for the adverse determination;
- Reference to the specific provision(s) on which the adverse determination was based;
- A statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the claim;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request;
- If the denied appeal was based on a medical/clinical necessity, experimental and/or investigational, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the chiropractic benefit plan to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request; and
- A statement describing any additional standard or voluntary appeal levels either required or offered by ASH, your right to obtain information about such procedures, and a statement of your right to bring suit under ERISA §502(a).

Notification of the decision on an urgent care claim may be provided verbally, but a follow-up written notification will be provided no later than three days after the verbal notice.

TERMS AND CONDITIONS OF COVERAGE

Access to Participating Chiropractors

You may access any participating chiropractor without a referral.

Concurrent Review of Covered Chiropractic Services

You shall cooperate with ASH in ASH's operation of its utilization management program.

Copays for Covered Chiropractic Services

Copays for covered chiropractic services, when applicable, are your obligation at the time covered chiropractic services are provided. Failure to pay a copay may result in termination of your coverage under the ASH health plan.

Emergency Chiropractic Services

Emergency chiropractic services are provided to you as described in the "Definitions" section of this document.

YOUR RIGHTS AND RESPONSIBILITIES

As a member of a SelectHealth plan, you have the right to privacy and a high level of medical care and customer service. As a member, you are also responsible for following plan guidelines and making informed decisions about your medical care.

Your suggestions regarding policies and services are welcome. Call SelectHealth Member Services or submit your comments in writing.

YOUR RIGHTS

You have the right to the following:

- Receive considerate, courteous care and treatment, with respect for personal privacy and dignity;
- Receive accurate information regarding your benefits in member literature and through telephone contact;
- Candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage;
- Have all claims processed accurately and in a timely manner;
- Participate in decisions involving your health and the medical care you receive;
- Have all medical records and other information kept confidential;
- Be informed by your doctor about your health so you may make educated decisions before you receive treatment;
- Refuse recommended medical treatment;
- Have reasonable access to appropriate medical services;
- Receive a copy of the member rights and responsibilities from SelectHealth;
- Be informed about available services, practitioners, and providers, as well as where, when, and how you can receive services;
- Express a concern or appeal about your health plan or the care it provides and receive a response in a reasonable period of time;
- Request a second opinion; and
- Make recommendations regarding SelectHealth members' rights and responsibilities policies.

YOUR RESPONSIBILITIES

You have the responsibility for the following:

- Treat all network doctors and personnel courteously;
- Read all SelectHealth materials carefully as soon as you enroll and ask questions when necessary;
- Take charge of your health, make positive choices, seek appropriate care, and follow your doctor's instructions;
- Provide all pertinent information to your doctor to assess your condition and recommend treatment;
- Ask questions and make certain that you understand the explanations and instructions you are given;
- Ask questions and understand the consequences of refusing a recommended medical treatment;
- Keep scheduled appointments or give adequate notice of cancellation;
- Communicate openly with your doctor and develop a patient/doctor relationship based on trust and cooperation;
- Read and understand your benefits and limitations and call with any questions you may have;
- Express constructively your opinions, concerns, and complaints to the appropriate people at SelectHealth;
- Participate in understanding your health problems and developing mutually agreed upon treatment goals; and
- Follow the policies and procedures of SelectHealth. Call Member Services if you need assistance.

NOTICE OF PRIVACY PRACTICES FROM SELECTHEALTH

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

ABOUT THIS NOTICE

This notice describes the privacy practices of SelectHealth, Inc. and SelectHealth Benefit Assurance Co., Inc. (collectively "SelectHealth"). This notice is intended for our health plan members. SelectHealth is part of Intermountain Healthcare®, which is a healthcare delivery system consisting of hospitals, health plans, doctors, and other practitioners that work together to provide healthcare.

For the purposes of this notice, we have defined the following terms:

- "Intermountain" refers to SelectHealth, Inc., SelectHealth Benefit Assurance Co., Inc., and IHC Health Services, Inc.

- "SelectHealth" or "we" refers to all coverage plans offered by SelectHealth, Inc. and SelectHealth Benefit Assurance Co., Inc. but does not include plans offered by other companies that contract to use the SelectHealth panel of providers.
- "intermountain Healthcare" means the hospitals, clinics, doctor offices, and other healthcare facilities owned and operated by IHC Health Services, Inc., as well as the individuals employed by Intermountain Healthcare at these facilities.
- "Affiliated Providers" are doctors and other healthcare practitioners who are not employed by Intermountain Healthcare but either have a contractual relationship with SelectHealth or are credentialed to admit patients to an Intermountain hospital.
- "Personal Information" means your personal medical information that describes your physical or mental health or the payment for the provision of your healthcare as well as any other financial information that we may have collected about you.
- "Personal Representative" means an individual who has authority under law to make healthcare decisions on behalf of another person, e.g. a parent for a minor child.

In some situations, Intermountain Healthcare and Affiliated Providers have different privacy practices than SelectHealth because of the type of services they provide. As a result, if you are a patient of Intermountain Healthcare or an Affiliated Provider, you may receive a separate notice of their privacy practices. To request a copy of the privacy notices of Intermountain Healthcare, please call 800-442-4845; to receive a copy of the privacy notices of Affiliated Providers, please contact those providers directly.

SELECTHEALTH'S PRIVACY RESPONSIBILITIES

We are committed to protecting your privacy as described in this document. In addition, certain laws require that we maintain the privacy of your Personal Information and provide you with this notice. This notice describes our legal duties and privacy practices with respect to Personal Information. When we use or disclose Personal Information, we must abide by the terms of this notice (or other notice in effect at the time of the use or disclosure).

COLLECTION OF PERSONAL INFORMATION

We may collect Personal Information from you, healthcare providers, and other payers of healthcare. We may also collect Personal Information from governmental agencies, legal proceedings, and consumer reporting agencies.

USES AND DISCLOSURES WITH AN AUTHORIZATION

An authorization is a written document signed by you or your Personal Representative that gives us permission to use your Personal Information for a specific purpose. We will only use your Personal Information without an authorization in ways described in the next section of this notice entitled "Uses and Disclosures Permitted by Law Without an Authorization." You may revoke an authorization at any time in writing except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

USES AND DISCLOSURES PERMITTED BY LAW WITHOUT AN AUTHORIZATION

Use or Disclosure by SelectHealth for Payment or Healthcare Operations

SelectHealth uses Personal Information for the following routine purposes:

Payment

SelectHealth uses and discloses Personal Information for payment of health coverage premiums and to determine and fulfill its responsibility to provide you benefits—for example, to make coverage determinations, administer claims, and coordinate benefits with other coverage you may have. SelectHealth may also disclose Personal Information to consumer reporting agencies or other individuals or companies that assist with its payment activities.

Finally, SelectHealth will disclose Personal Information about any dependent on a policy to the subscriber, his or her spouse, or the authorized representative of either of these people. This is limited to information necessary to understand how a claim was processed. We disclose this information to allow the subscriber and his or her spouse to manage the policy effectively. You may have rights to limit these disclosures. See the subsection "Right to Request Confidential Communications" in the "Your Individual Rights" section.

Healthcare Operations

SelectHealth uses and discloses Personal Information for its Healthcare Operations, which includes internal administration,

planning, and various activities that improve the quality of the healthcare that we pay for. For example, we may use your Personal Information to assess insurance rates and to evaluate how many of the children on our plans have received the recommended immunizations. SelectHealth may disclose Personal Information to individuals or companies that assist with payment and healthcare operations. However, such disclosures are only made if the person or company agrees to safeguard Personal Information as required by SelectHealth's privacy policy.

In addition, SelectHealth may disclose Personal Information as follows:

- To another healthcare entity for its healthcare operations or payment activities.
- To Affiliated Providers and Intermountain Healthcare to improve the overall Intermountain system as well as to help them better manage your care. For example, Intermountain has programs in place to manage the treatment of chronic conditions, such as diabetes or asthma, and as part of these programs, we share information with Affiliated Providers and Intermountain Healthcare to facilitate improved coordination of the care members receive for these conditions.

We may use Personal Information to identify health-related services and products that may be beneficial to your health and then contact you about these services and products.

Treatment

SelectHealth may disclose Personal Information to healthcare providers to support them in providing treatment.

Special Protections for Certain Types of Information

SelectHealth may request Personal Information for underwriting purposes. If the health insurance is not placed with us, we will not use or disclose this information for any other purpose. We may request an HIV/AIDS test for underwriting purposes, but only if we provide proper notice and follow other requirements of state law. If we do require an HIV/AIDS test, we will not release the results of this test unless we have specific written permission to do so. Additionally, we will not request private genetic information from asymptomatic individuals for underwriting purposes. However, we may request private genetic information in certain circumstances to determine our obligation to pay for healthcare services.

Disclosures to the Sponsor of Your Health Plan

SelectHealth discloses enrollment and disenrollment information to the plan sponsor of your health plan (this is usually your employer if your health insurance is offered through your employer). SelectHealth may also share information with the plan sponsor that summarizes the claims' history, expenses, or types of claims of individuals enrolled in your health plan. SelectHealth shares such summary health information with your plan sponsor for your plan sponsor to obtain premium bids from other health insurance companies or to make decisions about modifying, amending, or terminating your health plan.

SelectHealth may also share limited Personal Information with your plan sponsor. However, SelectHealth will only do so if the plan sponsor specifically requests Personal Information for the administration of your health plan and agrees in writing not to use your Personal Information for employment-related actions or decisions.

Public Health Activities

We may disclose Personal Information for the following public health activities and purposes: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury, or disability as required by law and public health concerns; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products under the jurisdiction of the U.S. Food and Drug Administration; and (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk to contracting or spreading a disease or condition.

Disclosure to Relatives and Close Friends

We may use or disclose Personal Information to a family member, other relative, a close personal friend or any other person identified by you when you are either present for or otherwise available prior to the disclosure if we (1) obtain your agreement; (2) provide you with the opportunity to object to the disclosure and you do not object; or (3) reasonably infer that you do not object to the disclosure.

If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a

disclosure is in your best interest. If we disclose information to a family member, other relative, or a close personal friend, we would disclose only information that is directly relevant to the person's involvement with your healthcare.

Victims of Abuse, Neglect, or Domestic Violence

If we reasonably believe you are a victim of abuse, neglect, or domestic violence, we may disclose your Personal Information to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

Health Oversight Activities

We may disclose Personal Information to a health oversight agency that oversees the healthcare system and ensures compliance with the rules of government health programs such as Medicare or Medicaid.

Judicial and Administrative Proceedings

We may disclose Personal Information in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

Law Enforcement Officials

We may disclose Personal Information to the police or other law enforcement officials as required by law or in compliance with a court order.

Health or Safety

We may use and disclose Personal Information to prevent or lessen a serious and imminent threat to an individual's or the public's health or safety.

Specialized Government Functions

We may disclose to military authorities the personal and health information of armed forces personnel under certain circumstances. We may disclose to authorized federal officials personal and health information required for lawful intelligence, counterintelligence, and other national security activities.

Workers' Compensation

We may disclose Personal Information as necessary to comply with workers' compensation laws.

Research

We may use or disclose Personal Information without your consent or authorization for purposes of research if an Institutional Review Board or Privacy Board approves a waiver of authorization for disclosure.

An Institutional Review Board or a Privacy Board is responsible for reviewing research that involves human subjects and for reviewing the effect of the research on the subjects' privacy rights. Either board must have at least one member who is not affiliated with Intermountain.

Required by Law

We may use or disclose Personal Information to the extent that:

- Such use or disclosure is required by law; and
- The use or disclosure complies with and is limited to the relevant requirements of such law.

YOUR INDIVIDUAL RIGHTS

For More Information; Complaints

If you would like more information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to Personal Information, you may contact our Privacy Office. Please see the last section of this notice entitled "Privacy Office", for information on contacting our Privacy Office. You may also file written complaints with the director of the Office of Civil Rights in the U.S. Department of Health and Human Services. Upon request, our Privacy Office will provide you with the correct address for the director. We will not take action against you if you file a complaint with us or the director.

Right to Request Additional Restrictions

You may request restrictions on our use and disclosure of Personal Information (1) for payment and healthcare operations; or (2) to individuals (such as a family member, other relative, close personal friend, or any other person identified by you) involved with your care or with payment related to your care. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction.

Right to Inspect and Copy Your Health Information

You may request access to our records which (1) we use for decision-making purposes; and (2) contain your Personal Information, including your enrollment, payment, claims adjudication, case, medical management records, and your billing records. You may request access in order to inspect and ask for copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you

request a copy or copies of your record, you will be charged a cost-based fee for each copy. If you wish to access the Personal Information maintained by an Affiliated Provider or by Intermountain Healthcare, please contact them directly.

Right to Request Amendment to Your Records

You have the right to request an amendment to your Personal Information that SelectHealth created and used for decision-making purposes. SelectHealth will comply with your request unless we are not the originator of the information, or we believe that the information that would be amended is accurate and complete, or other special circumstances apply. If you wish to amend the Personal Information maintained by an Affiliated Provider or by Intermountain Healthcare, please contact them directly.

Right to Receive an Accounting of Disclosures

Upon request, you may obtain a written summary of certain disclosures of your Personal Information made by us. Your request must state a time period, which may not exceed the six years prior to the date of your request and may not include dates before April 14, 2003.

If you request an accounting more than once during a twelve-month period, we will charge you a reasonable fee for each additional accounting statement.

Right to Request Confidential Communications

You have the right to request to receive communications of your personal Information by alternative means or at alternative locations if the normal means/location of disclosure could endanger you. We will accommodate all reasonable written requests.

Right to Receive a Paper Copy of This Notice

If you have not already received one, you have the right to receive a paper copy of this notice. To request a paper copy of this notice, please contact our Privacy Office.

Note: Any Personal Representative of yours can exercise these rights related to your Personal Information.

MAINTAINING THE PRIVACY OF PERSONAL INFORMATION

We guard Personal Information by limiting access to this information to those who need it to perform assigned tasks and through physical safeguards (e.g., locked filing cabinets and password-protected computer systems).

In addition, when you or someone else acting on your behalf calls our Member Services department, the Member Services representative may need to limit the Personal Information disclosed. This is done to help safeguard your Personal Information. The Representative may ask for information to verify the identity of the caller before disclosing any Personal Information. The amount and type of Personal Information that we can release depends on several factors:

- Who is requesting the Personal Information
- What that person's relationship is to the subject of the Personal Information
- For what purpose the Personal Information is being requested
- If the Personal Information relates to the treatment of certain conditions

We realize that these restrictions may at times seem inconvenient, but they help us maintain the privacy of your Personal Information.

EFFECTIVE DATE AND DURATION OF THIS NOTICE

Effective Date

This notice describes the privacy practices of SelectHealth as of July 1, 2007.

Right to Change Terms of this Notice

We may change the terms of this notice at any time. If we change this notice, we may make the new notice terms effective for all Personal Information that we maintain, including any information created or received prior to issuing the new notice. If we change this notice, we will post the new notice on our Web site at www.selecthealth.org and will distribute it via our member materials. You may also obtain any new notice by contacting the Privacy Office.

Privacy Office

You may contact the Privacy Office at:

Intermountain Privacy Office

4646 West Lake Park Blvd.

Salt Lake City, UT 84120

800-442-4845

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CLAIMS AND APPEALS

This section contains the claims and appeals procedures and requirements applicable for new claims and appeals. 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 this Membership Guide and the Master Group Contract (available from your employer) and that, where appropriate, their provisions have been applied consistently with respect to similarly situated claimants.

DEFINED TERMS

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

Adverse Benefit Determination

The term adverse benefit determination means any of the following: a denial, reduction, or termination of a claim for benefits, or a failure to provide or make payment for such a claim in whole or in part. This includes determinations related to a claimant's eligibility, the application of a review under SelectHealth's Utilization Management program, and determinations that particular care or treatment is experimental and/or investigational, not medically necessary or appropriate.

Authorized Representative

An authorized representative is someone you have designated to represent you in the claims or appeals process. To designate an authorized representative, you must provide written authorization on a form provided by the Appeals department or Member Services. However, where an urgent care claim is involved, a healthcare professional with knowledge of the medical condition will be permitted to act as your authorized representative without a prior written authorization.

Benefit Determination

A benefit determination is the decision by SelectHealth regarding the acceptance or denial of a claim for benefits under the Master Group Contract.

Claimant

A claimant is any subscriber or member making a claim for benefits. Claimants may file claims themselves or may act through an authorized representative. In this section, the words "you" and "your" are used interchangeably with claimant.

Concurrent Care Decisions

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

Post-Service Appeal

A post-service appeal is a request to change an adverse benefit determination for care or treatment that has already been received by the member.

Post-Service Claim

A post-service claim is any claim related to care or treatment that has already been received by a member.

Pre-Service Appeal

A pre-service appeal is a request to change an adverse benefit determination for care or services that must be approved, in whole or in part, in advance of the member obtaining medical care or treatment in order for the claimant to receive full benefits under the Master Group Contract.

Pre-Service Claim

A pre-service claim is any claim that requires approval prior to obtaining medical care or treatment for the claimant to receive full benefits under the Master Group Contract. For example, a request for precertification under the Utilization Management program is a pre-service claim.

Pre-Service Inquiry

A pre-service inquiry is a member's oral or written inquiry to SelectHealth regarding the existence of coverage under the Master Group Contract for proposed care or treatment that does not involve a pre-service claim, i.e., does not require prior approval for the claimant to receive full benefits under the Master Group Contract. Pre-service inquiries are not claims and are not treated as adverse benefit determinations.

Urgent Care Claim

An urgent care claim is any pre-service claim which, if subject to the normal time frames for determination, could seriously jeopardize your life, health, or ability to regain maximum function. It is also any claim that in the opinion of your treating doctor would subject you to severe pain that could not be adequately managed without the requested

care or treatment. Whether a claim is an urgent care claim will be determined by an individual who acting on behalf of SelectHealth, will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that your treating doctor determines is an urgent care claim will be treated as an urgent care claim.

HOW TO MAKE A PRE-SERVICE INQUIRY

Pre-service inquiries should be directed to Member Services. A pre-service inquiry is not a claim for benefits.

HOW TO FILE A CLAIM FOR BENEFITS

Pre-Service Claims

The procedures for filing most pre-service claims—prenotifications and precertifications—are set forth in the "Miscellaneous Information" section of this document. If there is any other benefit that would be subject to a pre-service claim, you or your authorized representative may file a claim for that benefit by contacting Member Services. Under certain circumstances provided by federal law, if you or your authorized representative fail to follow the proper procedures for filing a pre-service claim, SelectHealth will provide notice of the failure and the proper procedures to be followed. This notification will be provided as soon as reasonably possible but not later than five days after receipt of the claim. It may be verbal unless you specifically request it in writing.

Urgent Care Claims

In order to file an urgent care claim, you or your authorized representative must provide SelectHealth with the following 1) information sufficient to determine whether or to what extent benefits are covered under the Master Group Contract; and 2) a description of the medical circumstances that give rise to the need for expedited review. Under certain circumstances provided by federal law, if you or your authorized representative fail to follow the proper procedures for filing an urgent care claim, SelectHealth will notify you of the failure and the proper procedures to be followed. This notification will be provided as soon as reasonably possible, but not later than 24 hours after receipt of the claim and may be verbal unless you specifically request it in writing.

Post-Service Claims

Participating providers directly file all post-service claims with SelectHealth. If you receive a bill from a participating provider or facility, please contact them to ask if SelectHealth has been billed before you make any payment. However, if you need to file a post-service claim from a nonparticipating provider, you or your authorized representative must submit the claim in writing in a form preapproved by SelectHealth. Contact Member Services or your employer to find out what information is needed to submit a post-service claim. SelectHealth must receive all claims within 12 months from the date of the expense. Claims not filed within one year of the date of service will not be eligible for reimbursement unless you can show that you filed the claim as soon as reasonably possible.

Timing of Benefit Determinations

SelectHealth will make and notify you or your authorized representative of its benefit determinations as follows:

Urgent Care Claims

Notice of a benefit determination will be provided as soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of the claim. However, if SelectHealth gives you notice of an incomplete claim, the notice will include a time period of not less than 48 hours for you to respond with the requested specified information. SelectHealth will then provide you with the notice of benefit determination within 48 hours after the earlier of 1) receipt of the specified information; or 2) the end of the period of time given you to provide the information. 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 care claim involves a concurrent care decision, notice of the benefit determination will be provided as soon as possible but not later than 24 hours after receipt of your claim for extension of treatment or care. The claim must be made at least 24 hours before the prescribed period of time expires or the prescribed number of treatments ends.

Other Pre-Service Claims and Inquiries

Notice of a benefit determination will be provided in writing within a reasonable period appropriate to the medical circumstances but not later than 15 days after receipt of the claim. However, this period may be extended one time by SelectHealth for up to an additional 15 days if determined that such an extension is necessary due to matters beyond its control. SelectHealth will provide 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 such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. You will have at least 45 days from your receipt of the notice to provide the specified information.

Notice of an adverse benefit determination regarding a concurrent care decision will be provided sufficiently in advance of any termination or reduction of benefits to allow you to appeal and obtain a determination before the benefit is reduced or terminates.

Post-Service Claims

Notice of adverse benefit determinations will be provided in writing within a reasonable period of time but not later than 30 days after receipt of the claim. However, this period may be extended one time by SelectHealth for up to an additional 15 days if determined that such an extension is necessary due to matters beyond its control. SelectHealth will provide 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. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. You will have at least 45 days from your receipt of the notice to provide the specified information.

The applicable time period for the benefit determination begins when your claim is filed in accordance with the reasonable procedures of SelectHealth, even if you have not submitted all of the information necessary to make a benefit determination. However, if the time period for the benefit determination is extended due to your failure to submit information necessary to decide a claim, the time period for making the benefit determination will be suspended until the earlier of 1) the date on which you respond to the request for additional information; or 2) the date established by SelectHealth for the furnishing of the requested information (at least 45 days).

PROCESSED CLAIMS/EXPLANATION OF BENEFITS

When your claim is processed, you will receive an Explanation of Benefits (EOB) listing payments made by SelectHealth and any charges you are responsible to pay directly to the provider or facility (if you have not already done so). The EOB is not a bill.

SelectHealth will request money back for excess or mistaken payments and may do so at any time. For example, if a claim is paid while you are not eligible, SelectHealth will request money back from you.

Notice of adverse benefit determinations

If your claim is subject to an adverse benefit determination, you will receive a notification that includes the following information:

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

PROBLEM SOLVING

SelectHealth is committed to making sure that all of your concerns or problems are investigated and resolved as soon as possible. Most situations can be resolved informally by contacting Member Services. A Member Services representative will attempt to resolve the matter informally, usually within seven days.

Formal Appeals

If you are not satisfied with the result of working with Member Services, you and/or your authorized representative may file a written formal appeal of any adverse benefit determination or the negative outcome of a pre-service inquiry. Written formal appeals should be sent to the Appeals department. As the delegated claims review fiduciary under your employer's plan, SelectHealth will conduct a full and fair review of your appeal.

General Rules and Procedures

You will, upon request and free of charge, be given reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. You will also have the opportunity to submit written comments, documents, records, and other information relating to your appeal. SelectHealth will consider this information regardless of whether it was considered in the adverse benefit determination.

At each level in the formal appeal process, no deference will be afforded to the adverse benefit determination, and decisions will be made by appropriately named fiduciaries who did not make the adverse benefit determination or report to anyone who did. If the adverse benefit determination was based on medical judgment, including determinations that treatments, drugs, or other services are experimental and/or investigational or not medically necessary, fiduciaries at each applicable level will consult with a medical professional with appropriate training and experience in the appropriate field of medicine and who was neither consulted in connection with the adverse benefit determination nor is the subordinate of such an individual. Upon request, you will be provided the identification of any medical expert(s) whose advice was obtained on behalf of SelectHealth in connection with the adverse benefit determination, whether or not the advice was relied upon in making the adverse benefit determination.

Form and Timing

All requests for a formal appeal of an adverse benefit determination (other than those involving an urgent care claim) must be submitted in writing and should include a copy of the adverse benefit determination and any other pertinent information that you wish SelectHealth to review in conjunction with your appeal. Send all information to the Appeals department at the following address:

SelectHealth Attn: Appeals Department

P.O. Box 30192

Salt Lake City, Utah 84130-0192

You may appeal an adverse benefit determination of an urgent care claim on an expedited basis either verbally or in writing. You may appeal verbally by calling SelectHealth's Appeals department at 801-442-4684. If the request is made verbally, SelectHealth will send (within 24 hours) written confirmation acknowledging the receipt of your request. All necessary information, including SelectHealth's determination on review, will be transmitted between SelectHealth and you by telephone, facsimile, or another available similarly expeditious method.

You may also formally appeal the negative outcome of a pre-service inquiry by writing to the Appeals department at the address noted previously. You should include any information that you wish SelectHealth to review in conjunction with your appeal.

You or your authorized representative must file a formal appeal within 180 days from the date you received notification of the adverse benefit determination or made the pre-service inquiry, as applicable.

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

Mandatory and Voluntary Appeal Levels

As described below, the formal appeals process differs for pre-service claims and post-service claims. In each case, there are both mandatory and voluntary levels of review. For purposes of the formal appeals process only, pre-service inquiries will be treated like pre-service claims.

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

Pre-Service Appeals

The formal process for pre-service appeals and appealing the negative outcome of an inquiry provides one mandatory review

level, two possible voluntary review levels, and the right to pursue civil action under Section 502(a) of ERISA.

Step 1—Mandatory Review

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

If your appeal involves an urgent care claim, you may request an expedited review. You will be notified of the appeal decision on an expedited review as soon as possible, taking into account the medical circumstances, but not later than 72 hours after the receipt of your appeal. A decision communicated verbally will be followed-up in writing.

Step 2—First Level Voluntary Review

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

If your appeal involves an urgent care claim, you may verbally request an expedited review. You will be notified of the appeal decision on an expedited review as soon as possible, taking into account the medical circumstances, but not later than 72 hours after the receipt of your appeal. A decision communicated verbally will be followed-up in writing.

Step 3—Second Level Voluntary Review

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

Note: This second level voluntary review is not available on an expedited basis. There is only one level of voluntary review (Step 2) for urgent care claims that require expedited review.

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

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

Post-Service Appeals

The formal process for post-service appeals provides two mandatory review levels, one voluntary review level, and the right to pursue civil action under Section 502(a) of ERISA.

Step 1—First Level Mandatory Review

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

Step 2—Second Level Mandatory Review

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

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

Step 3—Voluntary Appeals Committee Review

If you are dissatisfied with the results of Step 2, Second Level Mandatory Review (Grievance Committee), you or your authorized representative may voluntarily request a review of your appeal by the Appeals Committee. If you are appealing an adverse benefit determination regarding medical necessity, you may request a review of your appeal by either the Appeals Committee or an IRO. The Appeals Committee is generally comprised of the Chief Executive Officer (CEO), a practicing physician in the community, legal counsel, an employer from the community who also serves as a member of the Board of Trustees, and a consumer representative who will be present at every meeting. You and/or your authorized representative may appear in person or by telephone before the Appeals Committee to present any arguments or evidence you feel are relevant to the matter; however, participation is not a requirement. An IRO is an independent external review organization that is not connected in any way with SelectHealth. The IRO engages healthcare professionals with the appropriate level and type of clinical knowledge and experience to properly judge an appeal. There is no cost to you for the Appeals Committee or IRO review. For Appeals Committee review, your request for voluntary review must be made in writing to the Appeals department within 60 days, and for an IRO review within 180 days, from the date of SelectHealth's response to the second level mandatory review. If you are appealing an adverse benefit determination of medical necessity, your request must specify whether the appeal is to the Appeals Committee or to an IRO. SelectHealth will notify you of the result of the Appeals Committee or IRO review in writing within 60 days of the date you requested the review.

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

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

Notification of Appeal Decisions

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

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

criterion was relied upon in denying the appeal, either the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline protocol, or other similar criterion was relied upon in denying the appeal and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;

- If the denied appeal was based on a medical necessity, experimental and/or investigational, or similar exclusions or limits, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Master Group Contract to your medical circumstances, or a statement of such an explanation will be provided free of charge upon request;
- A list of titles and qualifications of the individuals participating in the review; and
- A statement describing any additional mandatory or voluntary appeal levels either required or offered by SelectHealth, including the opportunity for IRO assessment, if applicable, your right to obtain information about such procedures, and a statement of your right to bring suit under ERISA §502(a).

Notification of the decision on an urgent care claim may be provided verbally, but a follow-up written notification will be provided no later than three days after the verbal notice.

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