

**2011**

**CITIGROUP**





**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 - <i>Per Person</i> .....	None
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) .....	\$500/\$1000
Out-of-Pocket Maximum - Per Person/Family (per calendar year) .....	\$3000/\$6000
<i>(Deductible Included in the Out-of-Pocket Maximum)</i>	

**INPATIENT SERVICES**

**PARTICIPATING**

Medical, Surgical and Hospice .....	10% after deductible
Maternity and Adoption <sup>1</sup> .....	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) <sup>2</sup> .....	10% after deductible
Secondary Care Provider (SCP) <sup>2</sup> .....	10% after deductible
Preventive Care	
Primary Care Provider (PCP) <sup>2</sup> .....	Covered 100%
Secondary Care Provider (SCP) <sup>2</sup> .....	Covered 100%
Adult and Pediatric Immunizations .....	Covered 100%
Elective Immunizations - herpes zoster (shingles), rotavirus .....	Covered 100%
Diagnostic Tests: Minor <sup>3</sup> .....	Covered 100%
Allergy Tests .....	See Office Visits Above
Allergy Treatment and Serum .....	10% after deductible
Major Office Surgery ( <i>Surgical and Endoscopic Services Over \$350</i> ) .....	10% after deductible
Physician's Fees - ( <i>Medical, Surgical, Maternity, Anesthesia</i> ) .....	10% after deductible

**OUTPATIENT SERVICES**

**PARTICIPATING**

Outpatient Facility and Ambulatory Surgical .....	10% after deductible
Ambulance (Air or Ground) - <i>Emergencies Only</i> .....	10% after deductible
Emergency Room - ( <i>Participating facility</i> ) .....	10% after deductible
Emergency Room - ( <i>Nonparticipating facility</i> ) .....	10% after deductible
Intermountain InstaCare <sup>SM</sup> Facilities, Urgent Care Facilities .....	10% after deductible
Intermountain KidsCare <sup>SM</sup> Facilities .....	10% after deductible
Chemotherapy, Radiation and Dialysis .....	10% after deductible
Diagnostic Tests: Minor <sup>3</sup> .....	Covered 100% after deductible
Diagnostic Tests: Major <sup>3</sup> .....	10% after deductible
Home Health, Hospice, Outpatient Private Nurse .....	10% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational <i>Up to 20 visits per calendar year for each therapy type</i>	10% after deductible



**MEMBER PAYMENT SUMMARY**

**PARTICIPATING**  
*(In-Network)*

**MISCELLANEOUS SERVICES**

**PARTICIPATING**

Durable Medical Equipment (DME) <sup>4</sup>	10% after deductible
Miscellaneous Medical Supplies (MMS)	10% after deductible
Cochlear Implants - <i>Up to \$35,000 lifetime</i>	See Physician's Fees and Inpatient or Outpatient Services benefits
Infertility - <i>Selected Services</i> <i>(Max Plan Payment \$1,500/ calendar year; \$5,000 lifetime)</i>	*50% after deductible
Donor Fees for Covered Organ Transplants - <i>Up to \$40,000 per transplant</i>	10% after deductible
TMJ (Temporomandibular Joint) Services - <i>Up to \$2,000 lifetime</i>	See Physician's Fees and Inpatient or Outpatient Services benefits

**BENEFIT RIDERS**

**PARTICIPATING**

Mental Health and Chemical Dependency <sup>4</sup>	
Mental Health Office Visits	10% after deductible
Inpatient	10% after deductible
Outpatient	10% after deductible
Residential Treatment	10% after deductible
Chiropractic - up to 20 visits per calendar year 1-800-678-9133	*\$10
Injectable Drugs and Specialty Medications <sup>4</sup>	10% after deductible

**PRESCRIPTION DRUGS**

Pharmacy Deductible - Per Person per calendar year	*\$50
Prescription Drug List (formulary)	RxSelect <sup>SM</sup>
Prescription Drugs - <i>Up to 30 Day Supply of Covered Medications</i> <sup>4</sup>	
Tier 1	*\$10
Tier 2	*\$25 after pharmacy deductible
Tier 3	*\$45 after pharmacy deductible
Maintenance Drug Benefit-90 Day Supply (Medco by Mail or Retail <sup>90SM</sup> )- <i>selected drugs</i> <sup>4</sup>	
Tier 1	*\$10
Tier 2	*\$50 after pharmacy deductible
Tier 3	*\$135 after pharmacy deductible

To remain compliant with healthcare reform regulations, these benefits are subject to change.

- 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 Certificate of Coverage for more information.
- 4 Preauthorization is required for the following: (a) certain injectable drugs and specialty medications; (b) certain prescription drugs; (c) certain DME items; (d) certain mental health and chemical dependency services.; and (e) all services obtained outside the United States unless for a routine, urgent, or emergent condition. Please refer to your Certificate of Coverage or call Member Services for more information

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

*All deductible/copay/coinsurance amounts and plan payments are based on allowed amounts only and not on the provider's billed or other charges. You are responsible to pay for charges in excess of allowed amounts 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, Certificate of Coverage, or Provider & Facility Directory for more information.*

Select Med is administered and underwritten by SelectHealth.

## 2010-2011 MEDICAL BENEFIT CHANGES

The following information is a summary of significant changes and clarifications made for 2011 plans. These changes are effective January 1, 2011 for new and renewing business. Some changes were effective as of October 1, 2010. You may refer to your Member Payment Summary or call Member Services for additional benefit details.

### Affordable Care Act (ACA) Changes

As mandated by the ACA, please note the following changes to SelectHealth plans:

#### Lifetime and Annual Dollar Limits

Lifetime limits for “essential” health benefits will be removed, and annual limits will be restricted. (Essential health benefits have not yet been defined by the Department of Health and Human Services.) You can refer to your Member Payment Summary (MPS) for specific limit information.

#### No Cost-Sharing for Preventive Services

Plans will cover many preventive services without charging a deductible, copay, or coinsurance.

**Note:** *This change may not affect Large Employer plans that have elected to maintain “grandfathered” status.*

#### Expanded Coverage for Young Adults

You may choose to keep or enroll a dependent on your plan until your dependent turns age 26, regardless of financial or marital status.

Visit [www.selecthealth.org/healthcarereform](http://www.selecthealth.org/healthcarereform) for more information on healthcare reform and how it may affect your plan.

### Additional Policy Changes

#### Services Obtained Outside the United States

All services obtained outside the U.S. (unless for a routine, urgent, or emergency condition) require preauthorization.

**Note:** *If you are on an HMO plan (with no out-of-network coverage), the only services covered outside the U.S are urgent and emergency care.*

#### SelectHealth Prescriptions<sup>SM</sup>

SelectHealth Prescriptions, our pharmacy benefits management program, consists of two formularies: RxSelect<sup>SM</sup> and RxCore<sup>SM</sup>. Our traditional formulary, RxSelect, covers a wide range of medications and has minimal restrictions on drug selection. RxCore excludes brand-name drugs when there is a lower-cost generic option or over-the-counter equivalent available.

You can identify your formulary on your Member Payment Summary, ID Card, and in Appendix A of this Certificate of Coverage.







# medical

certificate of coverage

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## SECTION 1—INTRODUCTION

### 1.1 This Certificate

This Certificate of Coverage describes the terms and conditions of the health insurance Benefits provided under your employer's Group Health Insurance Contract with SelectHealth, Inc. Please read it carefully and keep it for future reference. Technical terms are capitalized and described in Section 16—"Definitions." Your Member Payment Summary, which contains a quick summary of the Benefits by category of service, is attached to and considered part of this Certificate.

### 1.2 SelectHealth

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

### 1.3 Managed Care

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

### 1.4 Your Agreement

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

### 1.5 No Vested Rights

You are only entitled to receive Benefits while the Contract is in effect and you, and your Dependents if applicable, are properly enrolled and recognized by SelectHealth as Members. You do not have any permanent or vested interest in any Benefits under the Plan. Benefits may change as the Contract is renewed or modified from year to year. Unless otherwise expressly stated in this Certificate, all Benefits end when the Contract ends.

### 1.6 Administration

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

### 1.7 Non-Assignment

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

### 1.8 Notices

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

### 1.9 Nondiscrimination

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

### 1.10 Questions

If you have questions about your Benefits, call Member Services at 801-442-5038 (Salt Lake area) or 800-538-5038, or visit [www.selecthealth.org](http://www.selecthealth.org). SelectHealth offers foreign language assistance.

### 1.11 Benefit Changes

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

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

## SECTION 2—ELIGIBILITY

### 2.1 General

Your employer decides, in consultation with SelectHealth, which categories of its employees, retirees, and their dependents are Eligible for Benefits, and establishes the other Eligibility requirements of the Plan. These Eligibility requirements are described in this section and in the Group Application of the Contract. In order to become and remain a Member, you and



your Dependents must continuously satisfy these requirements. No one, including your employer, may change, extend, expand, or waive the Eligibility requirements without first obtaining the advance, written approval of an officer of SelectHealth.

## 2.2 Subscriber Eligibility

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

## 2.3 Dependent Eligibility

Unless stated otherwise in the Group Application, your Dependents are:

### 2.3.1 Spouse

Your lawful spouse under the laws of the state where you reside. A person of the opposite sex to whom you are not formally married is your lawful spouse only if he or she qualifies as a common law spouse under the laws of the state where you reside at the time of enrollment. In Utah, you must obtain a court or administrative agency order establishing the common law marriage. Eligibility may not be established retroactively. In cases of court or administrative orders purporting to retroactively either establish or annul/declare void a marriage or divorce, SelectHealth will consider the change effective 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 is later.

### 2.3.2 Children

The children (natural, adopted, and children placed for adoption or under legal guardianship through testamentary appointment or court order, but not under temporary guardianship or guardianship for school residency purposes) of you or your lawful spouse, who are younger than age 26. If paternity is in question when determining a Dependent child's Eligibility, the Eligible father must provide the Dependent child's birth certificate. If the Eligible father is not listed on the birth certificate, then he must provide a Voluntary Declaration of Paternity that complies with state law. Each of these documents must be notarized.

### 2.3.3 Disabled Children

Unmarried Dependent children who meet the Eligibility requirements in Subsection 2.3.2 except for age may enroll or remain enrolled as Dependents after reaching age 26 as long as they: (1) are unable to engage in

substantial gainful employment to the degree they can achieve economic independence due to medically determinable physical or mental impairment which can be expected to last for a continuous period of not less than 12 months or result in death; (2) are chiefly dependent upon you or your lawful spouse for support and maintenance since they reached age 26; and (3) have been continuously enrolled in some form of healthcare coverage, with no break in coverage of more than 63 days since the date they reached age 26. SelectHealth may require you to provide proof of incapacity and dependency within 30 days of the Effective Date or the date the child reaches age 26 and annually after the two-year period following the child's turning age 26.

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

## 2.4 Court-Ordered Dependent Coverage

When you or your lawful spouse are required by a court or administrative order to provide health insurance coverage for a child, the child will be enrolled in your family coverage according to SelectHealth guidelines and only to the minimum extent required pursuant to U.C.A. § 31A-22-610 through 611, and 718. For more information about SelectHealth guidelines, please call Member Services.

### 2.4.1 Qualified Medical Child Support Order (QMCSO)

A QMCSO can be issued by a court of law or by a state or local child welfare agency. In order for the medical child support order to be qualified, the order must specify the following: (1) your name and last known mailing address (if any) and the name and mailing address of each alternate recipient covered by the order; (2) a reasonable description of the type of coverage to be provided, or the manner in which the coverage will be determined; and (3) the period to which the order applies.

### 2.4.2 National Medical Support Notice (NMSN)

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

### 2.4.3 Eligibility and Enrollment

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



#### 2.4.4 Effective Date

For a qualified order, the Effective Date of coverage will be the later of:

- a. The start date indicated in the order;
- b. The date any applicable Employer Waiting Period is satisfied; or
- c. The date SelectHealth receives the order.

#### 2.4.5 Duration of Coverage

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

### SECTION 3—ENROLLMENT

#### 3.1 General

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

You and your Dependents will not be considered enrolled until:

- a. All enrollment information is provided to SelectHealth; and
- b. The Premium has been paid to SelectHealth by your employer.

#### 3.2 Enrollment Process

Unless separately agreed to in writing by SelectHealth and your employer, you must enroll on a Subscriber Application specified by SelectHealth. You and your Dependents are responsible for obtaining and submitting to SelectHealth evidence of Eligibility and all other information required by SelectHealth in the enrollment process. You enroll yourself and any Dependents by completing, signing, and submitting a Subscriber Application and any other required enrollment materials to SelectHealth.

#### 3.3 Effective Date of Coverage

Coverage for you and your Dependents will take effect as follows:

##### 3.3.1 Annual Open Enrollment

Coverage elected during your Employer's Annual Open Enrollment will take effect on the day the Contract is effective.

##### 3.3.2 Newly Eligible Members

Coverage you elect as a newly Eligible employee will take effect on the date specified in the Group Application if SelectHealth receives a properly completed Subscriber Application from your employer in a timely manner.

If you do not enroll in the Plan for yourself and/or your Dependents within 31 days of the date you first become Eligible, you may not enroll until the

next Annual Open Enrollment unless you experience an event that creates a Special Enrollment Right.

#### 3.4 Special Enrollment Rights

SelectHealth provides Special Enrollment Rights in the following circumstances:

##### 3.4.1 Loss of Other Coverage

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

- a. You initially declined to enroll in the Plan due to the existence of other health plan coverage;
- b. The loss of the other health plan coverage occurred because of a loss of eligibility (this Special Enrollment Right will not apply if the other coverage is lost due to nonpayment of premiums). There is an exception to this condition for Dependents who voluntarily drop their coverage under another large group health plan (more than 51 Subscribers) during an open enrollment period for the other large group health plan that does not coincide with your Employer's Annual Open Enrollment. A special enrollment period will be permitted for such Dependents in order to avoid a gap in coverage; and
- c. You and/or your Dependents who lost the other coverage must enroll in the Plan within 31 days after the date the other coverage is lost.

Proof of loss of the other coverage (for example, a Certificate of Creditable Coverage) must be submitted to SelectHealth as soon as reasonably possible. Proof of loss of other coverage must be submitted before any Benefits will be paid.

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

##### 3.4.2 New Dependents

If you are enrolled in the Plan (or are Eligible to be covered but previously declined to enroll), and gain a Dependent through marriage, birth, adoption, placement for adoption or placement under legal guardianship with you or your lawful spouse, then you may enroll the Dependents (and yourself, if applicable) in the Plan. In the case of birth, adoption or placement for adoption of a child, you may also enroll your Eligible spouse, even if he or she is not newly Eligible as a Dependent. However, this Special Enrollment Right is only available by enrolling within 31 days of the marriage, birth, adoption, placement for adoption or placement under legal guardianship (there is an exception for enrolling a newborn, adopted child, or child placed for adoption or under legal guardianship if enrolling the child does not change the Premium, as explained in Section 3.5 "Enrolling a Newborn, Adopted Child, or Child Placed for Adoption or Under Legal Guardianship").



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

- a. As of the date of marriage;
- b. As of the date of birth;
- c. If the child is less than 31 days old when adopted or placed for adoption, as of the date of birth; if the child is more than 31 days old when adopted or placed for adoption, as of the child's date of placement; or
- d. As of the later of:
  - i. The effective date of the guardianship court order or testamentary appointment; or
  - ii. The date the order is received by SelectHealth.

### 3.4.3 Qualification for a Subsidy Through Utah's Premium Partnership

You and/or your Eligible Dependents who qualify for a subsidy through the state Medicaid program to purchase health insurance may enroll in the Plan if application is made within 30 days of receiving written notification of eligibility for the subsidy. If you timely enroll, the effective date of coverage is the first of the month following date of enrollment.

### 3.4.4 Loss of Medicaid or CHIP Coverage

If you and/or your Eligible Dependents lose coverage under a Medicaid or CHIP plan due to loss of eligibility, you may enroll in the Plan if application is made within 60 days. If you enroll within 60 days, the effective date of coverage is the first day after your Medicaid or CHIP coverage ended.

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

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

- a. If enrolling the child requires additional Premium, you must enroll the child within 31 days of the child's birth, adoption, or placement for adoption.
- b. If enrolling the child does not change the Premium, you must enroll the child within 31 days from the date SelectHealth mails notification that a claim for Services was received for the child.

If the child is not enrolled within these time frames, then you may not enroll the child until your Employer's next Annual Open Enrollment.

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

### 3.6 Leave of Absence

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

### 3.7 Family Medical Leave Act

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

- a. You and your enrolled Dependents may continue your coverage with SelectHealth to the minimum extent required by the FMLA as long as applicable Premiums continue to be paid to SelectHealth by your employer.
- b. If Premiums are not paid, your coverage will be terminated. Upon your return to work, you and any previously enrolled Dependents who are still Eligible will be prospectively reinstated if the applicable Premium for you is paid to SelectHealth by your employer within 30 days. SelectHealth will not be responsible for any claims incurred by you or your Dependents during this break in coverage.

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

## SECTION 4—TERMINATION

### 4.1 Group Termination

Coverage under the Plan for you and your Dependents will terminate when the Contract terminates.

#### 4.1.1 Nonrenewal by Your Employer

The Contract is generally issued on an annual basis. If it is not renewed by your employer, it will automatically terminate at the end of its term.

#### 4.1.2 Termination by Employer

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

#### 4.1.3 Termination of Employer Group by SelectHealth

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

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



- c. Your employer's coverage under the Contract is through an association and your employer terminates membership in the association;
- d. Your employer fails to satisfy SelectHealth's minimum group participation and/or employer contribution requirements;
- e. No Members live, reside, or work in the Service Area;
- f. SelectHealth elects to discontinue offering a particular health benefit plan. If that happens, you will be given at least 90 days advance notice; or
- g. SelectHealth withdraws from the market and discontinues all of its health benefit plans. If that happens, you will be given at least 180 days advance notice.

## 4.2 Individual Termination

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

### 4.2.1 Loss of Eligibility

If you and/or your enrolled Dependents lose Eligibility, then coverage will terminate at the end of the month in which the loss of Eligibility occurred. However, if the Eligibility is lost as the result of a termination of employment, your employer may choose on a uniform and consistent basis to terminate coverage as of the date of termination of employment. If your Spouse loses Eligibility because you divorce, he or she ceases to be a Member at the end of the month in which the decree of divorce or annulment is granted (whether or not the decree finally decides all property, support, and custody issues).

### 4.2.2 Fraud or Misrepresentation

- a. During Enrollment.
  - i. Coverage for you and/or your Dependents may be terminated during the two-year period after you enroll if you or they make an intentional misrepresentation of material fact in connection with insurability.
  - ii. Coverage for you and/or your Dependents may be terminated at any time if you or they make any fraudulent misrepresentation in connection with insurability.
  - iii. Please Note: If coverage is terminated as described above, the termination is retroactive to the Effective Date of coverage.
- b. After Enrollment. Coverage for you and/or your Dependents may be terminated if you or they commit fraud or make an intentional misrepresentation of material fact in connection with Benefits or Eligibility. At SelectHealth's discretion, the coverage may be terminated retroactively to the date of the fraud or misrepresentation.
- c. If coverage for you or your Dependents is terminated for fraud or intentional misrepresentation of material fact, you or they are allowed to reenroll 12 months after the date of the termination, provided

the Contract is still in force. You will be given notice of this provision at the time of termination.

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

### 4.2.3 Leaving the Service Area

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

### 4.2.4 Annual Open Enrollment

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

### 4.2.5 Nonpayment of Premium or Contributions

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

## 4.3 Member Receiving Treatment at Termination

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

## 4.4 Reinstatement

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

## SECTION 5—CONTINUATION/ CONVERSION COVERAGE

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

### 5.1 COBRA, Utah mini-COBRA, or Alternative to COBRA/Utah mini-COBRA Coverage (Continuation Coverage)

You and/or your Dependents may have the right to temporarily continue your coverage under the Plan when coverage is lost due to certain events. The federal law that governs this right is called COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1986) and generally applies to employers with 20 or more employees. For employers with fewer than 20 employees, Utah law provides for mini-COBRA coverage. Utah law also provides for alternative coverage.



### 5.1.1 Employer's Obligation

Continuation Coverage is an employer obligation. SelectHealth is not the administrator of Continuation Coverage procedures and requirements. SelectHealth has contractually agreed to assist your employer in providing Continuation Coverage in certain circumstances. It is your employer's responsibility to do the following in a timely manner: (1) notify persons entitled to Continuation Coverage, (2) notify SelectHealth of such individuals, and (3) collect and submit to SelectHealth all applicable Premiums. If the Contract is terminated, your Continuation Coverage with SelectHealth will terminate. Your employer is responsible for obtaining substitute coverage.

## 5.2 Conversion Coverage

Under Utah law, you and/or your Dependents may have the right in certain circumstances to obtain coverage under a separate, individual policy after your coverage in the group Contract is terminated.

### 5.2.1 Notice

Your employer is required to provide you written notification of your right to Conversion Coverage within 30 days of your losing coverage under the Plan.

### 5.2.2 Eligibility

In order to be eligible for Conversion Coverage, you must:

- a. Have been continuously covered by the Plan for a period of three months immediately prior to the termination of your coverage;
- b. Have exhausted Continuation Coverage;
- c. Not have acquired other group coverage that covers all conditions that are covered under the Plan;
- d. Reside in the Service Area;
- e. Not have lost coverage under the Plan because you either failed to pay any required Premium contribution or committed fraud or made an intentional misrepresentation of material fact; and
- f. Submit a written application for Conversion Coverage within 60 days of losing your coverage under the Plan.

### 5.2.3 Conversion Coverage for Dependents

You may elect Conversion Coverage on behalf of family members who were covered under the Plan on the date of termination. The only Dependents who may be added to your Conversion Coverage after it has been issued are Dependents who become eligible through birth, adoption, or court or administrative order.

If you are newly eligible for Conversion coverage, but are 65 and choose instead to enroll in Medicare, you may enroll your Dependents on Conversion Coverage for as long as they satisfy the Eligibility requirements.

If you choose to drop Conversion Coverage and enroll in Medicare because you turn 65, or in the event of your death, your Dependents may remain on Conversion Coverage for as long as they satisfy the Eligibility requirements.

### 5.2.4 Effective Date

If you properly enroll, Conversion Coverage is effective on the date your coverage under the Plan terminates.

### 5.2.5 Premium

Your Premium will likely increase but will be determined without reference to your health. You must submit your Premium to SelectHealth. Failure to make timely Premium payments will result in termination of Conversion Coverage.

### 5.2.6 Conversion Coverage May Be Different

You will receive SelectHealth's standard contract for Conversion Coverage in effect at the time your coverage under the Plan terminates, which may contain otherwise lawful terms, conditions, and Benefits that are different from those under the Plan.

## 5.3 Minimum Extent

Continuation or Conversion Coverage will only be provided for the minimum time and only to the minimum extent required by applicable federal law or pursuant to U.C.A. § 31A-22-723 and 724. SelectHealth will not provide Continuation Coverage if you, your Dependents, or your employer fails to strictly comply with all applicable notices and other requirements and deadlines.

# SECTION 6—PROVIDERS/NETWORKS

## 6.1 Providers and Facilities

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

## 6.2 Providers and Facilities not Agents/ Employees of SelectHealth

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

Providers and Facilities are not authorized to speak on behalf of SelectHealth or to cause SelectHealth to be



legally bound by what they say. A recommendation, order, or referral from a Provider or Facility, including Participating Providers and Facilities, does not guarantee coverage by SelectHealth.

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

### 6.3 Payment

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

#### 6.3.1 Incentives

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

#### 6.3.2 Payments to Members

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

### 6.4 Provider/Patient Relationship

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

### 6.5 Continuity of Care

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

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

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

- a. Accept SelectHealth's Allowed Amount as payment in full;
- b. Follow SelectHealth's Healthcare Management policies and procedures;
- c. Continue treating you and/or your Dependent; and
- d. Share information with SelectHealth regarding the treatment plan.

## SECTION 7—ABOUT YOUR BENEFITS—MEDICAL

### 7.1 General

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

### 7.2 Member Payment Summary

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

### 7.3 Identification (ID) Cards

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

If you or your enrolled Dependents permit the use of your ID card by any other person not covered by the card, the card will be confiscated by SelectHealth or by a Provider or Facility and all rights of such Member under the Plan will be immediately terminated.

### 7.4 Medical Necessity

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

### 7.5 Benefit Changes

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



### 7.6 Calendar-Year or Plan-Year Basis

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

### 7.7 Lifetime Maximums

Your Member Payment Summary will specify any applicable Lifetime Maximums.

### 7.8 Participating Benefits

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

### 7.9 Emergent Conditions

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

If you or your Dependent is hospitalized for an emergency:

- a. You or your representative must contact SelectHealth within two working days, or as soon as reasonably possible; and
- b. If you are in a Nonparticipating Facility, once the Emergent Condition has been stabilized, you may be asked to transfer to a Participating Facility in order to continue receiving Participating Benefits.

### 7.10 Urgent Conditions

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

### 7.11 Preauthorization

You or your Provider are required to contact SelectHealth before you receive certain Services. Depending on the circumstances, your Benefits may be reduced or denied if you do not comply with this requirement. Refer to Section 11—"Healthcare Management" and your Member Payment Summary for details.

## SECTION 8—COVERED SERVICES

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

(except for pharmacy Covered Services, which are separately described in Section 9—"Prescription Drug Benefits"). Certain Services must be Preauthorized; failure to obtain Preauthorization for these Services may result in a reduction or denial of Benefits. Refer to Section 11—"Healthcare Management" for a list of Services that must be Preauthorized.

Benefits are limited. Services must satisfy all of the requirements of the Contract to be covered by SelectHealth. For additional information affecting Covered Services, refer to your Member Payment Summary and Section 10—"Limitations and Exclusions."

## 8.1 Facility Services

### 8.1.1 Educational Training

Only when provided at a Participating Facility for diabetes or asthma.

### 8.1.2 Emergency Room (ER)

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

### 8.1.3 Inpatient Hospital

- a. Semiprivate room accommodations and other Hospital-related Services ordinarily furnished and billed by the Hospital.
- b. Private room accommodations in connection with a medical condition requiring isolation. If you choose a private room when a semiprivate room is available or isolation is not necessary, you are responsible for paying the difference between the Hospital's semiprivate room rate and the private room rate. However, you will not be responsible for the additional charge if the Hospital only provides private room accommodations or if a private room is the only room available.
- c. Intensive care unit.
- d. Preadmission testing.
- e. Short-term inpatient detoxification provided by a SelectHealth-approved treatment Facility for alcohol/drug dependency.
- f. Maternity/obstetrical Services.
- g. Services in connection with an otherwise covered inpatient Hospital stay.

### 8.1.4 Nutritional Therapy

Only when provided at a Participating Facility for:

- a. Diabetes;
- b. Anorexia nervosa, bulimia, or polyphagia; or
- c. Weight management as part of a program approved by SelectHealth.

### 8.1.5 Outpatient Facility and Ambulatory Surgical Facility

Outpatient surgical and medical Services



### 8.1.6 Skilled Nursing Facility

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

### 8.1.7 Urgent Care Facility

#### 8.2 Provider Services

##### 8.2.1 After-Hours Visits

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

##### 8.2.2 Anesthesia

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

##### 8.2.3 Dental Services

Only in three limited circumstances:

- a. When rendered to diagnose or treat medical complications of a dental procedure and administered under the direction of a medical Provider whose primary practice is not dentistry or oral surgery.
- b. When SelectHealth determines the following to be Medically Necessary:
  - i. Maxillary and/or mandibular procedures;
  - ii. Upper/lower jaw augmentation or reduction procedures, including developmental corrections or altering of vertical dimension; and
  - iii. Orthognathic Services.
- c. For repairs of physical damage to sound natural teeth, crowns, and the supporting structures surrounding teeth when:
  - i. Such damage is a direct result of an accident independent of disease or bodily infirmity or any other cause;
  - ii. Medical advice, diagnosis, care, or treatment was recommended or received for the injury at the time of the accident; and
  - iii. Repairs are initiated within one year of the date of the accident.

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

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

##### 8.2.4 Dietary Products

Only in the following limited circumstances:

- a. For hereditary metabolic disorders when:
  - i. The Member has an error of amino acid or urea cycle metabolism;

- ii. The product is specifically formulated and used for the treatment of errors of amino acid or urea cycle metabolism; and
- iii. The product is used under the direction of a Physician, and its use remains under the supervision of the Physician.

b. In all other situations when:

- i. The formula is used under the direction of a Physician and can only be obtained by prescription and through a pharmacy;
- ii. The formula is the Member's primary source of nutrition and is primarily given through a form of feeding tube; or
- iii. The Member has gastrointestinal dysfunction (e.g., malabsorption) and the product is specifically designed to be used in the management of the condition that prevents his or her ability to maintain adequate weight.

##### 8.2.5 Genetic Counseling

Only when provided by a Participating Provider who is a certified genetic counselor.

##### 8.2.6 Genetic Testing

Only in the following circumstances and according to SelectHealth criteria:

- a. Prenatal testing when performed as part of an amniocentesis to assess specific chromosomal abnormalities in women at high risk for inheritable conditions that can lead to significant immediate and/or long-term health consequences to the child after birth;
- b. Neonatal testing for specific inheritable metabolic conditions (e.g., PKU);
- c. When the Member has a more than five-percent probability of having an inheritable genetic condition and has signs or symptoms suggestive of a specific condition or a strong family history of the condition (defined as two or more first-degree relatives with the condition) and results of the testing will directly affect the patient's treatment; or
- d. Pre-implantation embryonic genetic testing performed to identify an inherited genetic condition known to already exist in either parent's family which has the potential to cause serious and impactful medical conditions for the child.

##### 8.2.7 Home Visits

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

##### 8.2.8 Infertility Diagnosis and Treatment

Only the following Services:

Fulguration of ova ducts, hysteroscopy, hysterosalpingogram, certain laboratory tests, and laparoscopy.



**8.2.9 Major Office Surgery****8.2.10 Mastectomy/Reconstructive Services**

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

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

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

**8.2.11 Medical/Surgical**

In an inpatient, outpatient, or Ambulatory Surgical Facility.

**8.2.12 Maternity Services**

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

**8.2.13 Office Visits including Minor Surgery**

For consultation, diagnosis, and treatment.

**8.2.14 Preventive Services****8.2.15 Sleep Studies**

Only when conducted by a designated sleep-study Participating Provider at a Participating Facility.

**8.2.16 Sterilization Procedures****8.3 Miscellaneous Services****8.3.1 Adoption Indemnity Benefit**

SelectHealth provides an adoption indemnity Benefit to the extent required by Utah law. In order to receive this Benefit, the child must be placed with you for adoption within 90 days of the child's birth and the adoption must be finalized within one year of the child's birth. You must submit a claim for the Benefit within one year from the date of placement.

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

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

**8.3.2 Allergy Tests, Treatment, or Serum.**

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

**8.3.3 Ambulance/Transportation Services**

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

**8.3.4 Chemotherapy, Radiation Therapy, and Dialysis****8.3.5 Cochlear Implants**

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

**8.3.6 Durable Medical Equipment (DME)**

Only:

- a. When used in conjunction with an otherwise covered condition and must be:
  - i. Prescribed by a Provider;
  - ii. Primarily used for medical purposes and not for convenience, personal comfort, or other nontherapeutic purposes; and
  - iii. Required for Activities of Daily Living.
- b. Batteries only when used to power a wheelchair or an insulin pump for treatment of diabetes.
- c. Continuous passive motion therapy for any indication for up to 21 days of continuous coverage from the first day applied.

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

**8.3.7 Home Healthcare**

- a. When you:
  - i. Have a condition that requires the services of a licensed Provider;
  - ii. Are home bound for medical reasons;
  - iii. Are physically unable to obtain necessary medical care on an outpatient basis; and



- iv. Are under the care of a Physician.
- b. In order to be considered home bound, you must either:
- i. Have a medical condition that restricts your ability to leave the home without the assistance of another individual or supportive device or because absences from the home are medically contraindicated; or
  - ii. Leave the home only to receive medical treatment that cannot be provided in your home or other treatments that require equipment that cannot be made available in your home or infrequently and for short periods of time for nonmedical purposes.

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

### 8.3.8 Hospice Care

### 8.3.9 Injectable Drugs and Specialty Medications

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

### 8.3.10 Miscellaneous Medical Supplies (MMS)

Only when prescribed by a Physician and not generally usable in the absence of an illness or injury.

### 8.3.11 Neuropsychological Testing (Medical)

As a medical Benefit, only as follows:

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

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

### 8.3.12 Organ Transplants

- a. Only if:
  - i. Preauthorized in advance by SelectHealth; and

- ii. Provided by Participating Providers in a Participating Facility unless otherwise approved in writing in advance by SelectHealth.

b. And only the following:

- i. Bone marrow as outlined in SelectHealth criteria;
- ii. Combined heart/lung;
- iii. Combined pancreas/kidney;
- iv. Cornea;
- v. Heart;
- vi. Kidney (but only to the extent not covered by any government program);
- vii. Liver;
- viii. Pancreas after kidney; and
- ix. Single or double lung.

For covered transplants, organ harvesting from donors is covered up to a limit specified in your Member Payment Summary. Services for both the donor and the recipient are only covered under the recipient's coverage.

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

### 8.3.13 Orthotics and Other Corrective Appliances for the Foot

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

### 8.3.14 Osteoporosis Screening

Only central bone density testing (DEXA scan).

### 8.3.15 Private Duty Nursing

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

### 8.3.16 Rehabilitation Therapy

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

### 8.3.17 Temporomandibular Joint (TMJ)

### 8.3.18 Vision Aids

Only:

- a. Contacts for Members diagnosed with keratoconus, congenital cataracts, or when used as a bandage after eye trauma/injury; or
- b. Monofocal intraocular lenses after cataract surgery.



## 8.4 Prescription Drug Services

Refer to Section 9—"Prescription Drug Benefits" for details.

## SECTION 9—PRESCRIPTION DRUG BENEFITS

This section includes important information about how to use your Prescription Drug Benefits. For additional information, refer to your Member Payment Summary and Section 10—"Limitations and Exclusions." Note: this section does not apply to you if your Member Payment Summary indicates that your Plan does not provide Prescription Drug Benefits.

### 9.1 Use Participating Pharmacies

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

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

### 9.2 Tiered Benefits

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

Drugs on each tier are selected by an expert panel of Physicians and pharmacists and may change periodically. To determine which tier a drug is assigned to, call Member Services or log in to *My Health* at [www.selecthealth.org/myhealth](http://www.selecthealth.org/myhealth).

### 9.3 Filling Your Prescription

#### 9.3.1 Copay/Coinsurance

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

#### 9.3.2 Quantity and Day Supply

Prescriptions are subject to SelectHealth quantity and day-supply Limitations that have been defined based upon FDA guidance or evidence-based literature.

#### 9.3.3 Refills

Refills are allowed after 75 percent of the last refill has been used for a 30-day supply, and 50 percent

for a 10-day supply. Some exceptions may apply; call Pharmacy Services for more information.

### 9.4 Generic Drug Substitution Required

Your Member Payment Summary will indicate if generic substitution is required. When generic substitution is required, the following guidelines apply:

- a. A Generic Drug will be substituted for a brand-name drug unless your Provider indicates otherwise on the prescription.
- b. If you request a brand-name drug instead of a Generic Drug, then you must pay the difference between the Allowed Amount for the Generic Drug and the Allowed Amount for the brand-name drug, plus your Copay/Coinsurance. The difference in cost between the Generic Drug and brand-name drug will not apply to your pharmacy Deductible or Out-of-Pocket Maximum.
- c. If your Provider prescribes a brand-name drug for medical reasons, this penalty will not apply.

### 9.5 Maintenance Drugs

SelectHealth offers a maintenance drug Benefit, allowing you to obtain a 90-day supply of certain medications. This Benefit is available for maintenance drugs you have been using for at least one month and expect to continue using for the next year. Maintenance drugs are identified by the letter (M) on the Prescription Drug List. You have two options when filling prescriptions under the maintenance drug Benefit: (1) Retail90<sup>SM</sup>, which is available at certain retail pharmacies; and (2) mail order. Please refer to your Member Payment Summary or contact Member Services to verify if the 90-day maintenance drug Benefit is available on your Plan.

### 9.6 Preauthorization of Prescription Drugs

There are certain drugs that require Preauthorization by your Physician to be covered by SelectHealth. Prescription drugs that require Preauthorization are identified on the Prescription Drug List. The letters (PA) appear next to each drug that requires Preauthorization. Preauthorization is also required if the medication is in excess of the Plan limits (quantity, duration of use, maximum dose, etc.).

To obtain Preauthorization for these drugs, please have your Physician call SelectHealth Pharmacy Services at 801-442-4912 (Salt Lake area) or 800-442-3129.

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



## 9.7 Step Therapy

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

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

## 9.8 Prescription Drug Benefit Resources

There are several resources you can use to obtain information about tiers, Participating Pharmacies, Preauthorization requirements, maintenance drugs, step therapy, generic substitutions, and your Prescription Drug Benefits. You can:

- a. Log in to *My Health* at [www.selecthealth.org/myhealth](http://www.selecthealth.org/myhealth) and use Pharmacy Tools;
- b. Visit [www.selecthealth.org/pharmacy](http://www.selecthealth.org/pharmacy);
- c. Refer to your Provider & Facility Directory; or
- d. Call Member Services at 801-442-5038 (Salt Lake area) or 800-538-5038.

## 9.9 Coordination of Benefits

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

## 9.10 Inappropriate Prescription Practices

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

- a. These medications include:
  - i. Narcotic analgesics;
  - ii. Other addictive or potentially addictive medications; and
  - iii. Medications or drugs prescribed in quantities, dosages, or usages that are outside the usual standard of care for the medication in question.
- b. These medications are not covered when they are prescribed:

- i. Outside the usual standard of care for the practitioner prescribing the medication;
- ii. In a manner inconsistent with accepted medical practice; or
- iii. For indications that are Experimental and/or Investigational.

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

## 9.11 Prescription Drug Benefit Abuse

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

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

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

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

## 9.12 Pharmacy Injectable Drugs and Specialty Medications

While injectable drugs apply to your medical Benefits, some injectable drugs may also be covered under your Prescription Drug Benefits when filled at a pharmacy. For more specific information, please contact Member Services.

## 9.13 Prescription Drug List (PDL)

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



not covered at all, by your Plan. Refer to Appendix A—"Prescription Drug List" for the PDL.

### 9.14 Exceptions Process

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

### 9.15 Disclaimer

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

## SECTION 10—LIMITATIONS AND EXCLUSIONS

Unless otherwise noted in your Member Payment Summary or Appendix B—"Benefit Riders," the following Limitations and Exclusions apply.

### 10.1 Abortions/Termination of Pregnancy

Abortions are not covered except:

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

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

### 10.2 Acupuncture/Acupressure

Acupuncture and acupressure Services are not covered.

### 10.3 Administrative Services/Charges

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

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

### 10.4 Allergy Tests/Treatments

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

### 10.5 Anesthesia

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

### 10.6 Attention-Deficit/Hyperactivity Disorder

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

### 10.7 Bariatric Surgery

Surgery to facilitate weight loss is not covered. The reversal or revision of such procedures and Services required for the treatment of complications from such procedures are not covered. However, medical or surgical complications that can be reasonably attributed to such a surgery will be considered for coverage if they arise ten years or more after the surgery. This Exclusion does not apply if your Member Payment Summary indicates that your Plan includes the Bariatric Surgery Benefit Rider.

### 10.8 Biofeedback/Neurofeedback

Biofeedback/neurofeedback is not covered



## 10.9 Birthing Centers and Home Childbirth

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

## 10.10 Certain Cancer Therapies

Neutron beam and proton beam therapy are not covered.

## 10.11 Certain Illegal Activities

Services for an illness, condition, accident, or injury are not covered if it occurred:

- a. While the Member was a voluntary participant in the commission of a felony;
- b. While the Member was a voluntary participant in disorderly conduct, riot, or other breach of the peace;
- c. While the Member was engaged in any conduct involving the illegal use or misuse of a firearm or other deadly weapon;
- d. 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:
  - i. Had sufficient alcohol in the Member's body that a subsequent test shows that the Member has either a blood or breath alcohol concentration of .08 grams or greater at the time of the test; or
  - ii. Had any illegal drug or other illegal substance in the Member's body to a degree that it affected the Member's ability to drive or operate the vehicle safely;
- e. 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 driver's permit or license, if required under the circumstances or without the permission of the owner of the vehicle; or
- f. 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.

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

## 10.12 Chiropractic Services

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

## 10.13 Claims After One Year

Claims are denied if submitted more than one year after the Services were provided unless notice was given or proof of loss was filed as soon as reasonably possible. Adjustments or corrections to claims can be

made only if the supporting information is submitted within one year after the claim was first processed by SelectHealth unless the additional information relating to the claim was filed as soon as reasonably possible.

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

## 10.14 Complementary and Alternative Medicine (CAM)

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

## 10.15 Complications

All Services provided or ordered to treat complications of a non-Covered Service are not covered unless stated otherwise in this Certificate.

## 10.16 Custodial Care

Custodial Care is not covered.

## 10.17 Dental Anesthesia

Services including local, regional, general, and/or intravenous sedation anesthesia, are not covered except for at Participating Facilities when members meet the following criteria:

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

## 10.18 Dry Needling

Dry needling procedures are not covered.

## 10.19 Duplication of Coverage

The following are not covered:

- a. Services that are covered by, or would have been covered if you or your Dependents had enrolled and maintained coverage in automobile insurance, including no-fault type coverage up



to the minimum amount required by law. In the event of a claim, you should provide a copy of the Personal Injury Protection (PIP) documentation from the automobile insurance carrier.

- b. Services that are covered by, or would have been covered if your employer had enrolled and maintained coverage in, Workers' Compensation insurance.
- c. Services for which you have obtained a payment, settlement, judgment, or other recovery for future payment intended as compensation.
- d. Services received by a Member incarcerated in a prison, jail, or other correctional facility at the time Services are provided, including care provided outside of a correctional facility to a person who has been arrested or is under a court order of incarceration.

#### 10.20 Exercise Equipment or Fitness Training

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

#### 10.21 Experimental and/or Investigational Services

Experimental and/or Investigational Services are not covered.

#### 10.22 Eye Surgery, Refractive

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

#### 10.23 Food Supplements

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

#### 10.24 Gene Therapy

Gene therapy or gene-based therapies are not covered.

#### 10.25 Habilitation Therapy Services

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

#### 10.26 Hearing Aids

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

#### 10.27 Home Health Aides

Services provided by a home health aide are not covered.

#### 10.28 Immunizations

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

#### 10.29 Mental Health

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

#### 10.30 Methadone Therapy

Methadone maintenance/therapy clinics or Services are not covered.

#### 10.31 Non-Covered Service in Conjunction with a Covered Service

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

#### 10.32 Pain Management Services

The following Services are not covered:

- a. Prolotherapy;
- b. Radiofrequency ablation of dorsal root ganglion; and
- c. IV pamidronate therapy for the treatment of reflex sympathetic dystrophy.

#### 10.33 Pervasive Developmental Disorder

Services for Pervasive Developmental Disorder are not covered.

#### 10.34 Prescription Drugs/Injectable Drugs and Specialty Medications

The following are not covered:

- a. Appetite suppressants and weight loss medications;
- b. Certain off-label drug usage, unless the use has been approved by a SelectHealth Medical Director or clinical pharmacist;
- c. Compound drugs when alternative products are available commercially;
- d. Cosmetic health and beauty aids;
- e. Drugs not on your Formulary;
- f. Drugs purchased from Nonparticipating Providers over the Internet;
- g. Drugs and medications purchased through a foreign pharmacy. However, please call Member Services if you have a special need for medications from a foreign pharmacy (for example, for an emergency while traveling out of the country);
- h. Flu symptom medications;
- i. Human growth hormone for the treatment of idiopathic short stature;



- j. Infertility medications;
- k. Medications not meeting the minimum levels of evidence based upon one of more of the following:
  - i. Food and Drug Administration (FDA) approval
  - ii. DrugDex;
  - iii. National Comprehensive Cancer Network (NCCN); or
  - iv. As defined within SelectHealth's Preauthorization criteria or medical policy.
- l. Minerals, fluoride, and vitamins other than prenatal or when determined to be Medically Necessary to treat a specifically diagnosed disease;
- m. Nicotine and smoking cessation medications, except in conjunction with a SelectHealth-sponsored smoking cessation program;
- n. Over-the-counter (OTC) medications, except as required by the Affordable Care Act, or when all of the following conditions are met:
  - i. The OTC medication is listed on a SelectHealth Formulary as a covered medication;
  - ii. The SelectHealth Pharmacy & Therapeutics Committee has approved the OTC medication as a medically appropriate substitution of a Prescription Drug or medication; and
  - iii. The Member has obtained a prescription for the OTC medication from a licensed Provider and filled the prescription at a Participating Pharmacy;
- o. Prescription Drugs used for cosmetic purposes;
- p. Prescriptions written by a licensed dentist, except for the prevention of infection or pain in conjunction with a dental procedure;
- q. Replacement of lost, stolen, or damaged drugs and medications;
- r. Sexual dysfunction medications. This Exclusion does not apply if your Member Payment Summary indicates that your Plan includes the Sexual Dysfunction Benefit rider; and
- s. Travel-related medications, including preventive medication for the purpose of travel to other countries. See Immunizations In Section 10—"Limitations and Exclusions."

### 10.35 Reconstructive, Corrective, and Cosmetic Services

- a. Services provided for the following reasons are not covered:
  - i. To improve form or appearance;
  - ii. To correct a deformity, whether congenital or acquired, without restoring physical function;
  - iii. To cope with psychological factors such as poor self-image or difficult social relations;

- iv. As the result of an accident unless the Service is rendered within 12 months of the cause or onset of the injury, illness, or therapeutic intervention, or a planned, staged series of Services (as specifically documented in the Member's medical record) is initiated within the 12-month period;
- v. To revise a scar, whether acquired through injury or surgery, except when the primary purpose is to improve or correct a functional impairment.

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

- i. Breast reduction (except according to SelectHealth criteria);
- ii. Congenital cleft lip except for treatment rendered within 12 months of birth, or a planned, staged series of Services (as specifically documented in the Member's medical record) is initiated, or when congenital cleft lip surgery is performed as part of a cleft palate repair;
- iii. Port wine stain treatment (except according to SelectHealth criteria);
- iv. Sclerotherapy of superficial varicose veins (spider veins);

### 10.36 Rehabilitation Therapy Services

The following are not covered:

- a. Services for functional nervous disorders;
- b. Speech therapy for developmental speech delay; and
- c. Vision rehabilitation therapy Services.

### 10.37 Related Provider Services

Services provided to a Member by a Provider who ordinarily resides in the same household as the Member are not covered.

### 10.38 Respite Care

Respite Care is not covered.

### 10.39 Robot-Assisted Surgery

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

### 10.40 Sexual Dysfunction

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

### 10.41 Specialty Services

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



## 10.42 Specific Services

The following Services are not covered:

- a. Anodyne infrared device for any indication;
- b. Auditory brain implantation;
- c. Automated home blood pressure monitoring equipment;
- d. Chronic intermittent insulin IV therapy/ metabolic activation therapy;
- e. Coblation therapy of the soft tissues of the mouth, nose, throat, or tongue;
- f. Computer-assisted interpretation of X-rays (except mammograms);
- g. Computer-assisted navigation for orthopedic procedures;
- h. Cryoablation therapy for plantar fasciitis and Morton's neuroma;
- i. Extracorporeal shock wave therapy for musculoskeletal indications;
- j. Freestanding/home cervical traction;
- k. Home anticoagulation or hemoglobin A1C testing;
- l. Infrared light coagulation for the treatment of hemorrhoids;
- m. Interferential/neuromuscular stimulators;
- n. Intimal Media Thickness (IMT) testing to assess risk of coronary disease;
- o. Lovaas therapy;
- p. Magnetic Source Imaging (MSI);
- q. Manipulation under anesthesia for treatment of back and pelvic pain;
- r. Microprocessor controlled, computerized lower extremity limb prostheses;
- s. Mole mapping;
- t. Nonsurgical spinal decompression therapy (e.g., VAX-D or DRS therapy);
- u. Nucleoplasty or other forms of percutaneous disc decompression;
- v. Pediatric/infant scales;
- w. Peripheral nerve stimulation for occipital neuralgia and chronic headaches;
- x. Pressure Specified Sensory Device (PSSD) for neuropathy testing;
- y. Prolotherapy;
- z. Radiofrequency ablation for lateral epicondylitis;
- aa. Radiofrequency ablation of the dorsal root ganglion;
- ab. Secretin infusion therapy for the treatment of autism; and
- ac. Virtual colonoscopy as a screening for colon cancer.
- ad. Whole body scanning

## 10.43 Telephone/E-mail Consultations

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

## 10.44 Terrorism or Nuclear Release

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

## 10.45 Travel-related Expenses

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

## 10.46 War

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

## SECTION 11—HEALTHCARE MANAGEMENT

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

### 11.1 Preauthorization

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

#### 11.1.1 Services requiring Preauthorization

Preauthorization is required for the following major Services:



- a. All admissions to facilities, including rehabilitation, transitional care, skilled nursing, and all routine hospitalizations;
- b. All nonroutine obstetrics admissions and maternity stays longer than two days for a normal delivery or longer than four days for a cesarean section;
- c. Home Healthcare, Hospice Care, Private Duty Nursing;
- d. Pain management/pain clinic Services;
- e. Selected Prescription Drugs (Refer to the Prescription Drug List in Appendix A—"Prescription Drug Benefits");
- f. All Services obtained outside of the United States unless a routine, Urgent or Emergent Condition;
- g. BRCA1 and BRCA2 genetic testing;
- h. The following Durable Medical Equipment:
  - i. Insulin pumps and continuous glucose monitors;
  - ii. Prosthetics (except eye prosthetics);
  - iii. Negative pressure wound therapy electrical pump (wound vac);
  - iv. Motorized or customized wheelchairs; and
  - v. DME with a purchase price over \$5,000;
- i. The following Injectable Drugs and Specialty Medications\*:

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

\* This list is updated periodically. For the most current list, visit [www.selecthealth.org/pharmacy](http://www.selecthealth.org/pharmacy) or call Member Services.

### 11.1.2 Who is responsible for obtaining Preauthorization

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

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

### 11.1.3 How to request Preauthorization

If you need to request Preauthorization, call Member Services at 801-442-5038 (Salt Lake area) or 800-538-5038.

You should call SelectHealth as soon as you know you will be using a Nonparticipating Provider or Facility for any of the Services listed. Preauthorization is valid for up to six months.

### 11.1.4 Penalties

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

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

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

### 11.2 Case Management

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

### 11.3 Benefit Exceptions

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

When making such exceptions, SelectHealth reserves the right to specify the Providers, Facilities, and circumstances in which the additional care will be provided and to limit payment for additional Services to the amount SelectHealth would have paid had the Service been provided in accordance with the other



provisions of the Plan. Benefits paid under this section are subject to all other Member payment obligations of the Plan such as Copays, Coinsurance, and Deductibles.

#### 11.4 Second Opinions/Physical Examinations

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

#### 11.5 Medical Policies

SelectHealth has developed medical policies to serve as guidelines for coverage decisions. These guidelines detail when certain Services are considered Medically Necessary or Experimental and/or Investigational by SelectHealth. Medical policies generally apply to all of SelectHealth's fully insured Plans. Some Plans administered by SelectHealth, such as some self-funded employer plans or governmental plans, may not utilize SelectHealth's medical policies. Medical policies do not supersede the express provisions of this Certificate. Some Plans may not provide coverage for certain Services discussed in medical policies. Coverage decisions are subject to all terms and conditions of the applicable Plan, including specific Exclusions and Limitations. Because medical policies are based on constantly changing science, they are periodically reviewed and updated by SelectHealth. For questions about SelectHealth's medical policies, call Member Services at 801-442-5038 (Salt Lake area) or 800-538-5038.

## SECTION 12—CLAIMS AND APPEALS

### 12.1 Administrative Consistency

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

### 12.2 Claims and Appeals Definitions

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

#### 12.2.1 Adverse Benefit Determination

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

#### 12.2.2 Appeals

Review by SelectHealth of an Adverse Benefit Determination.

#### 12.2.3 Authorized Representative

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

#### 12.2.4 Benefit Determination

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

#### 12.2.5 Claimant

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

#### 12.2.6 Concurrent Care Decisions

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

#### 12.2.7 External Review

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

#### 12.2.8 Final Internal Adverse Benefit Determination

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

#### 12.2.9 Independent Review Organization

An entity that conducts independent External Reviews.

#### 12.2.10 Postservice Appeal

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

#### 12.2.11 Postservice Claim

Any claim related to Services you have already received.

#### 12.2.12 Preservice Appeal

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

#### 12.2.13 Preservice Claim

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



### 12.2.14 Preservice Inquiry

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

### 12.2.15 Urgent Preservice Claim

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

## 12.3 How to Make a Preservice Inquiry

Preservice Inquiries should be directed to Member Services at 801-442-5038 (Salt Lake area) or 800-538-5038. A Preservice Inquiry is not a claim for Benefits.

## 12.4 How to File a Claim for Benefits

### 12.4.1 Urgent Preservice Claims

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

- a. Information sufficient to determine to what extent Benefits are covered by the Plan; and
- b. A description of the medical circumstances that give rise to the need for expedited review.

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

Notice of a Benefit Determination will be provided as soon as possible, taking into account the medical circumstances, but no later than 24 hours after receipt of the claim. However, if SelectHealth gives you notice of an incomplete claim, the notice will give you at least 48 hours to provide the requested information. SelectHealth will then provide a notice of Benefit Determination within 24 hours after receiving the specified information or the end of the period of time given you to provide the information, whichever occurs first. If the Benefit Determination is provided verbally, it will be followed in writing no later than three days after the verbal notice.

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

### 12.4.2 Other Preservice Claims

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

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

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

### 12.4.3 Postservice Claims

- a. Participating Providers and Facilities. Participating Providers and Facilities file Postservice Claims with SelectHealth and SelectHealth makes payment to the Providers and Facilities.
- b. Nonparticipating Providers and Facilities. Nonparticipating Providers and Facilities are not required to file claims with SelectHealth. If a Nonparticipating Provider or Facility does not submit a Postservice Claim to SelectHealth or you pay the Nonparticipating Provider or Facility, you must submit the claim in writing in a form approved by SelectHealth. Call Member Services or your employer to find out what information is needed to submit a Postservice Claim. All claims must be received by SelectHealth within a



36-month period from the date of the expense or as soon as reasonably possible. Claims received outside of this timeframe will be denied.

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

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

### 12.5 Notice of Adverse Benefit Determinations

If your claim is subject to an Adverse Benefit Determination, you will receive a notification that includes:

- a. Information sufficient to identify the claim involved;
- b. The specific reason(s) for the Adverse Benefit Determination;
- c. Reference to the specific provisions on which the Adverse Benefit Determination was based;
- d. A description of any additional information or material needed from you to complete the claim and an explanation of why it is necessary;
- e. 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 upon request free of charge;
- f. If the Adverse Benefit Determination was based on a Medical Necessity, Experimental and/or Investigational or similar Exclusion or Limitation, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such an explanation will be provided upon request free of charge;
- g. If an Urgent Preservice Claim was denied, a description of the expedited review process applicable to the claim;
- h. A description of SelectHealth's review procedures and the applicable time limits including a statement of your right to bring suit under ERISA Section 502(a), as applicable, with respect to any claim denied after an Appeal; and

- i. Contact information for any applicable office of health insurance consumer assistance.

### 12.6 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 a Member Services representative, usually within seven days. Call Member Services at 801-442-5038 (Salt Lake area) or 800-538-5038. SelectHealth offers foreign language assistance.

### 12.7 Formal Appeals

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

#### 12.7.1 General Rules and Procedures

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

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

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



### 12.7.2 Form and Timing

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

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

You may Appeal an Adverse Benefit Determination of an Urgent Preservice Claim on an expedited basis either verbally or in writing. You may Appeal verbally by calling the SelectHealth Appeals Department at 801-442-4684 (Salt Lake area) or 800-538-5038, ext.4684. If the request is made verbally, the SelectHealth Appeals Department will within 24 hours send written confirmation acknowledging the receipt of your request.

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

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

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

### 12.7.3 Mandatory and Voluntary Appeals

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

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

At any point after a mandatory review process, you may choose to pursue civil action under ERISA Section

502(a). Failure to properly pursue the mandatory Appeals process may result in a waiver of the right to challenge SelectHealth's original decision.

### 12.7.4 Preservice Appeals

The formal process for Preservice Appeals and Appealing the negative outcome of a Preservice Inquiry provides one mandatory review, possible voluntary reviews, and the right to pursue civil action under ERISA Section 502(a).

#### Mandatory Review

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

If your Appeal involves an Urgent Preservice Claim, you may request an expedited review. You will be notified of the Appeal decision on an expedited review as soon as possible, taking into account the medical circumstances, but no later than 24 hours after the receipt of your Appeal. A decision communicated verbally will be followed up in writing.

#### Voluntary Review

If you are dissatisfied with the Final Internal Adverse Benefit Determination, you may voluntarily request further review of your Appeal. If you are Appealing an Adverse Benefit Determination regarding Medical Necessity, you may request a review of your Appeal by either internal or External Review. Such a request for a voluntary review must be made in writing to the Appeals Department within 60 days (180 days for an External Review) from the date the Appeals Department notifies you of the Final Internal Adverse Benefit Determination Appeal.

Additional voluntary review may be available. Contact the Appeals Department for further information.

### 12.7.5 Postservice Appeals

The formal process for Postservice Appeals provides two mandatory review, an additional voluntary review, and the right to pursue civil action under ERISA Section 502(a).

#### First Mandatory Review

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



## Second Mandatory Review

If you are dissatisfied with the decision, you may request further consideration. Such a request must be made in writing to the Appeals Department within 60 days of the date the Appeals Department notifies you of its Appeal decision. SelectHealth will notify you of the result of the second mandatory review in writing within 30 days of the date you requested the review.

SelectHealth may, in 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.

## Voluntary Review

If you are dissatisfied with the Final Internal Adverse Benefit Determination, you may voluntarily request further review of your Appeal. If you are Appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, you may request an internal or External Review. Your request for voluntary review must be made in writing to the Appeals Department within 60 days (180 days for External Review) from the date of SelectHealth's Final Internal Adverse Benefit Determination. SelectHealth will notify you of the result of the voluntary review in writing generally within 60 days of the date you requested the review.

### 12.7.6 Notification of Appeal Decisions

If SelectHealth denies your Appeal, the written notification will include the following information:

- a. Information sufficient to identify the claim involved;
- b. A statement of SelectHealth's understanding of the pertinent facts of the Appeal;
- c. The specific reason(s) for the adverse determination, in easily understandable language;
- d. Reference to the specific provisions on which the adverse determination was based;
- e. 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;
- f. 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 upon request free of charge;
- g. If the denied Appeal was based on a Medical Necessity, Experimental and/or Investigational or similar Exclusion or Limitation, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, or a statement that such an explanation will be provided upon request free of charge;
- h. A list of titles and qualifications of the individuals participating in the review;
- i. A statement describing any additional mandatory or voluntary Appeal either required or offered by SelectHealth, including the opportunity for External Review, if applicable, your right to obtain information about such procedures, and a statement of your right to bring suit under ERISA Section 502(a);
- j. Notification of the decision on an Urgent Preservice Claim may be provided verbally, but a follow-up written notification will be provided no later than three days after the verbal notice; and
- k. Contact information for any applicable office of health insurance consumer assistance.

## SECTION 13—OTHER PROVISIONS AFFECTING YOUR BENEFITS

### 13.1 Coordination of Benefits

When you or your Dependents have healthcare coverage under more than one health benefit plan, SelectHealth will coordinate Benefits with the other healthcare coverage according to the Coordination of Benefits rules set forth in Utah Code, Section 31A-22-619.

#### 13.1.1 Required Cooperation

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

#### 13.1.2 Direct Payments

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

### 13.2 Subrogation/Restitution

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



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

SelectHealth shall have the right to intervene in any lawsuit, threatened lawsuit, or settlement negotiation involving a third party for purposes of asserting and collecting its equitable restitution interest as described in this section. SelectHealth shall have the right to bring a lawsuit against, or assert a counterclaim or cross-claim against, you (or your agent or attorney) for purposes of collecting SelectHealth's equitable restitution interest or to enforce the constructive trust required by this section.

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

You are required to:

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

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

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

If you fail to fully cooperate with SelectHealth or its designated agent in asserting SelectHealth's

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

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

### 13.3 Right of Recovery

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

## SECTION 14—SUBSCRIBER RESPONSIBILITIES

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

### 14.1 Payment

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

### 14.2 Changes in Eligibility or Contact Information

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

### 14.3 Other Coverage

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

### 14.4 Information/Records

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



### 14.5 Notification of Members

Notify your enrolled Dependents of all Benefit and other Plan changes.

## SECTION 15—EMPLOYER RESPONSIBILITIES

### 15.1 Enrollment

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

### 15.2 Payment

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

### 15.3 Contract

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

### 15.4 Compliance

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

## SECTION 16—DEFINITIONS

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

### 16.1 Activities of Daily Living

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

### 16.2 Allowed Amount

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

### 16.3 Ambulatory Surgical Facility

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

### 16.4 Annual Open Enrollment

The period of time each year specified by your employer during which you are given the opportunity to enroll yourself and your Dependents in the Plan.

### 16.5 Benefit Rider

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

### 16.6 Benefit(s)

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

### 16.7 Certificate of Coverage (Certificate)

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

### 16.8 COBRA Coverage

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

### 16.9 Coinsurance

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

### 16.10 Continuation Coverage

COBRA Coverage and/or Utah mini-COBRA Coverage.

### 16.11 Contract

The Group Health Insurance Contract between SelectHealth and your employer.

### 16.12 Conversion Coverage

A separate, individual policy you may have the right under Utah law to obtain after your coverage under the group Contract is terminated.

### 16.13 Copay (Copayment)

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

### 16.14 Covered Services

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

### 16.15 Custodial Care

Services provided primarily to maintain rather than improve a Member's condition or for the purpose of controlling or changing the Member's environment. Services requested for the convenience of the Member



or the Member's family that do not require the training and technical skills of a licensed Nurse or other licensed Provider, such as convalescent care, rest cures, nursing home services, etc. Services that are provided principally for personal hygiene or for assistance in daily activities.

#### **16.16 Deductible(s)**

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

#### **16.17 Dental Services**

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

#### **16.18 Dependents**

Your lawful spouse and any child who meets the Eligibility criteria set forth in Section 2—"Eligibility" and the Group Application.

#### **16.19 Durable Medical Equipment (DME)**

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

#### **16.20 Effective Date**

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

#### **16.21 Eligible, Eligibility**

In order to be Eligible, you or your Dependents must meet the criteria for participation specified in Section 2—"Eligibility" and in the Group Application.

#### **16.22 Emergent Condition(s)**

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

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

#### **16.23 Employer Waiting Period**

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

#### **16.24 Employer's Plan**

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

#### **16.25 Endorsement**

A document that amends the Contract.

#### **16.26 ERISA**

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

#### **16.27 Excess Charges**

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

#### **16.28 Exclusion(s)**

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

#### **16.29 Experimental and/or Investigational**

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

- a. It cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use;
- b. It is the subject of a current investigational new drug or new device application on file with the FDA;
- c. It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial;
- d. It is being or should be delivered or provided subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS); or
- e. If the predominant opinion among appropriate experts as expressed in the peer-reviewed medical literature is that further research is necessary in order to define safety, toxicity, effectiveness, or comparative effectiveness, or there is no clear medical consensus about the role and value of the Service.

#### **16.30 Facility**

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

#### **16.31 Formulary**

The Prescription Drugs covered by your Plan.

#### **16.32 Generic Drug(s)**

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



**16.33 Group Application**

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

**16.34 Group Health Insurance Contract**

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

**16.35 Healthcare Management Program**

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

**16.36 Home Healthcare**

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

**16.37 Hospice Care**

Supportive care provided on an inpatient or outpatient basis to a terminally ill Member not expected to live more than six months. May also be provided to the Member's immediate family at the family's expense.

**16.38 Hospital**

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

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

- a. Operates primarily for the admission, acute care, and treatment of injured or sick persons as inpatients;
- b. Has a 24-hour-a-day nursing service by or under the supervision of a graduate registered Nurse (R.N.) or a licensed practical Nurse (L.P.N.);
- c. Has a staff of one or more licensed Physicians available at all times; and
- d. Provides organized facilities for diagnosis and surgery either on its premises or in facilities available to the Hospital on a contractual prearranged basis.

**16.39 Infertility**

The inability to become pregnant or impregnate.

**16.40 Injectable Drugs and Specialty Medications**

A class of drugs that may be administered orally, as a single injection, intravenous infusion or in an inhaled/

nebulizer solution. Injectable drugs and specialty medications include all or some of the following:

- a. Are often products of a living organism or produced by a living organism through genetic manipulation of the organism's natural function;
- b. Are generally used to treat an ongoing chronic illness;
- c. Require special training to administer;
- d. Have special storage and handling requirements;
- e. Are typically limited in their supply and distribution to patients or Providers; and
- f. Often have additional monitoring requirements.

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

**16.41 Initial Eligibility Period**

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

**16.42 Lifetime Maximum**

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

**16.43 Limitation(s)**

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

**16.44 Major Diagnostic Tests**

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

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



- b. Cardiovascular procedures such as coronary angiograms;
- c. Gastrointestinal procedures such as EGDs, ERCPs, and colonoscopies;
- d. Gene-based testing and genetic testing; and
- e. Neurologic studies such as EMGs and nerve conduction studies.

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

#### **16.45 Major Office Surgery**

Surgical and endoscopic procedures in a Provider's office for which SelectHealth's Allowed Amount is more than the dollar threshold indicated in your Member Payment Summary.

#### **16.46 Medical Director**

The Physician(s) designated as such by SelectHealth.

#### **16.47 Medical Necessity/Medically Necessary**

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

- a. In accordance with generally accepted standards of medical practice in the United States;
- b. Clinically appropriate in terms of type, frequency, extent, site, and duration; and
- c. Not primarily for the convenience of the patient, Physician, or other Provider.

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

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

#### **16.48 Member**

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

#### **16.49 Member Payment Summary**

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

#### **16.50 Minor Diagnostic Tests**

Tests not categorized as Major Diagnostic Tests.

Examples of common minor diagnostic tests are:

- a. Bone density tests;
- b. Certain EKGs;
- c. Echocardiograms ;
- d. Routine blood and urine tests;
- e. Simple X-rays such as chest and long bone X-rays; and
- f. Spirometry/pulmonary function testing.

#### **16.51 Minor Office Surgery**

Surgical and endoscopic procedures in a Provider's office for which SelectHealth's Allowed Amount is less than the dollar threshold indicated in your Member Payment Summary.

#### **16.52 Miscellaneous Medical Supplies (MMS)**

Supplies that are disposable or designed for temporary use.

#### **16.53 Nonparticipating (Out-of-Network) Facility**

Healthcare Facilities that are not under contract with SelectHealth.

#### **16.54 Nonparticipating (Out-of-Network) Pharmacies**

Pharmacies that are not under contract with SelectHealth.

#### **16.55 Nonparticipating (Out-of-Network) Provider**

Providers that are not under contract with SelectHealth.

#### **16.56 Nurse**

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

#### **16.57 Out-of-Pocket Maximum**

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

#### **16.58 Participating (In-Network) Benefits**

Benefits available to you when you obtain Covered Services from a Participating Provider or Facility.



**16.59 Participating (In-Network) Facility**

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

**16.60 Participating (In-Network) Pharmacies**

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

**16.61 Participating (In-Network) Providers**

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

**16.62 Pervasive Developmental Disorder (PDD/Developmental Delay)**

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

- a. Asperger's Syndrome
- b. Autistic Disorder
- c. Childhood Disintegrative Disorder
- d. Pervasive developmental disorder not otherwise specified
- e. Rett's Disorder

**16.63 Physician**

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

**16.64 Plan**

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

**16.65 Plan Sponsor**

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

**16.66 Preauthorization**

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

**16.67 Premium(s)**

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

**16.68 Prescription Drugs**

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

**16.69 Preventive Services**

Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems as required by the ACA.

**16.70 Primary Care Physician or Primary Care Provider (PCP)**

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

- a. Certified Nurse Midwives;
- b. Family Practice;
- c. Geriatrics;
- d. Internal Medicine;
- e. Obstetrics and Gynecology (OB/GYN); and
- f. Pediatrics.

**16.71 Private Duty Nursing**

Services rendered by a Nurse to prepare and educate family members and other caregivers on proper procedures for care during the transition from an acute Hospital setting to the home setting. These Services must improve, rather than maintain, your health condition and require the skills of a Nurse in order to be provided safely and effectively.

**16.72 Provider**

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

**16.73 Qualified Medical Child Support Order**

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

**16.74 Rescission**

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

**16.75 Respite Care**

Care provided primarily for relief or rest from caretaking responsibilities.



## 16.76 Secondary Care Physician or Secondary Care Provider (SCP)

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

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

## 16.77 Service Area

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

Select Care Service Area. 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. The following ZIP codes are not part of the Select Care Service Area: 84034, 84083, 84313, and 84329.

Select Med Service Area. 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. The following ZIP codes are not part of the Select Med Service Area: 84008, 84034, 84035, 84078, 84079, 84083, 84313, 84329, 84712, 84716, 84717, 84718, 84723, 84734, 84736, 84759, 84764, and 84776.

Select Value Service Area. The following counties: Davis, Salt Lake, Summit, Utah, and Weber. However, not all ZIP codes within these counties are included. As of January 2006, the following ZIP codes are not part of the Select Value Service Area: 84017, 84024, 84033, 84036, 84055, 84061, 84013, 84626, 84651, 84653, 84655, 84660, and 84633.

## 16.78 Service(s)

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

## 16.79 Skilled Nursing Facility

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

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

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

## 16.80 Special Enrollment Right

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

## 16.81 Subscriber

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

## 16.82 Subscriber Application

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

## 16.83 Urgent Condition(s)

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

## 16.84 Utah mini-COBRA

Continuation coverage required by Utah law for employers with fewer than 20 employees.

## 16.85 Year

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

- a. The calendar year begins on January 1 at 12:00 a.m. Mountain Standard Time and ends on December 31, at 11:59 p.m. Mountain Standard Time.
- b. The plan Year, if applicable, is indicated in the Group Application.







# appendix A

## prescription drug list



# RXSELECT<sup>SM</sup> PRESCRIPTION DRUG LIST

A formulary is the list of prescription drugs covered on your plan. This printed version contains only the most commonly prescribed drugs in their most common strengths and formulations. It does not include injectable drugs.

Your drug benefit has three tiers (levels) of coverage. The tiers determine the amount you are responsible to pay. Copay and coinsurance amounts are shown on your Member Payment Summary (MPS) and ID Card.

This is not a complete list of all drugs and may change due to new drugs, therapies, or other factors. 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.

**View the most current drug coverage and pharmacy benefit information by logging in to My Health at [www.selecthealth.org](http://www.selecthealth.org).** Once logged in, click on “Pharmacy Tools,” then go to “My Pharmacy Tools,” to find:

- Drug prices and potential lower-cost alternatives for drugs you already take
- A drug lookup, searchable by drug name and dose
- Tier statuses of prescription drugs, including injectables
- Your prescription copays and benefits
- Maintenance drug (90-day) medications
- Explanations of Benefits (EOBs) for your drug claims
- Preauthorization and step therapy requirements
- Participating pharmacies, including Retail90<sup>SM</sup>

## LEGEND

### (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.

### (GS) GenericSample<sup>SM</sup>

This program eliminates your copay/coinsurance for the first 30-day fill of select generic prescriptions.

### (M) Maintenance Drug

These drugs qualify for the 90-day maintenance drug benefit.

### (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). Step therapy generally applies only to brand-name drugs.

### (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.

### (AGE) Age Limit

A minimum or maximum age limit requirement must be met for coverage.

Drugs with an “\*” are considered **preventive drugs** and may be covered at a different benefit than other drugs. Prescriptions vary in strength and formulation, and your specific prescription may be covered at a different tier than is listed here. If your plan includes the **value-based option**, Tier 2 drugs in these categories are covered at the Tier 1 benefit. Refer to your Member Payment Summary (MPS) and ID Card for details.

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.



Category	Generic Name	Gen. Tier	Brand Name	Brand Tier	Spec. Requirements
<i>ALLERGY ANTIHISTAMINES</i>					
	fexofenadine	1	Allegra	3	
	fexofenadine/ pseudoephedrine	1	Allegra-D	3	
<i>ALLERGY NASAL PREPARATIONS</i>					
	azelastine	1	Astelin	3	(M)
			Astepro	3	(M)
	ipratropium	1	Atrovent	3	(M)
			Beconase AQ	3	(M)
	fluticasone	1	Flonase	3	(M) (GS)
			Nasacort AQ	3	(M)
	flunisolide	1	Nasarel	3	(M)
			Nasonex	2	(M)
			Omnaris	3	(M)
			Rhinocort Aqua	3	(M)
			Veramyst	3	(M)
<i>ANTIBIOTICS CEPHALOSPORINS</i>					
			Cedax	3	
	cefprozil	1	Cefzil	3	
	cephalexin	1	Keflex	3	
	cefdinir	1	Omnicef	3	
			Suprax	3	
<i>ANTIBIOTICS MACROLIDES</i>					
	clarithromycin	1	Biaxin	3	
	clarithromycin ER	1	Biaxin XL	3	
	erythromycin	1	Ery-Tab	2	
	azithromycin	1	Zithromax	3	(QL)
<i>ANTIBIOTICS MISC. ANTIBIOTICS</i>					
			Alinia	3	(QL)
	smz-tmp	1	Bactrim	3	
	nitrofurantoin	1	Macrobid	3	
			Xifaxan 200mg	3	(PA) (QL)
			Xifaxan 550mg	2	(PA) (QL)
			Zyvox	3	
<i>ANTIBIOTICS PENICILLINS</i>					
	amoxicillin	1	Amoxil/Trimox	1	(GS)
	amoxicillin/clavulanate	1	Augmentin	3	
			Augmentin XR	2	
			Moxatag	3	(QL)
	penicillin	1	Pen VK	3	
	ampicillin	1	Polycillin	3	
<i>ANTIBIOTICS QUINOLONES</i>					
			Avelox	3	
	ciprofloxacin	1	Cipro	3	
	ciprofloxacin ER	1	Cipro XR	3	
			Levaquin	3	
<i>ANTIBIOTICS TETRACYCLINES</i>					
			Doryx	3	(ST)



Category	Generic Name	Gen. Tier	Brand Name	Brand Tier	Spec. Requirements
<i>ANTIBIOTICS TETRACYCLINES</i>					
	minocycline	1	Dynacin/Minocin	3	(ST)
	doxycycline	1	Periostat	3	(ST)
	minocycline ER	1	Solodyn	3	(ST)
	doxycycline	1	Vibramycin	3	(GS)
<i>ANTIFUNGALS</i>					
	fluconazole	1	Diflucan	3	
	fluconazole 150mg	1	Diflucan 150mg	3	(QL)
	terbinafine	1	Lamisil	3	(QL)
	clotrimazole	1	Mycelex	3	
	nystatin	1	Mycostatin	3	
	ketoconazole	1	Nizoral	3	
	itraconazole	1	Sporanox	3	(QL)
			Vfend	3	(QL)
<i>ANTIVIRALS</i>					
	famciclovir	1	Famvir	3	
	valacyclovir	1	Valtrex	3	(QL)
	acyclovir	1	Zovirax	3	
<i>ANXIETY &amp; SLEEP DISORDER</i>					
	zolpidem	1	Ambien	3	(ST) (QL)
	zolpidem CR	1	Ambien CR	3	(ST) (QL)
	lorazepam	1	Ativan	3	
	buspirone	1	Buspar	3	
			Edluar	3	(ST) (QL)
			Lunesta	3	(ST) (QL)
			Rozerem	2	(QL)
			Silenor	3	(ST) (QL)
	zaleplon	1	Sonata	3	(ST) (QL)
	alprazolam	1	Xanax	3	
	alprazolam ER	1	Xanax XR	3	(QL)
<i>ASTHMA*</i>					
			Accolate	2	(QL) (M)
			Advair	2	(M)
			Asmanex	2	(QL) (M)
			Atrovent HFA	3	(M)
			Azmacort	3	(M)
			Brovana	3	(QL) (M)
			Combivent	2	(M)
			Flovent HFA	2	(M)
			Foradil	3	(M)
			Maxair	2	(M)
			Proair HFA	2	(M)
			Proventil HFA	3	(M)
			Pulmicort	2	(M)
			Qvar	2	(M)
			Serevent	2	(M)
			Singulair 10mg	2	(ST) (QL) (M)
			Singulair 4mg & 5mg	2	(QL) (M)

ANTIBIOTICS TETRACYCLINES TO ASTHMA



Category	Generic Name	Gen. Tier	Brand Name	Brand Tier	Spec. Requirements
<i>ASTHMA</i>					
			Spiriva	2	(QL) (M)
			Symbicort	2	(M)
	theophylline	1	Theo-24	3	(M)
			Uniphyll	2	(M)
			Ventolin HFA	2	(M)
			Xopenex	3	(M)
			Xopenex HFA	3	(M)
			Zyflo CR	3	(ST) (QL) (M)
<i>CARDIOVASCULAR ACE INHIBITORS*</i>					
	quinapril	1	Accupril	3	(M) (GS)
	perindopril	1	Aceon	3	(M)
	ramipril	1	Altace	3	(M)
	captopril	1	Capoten	3	(M)
	trandolapril	1	Mavik	3	(M)
	lisinopril	1	Prinivil/Zestril	3	(M) (GS)
	enalapril	1	Vasotec	3	(M) (GS)
<i>CARDIOVASCULAR ALPHA-1 BLOCKERS*</i>					
	terazosin	1	Hytrin	3	(M)
<i>CARDIOVASCULAR ANGIOTENSIN II RECEPTOR BLOCKERS*</i>					
			Atacand	3	(ST) (QL) (M)
			Avapro	3	(ST) (QL) (M)
			Benicar	3	(ST) (QL) (M)
	losartan	1	Cozaar	3	(QL) (M)
			Diovan	2	(QL) (M)
			Micardis	3	(ST) (QL) (M)
			Teveten	3	(ST) (QL) (M)
			Tribenzor	3	(ST) (QL) (M)
<i>CARDIOVASCULAR ANTIADRENERGICS*</i>					
	methyldopa	1	Aldomet	3	(M)
	clonidine	1	Catapres	3	(M)
	clonidine patch	1	Catapres TTS	3	(M)
<i>CARDIOVASCULAR BETA-BLOCKERS*</i>					
	sotalol/AF	1	Betapace / AF	3	(M)
			Bystolic	3	(QL) (M)
	carvedilol	1	Coreg	3	(M) (GS)
			Coreg CR	2	(M)
	propranolol ER	1	Inderal LA	3	(M)
			Innopran XL	2	(M)
	metoprolol tartrate	1	Lopressor	3	(M)
	atenolol	1	Tenormin	3	(M)
	metoprolol succinate	1	Toprol XL	3	(M)
<i>CARDIOVASCULAR BLOOD MODIFIERS*</i>					
			Aggrenox	2	(M)
	warfarin	1	Coumadin	2	(M)
			Effient	2	(QL) (M)
	enoxaparin	1	Lovenox	3	
			Plavix	2	(QL) (M)



Category	Generic Name	Gen. Tier	Brand Name	Brand Tier	Spec. Requirements
<i>CARDIOVASCULAR CALCIUM CHANNEL BLOCKERS*</i>					
	verapamil	1	Calan	3	(M)
	diltiazem	1	Cardizem CD/LA	3	(M)
	amlodipine	1	Norvasc	3	(M) (GS)
	verapamil	1	Verelan	3	(M)
<i>CARDIOVASCULAR CARDIAC GLYCOSIDES*</i>					
	digoxin	1	Lanoxin	2	(M)
<i>CARDIOVASCULAR COMBINATION/OTHER*</i>					
			Atacand HCT	3	(ST) (QL) (M)
			Avalide	3	(ST) (QL) (M)
			Azor	3	(ST) (QL) (M)
			Benicar HCT	3	(ST) (QL) (M)
	captopril/HCTZ	1	Capozide	3	(M)
			Diovan HCT	2	(QL) (M)
			Exforge	2	(QL) (M)
			Exforge HCT	2	(QL) (M)
	losartan/HCTZ	1	Hyzaar	3	(QL) (M)
	benazepril/HCTZ	1	Lotensin HCT	3	(M) (GS)
	amlodipine/benazepril	1	Lotrel	3	(M)
			Micardis HCT	3	(ST) (QL) (M)
			Multaq	2	(M)
			Ranexa	2	(ST) (QL) (M)
			Rythmol	2	(M)
	trandolapril/verapamil	1	Tarka	3	(M)
			Tekamlo	3	(ST) (QL) (M)
			Tekturna	3	(ST) (QL) (M)
			Teveten HCT	3	(ST) (QL) (M)
			Twynsta	3	(ST) (QL)
			Valturna	2	(ST) (M)
<i>CARDIOVASCULAR DIURETICS (WATER PILLS)*</i>					
	eplerenone	1	Inspra	3	(ST) (M)
	furosemide	1	Lasix	3	(M)
	triamterene-HCTZ	1	Maxzide, Dyazide	3	(M)
	hydrochlorothiazide (HCTZ)	1	Microzide	3	(M) (GS)
<i>CARDIOVASCULAR NITRATES*</i>					
	isosorbide mononitrate	1	Imdur	3	(M)
	isosorbide dinitrate	1	Isordil	3	(M)
	nitroglycerin	1	Nitro-Dur	2	(M)
<i>CHOLESTEROL*</i>					
			Advicor	3	(ST) (QL) (M)
			Caduet	3	(ST) (M)
			Crestor 10/20/40mg	2	(QL) (M)
			Crestor 5mg	2	(ST) (QL) (M)
			Lescol	3	(QL) (M)
			Lipitor	3	(ST) (QL) (M)
			Livalo	3	(ST) (QL) (M)
			Lovaza	2	(M)

CARDIOVASCULAR CALCIUM CHANNEL BLOCKERS TO CHOLESTEROL



Category	Generic Name	Gen. Tier	Brand Name	Brand Tier	Spec. Requirements
<b>CHOLESTEROL*</b>					
			Niaspan	2	(QL) (M)
	pravastatin	1	Pravachol	3	(QL) (M) (GS)
	cholestyramine	1	Questran	3	(M)
			Simcor	3	(ST) (QL) (M)
	fenofibrate	1	Tricor	3	(M)
			Triglide	3	(M)
			Vytorin 10/10mg	2	(ST) (QL) (M)
			Vytorin 10/20, 1/40, 10/80mg	2	(QL) (M)
			Welchol	2	(M)
			Zetia	2	(M)
	simvastatin	1	Zocor	3	(QL) (M) (GS)
<b>CONTRACEPTION (BIRTH CONTROL)*</b>					
	cesia & velivet	1	Cyclessa	3	(M)
	zovia	1	Demulen	3	(M)
	apri / solia	1	Desogen	3	(M)
			Lybrel	3	(M)
	kariva	1	Mircette	3	(M)
			Nuvaring	2	(QL) (M)
			Ortho Evra	3	(QL) (M)
	Jolvette/norethindrone/ Errin/Camila		Ortho Micronor	3	(M)
	tri-previfem	1	Ortho Tri-Cyclen Lo	3	(M)
	Apri /Solia/Desogen	1	Ortho-Cept	3	(M)
	previfem	1	Ortho-Cyclen	3	(M)
	Notrel	1	Ortho-Novum	3	(M)
	Necon/Notrel	1	Ovcon	3	(M)
	Jolessa		Seasonale	3	(QL) (M)
	quasense	1	Seasonique	3	(QL) (M)
			TRIPHASIL 28	1	(M)
	ocella	1	Yasmin	3	(M)
	Gianvi	1	YAZ	3	(M)
<b>DERMATOLOGICALS (SKIN) ACNE</b>					
	isotretinoin / claravis / amnestem / sotret	1	Accutane	3	
			Aczone	3	
			Azelex	3	
			BENZACLIN	3	
	Erythromycin/benzoyl peroxide	1	Benzamycin	3	
			Brevoxyl	3	
			Differin	3	(AGE)
			Duac/CS	3	
	erythromycin gel	1	Emgel	1	
			Epiduo	2	(AGE)
	metronidazole	1	Metrocream	3	
			Metrogel	2	
	metronidazole	1	Metro lotion	2	



Category	Generic Name	Gen. Tier	Brand Name	Brand Tier	Spec. Requirements
<i>DERMATOLOGICALS (SKIN) ACNE</i>					
	tretinoin	1	Retin-A	3	(AGE)
			RETIN-A MICRO	2	(AGE)
			Ziana	3	(AGE)
<i>DERMATOLOGICALS (SKIN) ANTIFUNGALS</i>					
	clotrimazole	1	Clotrim	3	
<i>DERMATOLOGICALS (SKIN) ANTIPSORIATICS</i>					
			Dovonex	2	
			Soriatane	2	
			Tazorac	2	(AGE)
			Vectical	2	
<i>DERMATOLOGICALS (SKIN) MISC. DERMATOLOGICALS</i>					
	imiquimod	1	Aldara	3	
			Altabax	3	
	mupirocin	1	Bactroban	2	
			Carac	2	
	fluorouracil	1	Efudex	3	
			Elidel	2	(ST)
			Finacea	2	
			Oracea	3	(ST)
			Protopic	2	(ST)
			Qutenza	3	(PA)
			Regranex	3	(QL)
<i>DERMATOLOGICALS (SKIN) STEROIDS</i>					
	mometasone	1	Elocon	3	
	triamcinolone	1	Kenalog	3	
	fluocinonide	1	Lidex	3	
			Olux	3	
	clobetasol	1	Temovate	3	
	hydrocortisone	1	Westcort	3	
<i>DIABETIC DIAGNOSTIC AGENTS*</i>					
			Freestyle Test Strips	2	(QL) (M)
			Precision Test Strips	2	(QL) (M)
<i>DIABETIC INJECTABLES*</i>					
			Apidra	3	(M)
			Byetta	2	(ST) (QL) (M)
			Glucagon	2	
			Humalog	3	(PA) (M)
			Humalog 50/50 and 75/25	2	(M)
			Humulin	3	(PA) (M)
			Lantus	2	(M)
			Levemir	2	(M)
			Novolin	2	(M)
			Novolog	2	(M)
			Symlin	2	(ST) (QL) (M)
			Victoza	3	(ST) (M)



Category	Generic Name	Gen. Tier	Brand Name	Brand Tier	Spec. Requirements
<i>DIABETIC ORAL ANTIDIABETICS*</i>					
			ActoPlus Met/XR	2	(QL) (M)
			Actos	2	(QL) (M)
	glimepiride	1	Amaryl	3	(M)
			Avandamet	2	(M)
			Avandaryl	2	(M)
			Avandia	2	(QL) (M)
			Duetact	2	(QL) (M)
	metformin	1	Glucophage	3	(M) (GS)
	Metformin ER	1	Glucophage XR	3	(M) (GS)
	glipizide	1	Glucotrol	3	(M)
	glipizide ER	1	Glucotrol XL	3	(M)
	glyburide/metformin	1	Glucovance	3	(M)
			Janumet	2	(QL) (M)
			Januvia	2	(QL) (M)
	glipizide-metformin	1	Metaglip	3	(M)
			Onglyza	3	(QL) (M)
			Prandin	2	(M)
	acarbose	1	Precose	3	(M)
<i>GASTROINTESTINAL (DIGESTIVE) MISC. GASTROINTESTINAL</i>					
			Amitiza	2	(QL) (AGE)
			Asacol	2	(M)
			Canasa	2	(M)
			Chenodal	3	(PA)
			Entocort EC	3	
			Lialda	2	(QL) (M)
			Lotronex	3	(QL)
			Pentasa	2	(M)
			Renagel	2	(M)
			Renvela	2	(M)
			Zemplar	2	(M)
<i>GASTROINTESTINAL (DIGESTIVE) NAUSEA &amp; VOMITING</i>					
			Anzemet	3	(QL)
			Emend	3	(QL)
	granisetron	1	Kytril	3	(QL)
	promethazine	1	Phenergan	3	
	ondansetron	1	Zofran/ODT	3	(QL)
			Zuplenz	3	(ST) (QL)
<i>GASTROINTESTINAL (DIGESTIVE) ULCER TREATMENTS</i>					
			Aciphex	2	(ST) (QL) (M)
			Dexilant	3	(ST) (QL) (M)
			Nexium	3	(ST) (QL) (M)
	famotidine	Free	Pepcid	3	(QL) (M)
	lansoprazole	1	Prevacid	3	(ST) (QL) (M)
	Lansoprazole ODT	1	Prevacid Solutab	3	(QL) (M) (AGE)
			Prevpac	3	(QL) (M)
	omeprazole	1	Prilosec	3	(ST) (QL) (M) (GS)
	pantoprazole	1	Protonix	3	(ST) (QL) (M)



Category	Generic Name	Gen. Tier	Brand Name	Brand Tier	Spec. Requirements
<i>GASTROINTESTINAL (DIGESTIVE) ULCER TREATMENTS</i>					
			Pylera	3	(M)
	ranitidine hcl	Free	Zantac	3	(QL) (M)
	omeprazole/sodium bicarbonate	1	Zegerid	3	(ST) (QL) (M)
<i>HORMONE REPLACEMENT THERAPY FEMALE</i>					
			Activella	2	(M)
			Cenestin	2	(M)
	estradiol	1	Climara	2	(M)
			Crinone	3	(AGE)
			Enjuvia	2	(M)
			Estraderm	2	(M)
	syntest	1	Estratest	2	(M)
			Estrogel	2	(M)
			Evista	2	(QL)
			FemHRT	3	(M)
			Femtrace	3	(M)
			Premarin	2	(M)
			Premphase	2	(M)
			Prempro	2	(M)
			Progesterone	3	(PA)
			Prometrium	2	(M) (AGE)
	medroxyprogesterone	1	Provera	3	(M)
			Vagifem	2	(M)
			Vivelle/Dot	2	(M)
<i>HORMONE REPLACEMENT THERAPY MALE</i>					
			Androderm	2	(ST) (M)
			Androgel	2	(M)
			Striant	3	(ST) (M)
			Testim	3	(ST) (M)
<i>IMMUNOSUPPRESSANTS</i>					
	mycophenolate	1	Cellcept	3	(M)
	azathioprine	1	Imuran	3	(M)
			Myfortic	3	(M)
	cyclosporine	1	Neoral	2	(M)
	tacrolimus	1	Prograf	3	(M)
			Rapamune	2	(M)
	cyclosporine		Sandimmune	2	(M)
<i>MENTAL HEALTH ALZHEIMER'S</i>					
			Aricept	2	(M)
			Azilect	2	(M)
			Exelon	3	(M)
			Namenda	2	(M)
	galantamine/ER	1	Razadyne/ER	3	(M)
<i>MENTAL HEALTH ANTIDEPRESSANTS</i>					
			Aplenzin	3	(ST) (QL) (M)
	citalopram	1	Celexa	3	(ST) (QL) (M) (GS)
			Cymbalta	2	(ST) (QL) (M)



Category	Generic Name	Gen. Tier	Brand Name	Brand Tier	Spec. Requirements
<i>MENTAL HEALTH ANTIDEPRESSANTS</i>					
	trazodone	1	Desyrel	3	(M)
	venlafaxine	1	Effexor	3	(ST) (M)
	venlafaxine ER Caps	1	Effexor XR	3	(ST) (QL) (M)
			Emsam	3	(ST) (QL) (M)
			Lexapro	3	(ST) (QL) (M)
			Oleptro	3	(ST) (QL) (M)
	nortriptyline	1	Pamelor	3	(M)
	paroxetine	1	Paxil	3	(ST) (QL) (M) (GS)
	paroxetine ER		Paxil CR	3	(ST) (QL) (M)
			Pexeva	3	(ST) (QL) (M)
			Pristiq	2	(ST) (QL) (M)
	fluoxetine	1	Prozac/Rapiflux	3	(ST) (QL) (M) (GS)
	mirtazapine	1	Remeron	3	(ST) (QL) (M)
			Sarafem	3	(ST) (M)
			Savella	3	(QL) (M)
			Venlafaxine ER Tabs	3	(ST) (QL) (M)
	bupropion/SR/XL	1	Wellbutrin/SR/XL	3	(ST) (QL) (M) (GS)
	sertraline	1	Zoloft	3	(ST) (QL) (M) (GS)
<i>MENTAL HEALTH ANTIPSYCHOTICS</i>					
			Abilify	2	(QL) (M)
			Fanapt	3	(ST) (QL)
			Geodon	2	(QL) (M)
			Invega	3	(ST) (QL) (M)
	Risperidone	1	Risperdal	3	(QL) (M)
			Saphris	3	(ST) (QL) (M)
			Seroquel/XR	2	(QL) (M)
			Zyprexa	2	2 (QL) (M)
<i>MENTAL HEALTH STIMULANTS</i>					
	amphetamine salts	1	Adderall	3	
	amphetamine salts ER	1	Adderall XR	3	(QL)
			Concerta	3	(QL)
			Daytrana	3	(QL)
	dextroam/SR	1	Dexedrine/CR	3	(QL)
			Focalin XR	2	(QL)
			Intuniv	3	(QL) (M)
			Metadate CD	3	
	methylin ER	1	Metadate ER	3	(QL)
			Nuvigil	3	(PA) (QL)
			Provigil	3	(PA) (QL)
	methylphenidate	1	Ritalin	3	(QL)
			Ritalin LA	3	(QL)
	methylphenidate SR	1	Ritalin SR	3	(QL)
			Strattera	3	(QL)
			Vyvanse	2	(QL)
			Xyrem	3	(PA)
<i>MIGRAINE</i>					
	naratriptan	1	Amerge	3	(QL)



Category	Generic Name	Gen. Tier	Brand Name	Brand Tier	Spec. Requirements
<i>MIGRAINE</i>					
			Axert	3	(QL)
	ergotamine/caff.	1	Cafergot	3	
	butalbital/apap/caff.	1	Fioricet	3	
			Frova	3	(QL)
	sumatriptan		Imitrex	3	(QL)
			Maxalt/MLT	2	(QL)
			Relpax	3	(QL)
			Sumavel DosePro	3	(ST) (QL)
			Treximet	3	(QL)
			Zomig/ZMT	3	(QL)
<i>MUSCLE RELAXANTS</i>					
			Amrix	3	(ST) (QL)
	Cyclobenzaprine	1	Flexeril	3	
	methocarbamol	1	Robaxin	3	
	metaxalone	1	Skelaxin	3	
	carisoprodol / CMP	1	Soma / CMP	3	(QL)
			Soma 250mg	3	(ST) (QL)
	tizanidine		Zanaflex	3	
<i>ONCOLOGY/HEMATOLOGY</i>					
			Afinitor	2	(PA) (QL)
	anastrozole	1	Arimidex	3	(QL) (M)
			Aromasin	2	(QL) (M)
			Chromagen	3	(QL)
			Gleevec	2	
			Hycamtin	2	(QL)
			Iressa	2	(PA) (QL)
			Nexavar	2	(PA)
	tamoxifen	1	Nolvadex	3	(M)
			Oforta	3	(PA) (QL)
			Promacta	2	(PA)
			Revlimid	2	(PA) (QL)
			Sprycel	2	(PA) (QL)
			Sutent	2	(PA)
			Tarceva	2	(PA)
			Targetin	2	(QL)
			Tasigna	2	(PA)
			Tykerb	2	(PA) (QL)
			Votrient	2	(PA) (QL)
			Xeloda	2	
			Zolinza	2	(PA) (QL)
<i>OPHTHALMICS (EYE) ANTI-INFECTIVES</i>					
	ciprofloxacin	1	Ciloxan	3	
	gentamicin	1	Gentadol	1	
	ofloxacin	1	Ocuflox	3	
	tobramycin	1	Tobrex	3	
			Vigamox	3	
			Zymar	3	



Category	Generic Name	Gen. Tier	Brand Name	Brand Tier	Spec. Requirements
<i>OPHTHALMICS (EYE) MISC. OPHTHALMICS</i>					
			Alocril	2	(M)
	brimonidine	1	Alphagan	2	
	dorzolamide-timolol	1	Cosopt	3	(M)
			Elestat	2	
	azelastine	1	Optivar	3	
			Pataday	3	(M)
			Patanol	2	
			Restasis	3	
	timolol	1	Timoptic	3	(M)
	dorzolamide	1	Trusopt	3	(M)
<i>OPHTHALMICS (EYE) PROSTGLANDINS</i>					
			Combigan	2	(QL) (M)
			Lumigan	2	(M)
			Xalatan	2	(M)
<i>OSTEOPOROSIS TREATMENTS*</i>					
			Actonel	2	(ST) (QL) (M)
			Boniva	3	(ST) (QL) (M)
			Evista	2	(QL) (M)
	alendronate	1	Fosamax	3	(ST) (QL) (M) (GS)
			Fosamax D	2	(ST) (QL) (M)
	calcitonin	1	Miacalcin	2	(M)
<i>OTIC PREPARATIONS (EAR)</i>					
			Cipro HC	2	
			Ciprodex	2	
	ofloxacin	1	Floxin	3	
<i>PAIN MEDICATIONS NARCOTIC ANALGESICS</i>					
	fentanyl	1	Actiq	3	(PA) (QL)
			Avinza	2	(QL)
	propoxyphene-apap	1	Darvocet	3	(QL)
	propoxyphene	1	Darvon	3	(QL)
	fentanyl	1	Duragesic	3	(QL)
			Embeda	3	(ST) (QL)
			Exalgo	3	(ST) (QL)
			Fentora	3	(PA) (QL)
			Kadian	2	(QL)
	hydrocodone-apap	1	Lorcet	3	(QL)
	hydrocodone-apap	1	Lortab	3	(QL)
	MS Contin	1	Morphine Sulfate		
	morphine sulfate	1	MS Contin	3	
			Nucynta	3	(ST) (QL)
			Onsolis	3	(PA) (QL)
			Opana	3	(ST) (QL)
			Opana ER	3	(ST) (QL)
			Oxycontin CR	3	(ST) (QL)
	oxycodone-apap	1	Percocet	3	(QL)
	tramadol ER	1	Ultram ER	3	
	tramadol-apap	1	Ultram/Ultracet	3	(QL)



Category	Generic Name	Gen. Tier	Brand Name	Brand Tier	Spec. Requirements
<i>PAIN MEDICATIONS NARCOTIC ANALGESICS</i>					
	hydrocodone-apap	1	Vicodin	3	(QL)
	hydrocodone-ibu	1	Vicoprofen	3	(QL)
<i>PAIN MEDICATIONS NON-STEROIDAL ANTI-INFLAMMATORIES</i>					
			Celebrex	3	(QL) (M)
	oxaprozin	1	Daypro	3	(M)
	piroxican	1	Feldene	3	(M)
	indomethacin	1	Indocin	3	(M)
	meloxicam	1	Mobic	3	(M)
	Ibuprofen	1	Motrin	3	(M) (GS)
	naproxen	1	Naprosyn	3	(M) (GS)
			Prevacid Naprapac	3	(M)
	nabumetone	1	Relafen	3	(M)
	ketorolac	1	Toradol	3	(QL)
			Vimovo	3	(ST) (QL) (M)
	diclofenac	1	Voltaren	3	(M) (GS)
<i>PRENATAL VITAMINS*</i>					
	Prenatal Vitamins-Generic	1	Prenatal Vitamins-Brand	3	(M)
<i>PROSTATE</i>					
			Avodart	3	(M)
	doxazosin	1	Cardura	3	(M) (GS)
	tamulosin	1	Flomax	3	(M)
	terazosin	1	Hytrin	3	(M)
	lovastatin	1	Mevacor	3	(M) (GS)
	prazosin	1	Minipress	3	(M)
	finasteride	1	Proscar	3	(M)
			Uroxatral	3	(M)
<i>SEIZURE DISORDER</i>					
			Carbatrol	2	(M)
	divalproex	1	Depakote	3	(QL) (M)
	phenytoin	1	Dilantin	2	(M)
			Gabitril	2	(QL) (M)
	levetiracetam	1	Keppra	3	(QL) (M)
			Keppra XR	3	(QL) (M)
	clonazepam	1	Klonopin	3	(M)
			Lamictal XR	3	(QL) (M)
	lamotrigine/ODT	1	Lamictal/ODT	3	(QL) (M)
			Lyrica	3	(QL) (M)
	gabapentin	1	Neurontin	3	(QL) (M)
			Sabril	3	(PA) (QL)
	carbamazepine	1	Tegretol	2	(M)
	topiramate	1	topamax	3	(QL) (M)
	oxcarbazepine	1	Trileptal	3	(QL) (M)
			Vimpat	2	(QL) (M)
	zonisamide	1	Zonegran	3	(QL) (M)
<i>SMOKING CESSATION*</i>					
			Chantix	2	(QL)
	bupropion HCL	1	Zyban	3	(QL)



Category	Generic Name	Gen. Tier	Brand Name	Brand Tier	Spec. Requirements
<i>STERIODS</i>					
	hydrocortisone	1	Cortef	3	(M)
	methylprednisolone	1	Medrol	3	
	prednisolone sod phosphate	1	Orapred	3	
	prednisolone	1	Prelone	3	(M)
	prednisone	1	Sterapred	3	(M)
<i>THYROID</i>					
	thyroid	1	Armour Thyroid	3	(M)
			Cytomel	2	(M)
			Levothyroid	2	(M)
			Levoxyl	2	(M)
			Synthroid	1	(QL) (M)
			Unithroid	2	(M)
<i>UNCATEGORIZED</i>					
			Adcirca	2	(PA) (QL)
			Ampyra	3	(PA) (QL)
			Campral	2	
			Cayston	2	(PA) (QL)
			Creon	2	(M)
			Epipen/Jr.	2	
			Gilenya	3	(PA) (QL)
			Hectorol	2	(M)
			Kuvan	2	(QL)
			Letairis	3	(PA) (QL)
			Pancreaze	2	(M)
			Revatio	3	(PA)
			Tobi	3	(PA) (QL)
			Tracleer	2	(PA)
			Uloric	2	(ST) (QL)
			Ultrase	2	(M)
			Xenazine	2	(PA) (QL)
			Zenpep	2	
			Zortress	3	(M)
<i>URINARY INCONTINENCE</i>					
	Minirin	1			(PA)
	hyoscyamine	1	Cystospaz	3	(M)
	desmopressin	1	DDAVP	3	(QL)
			Detrol/LA	3	
	oxybutynin	1	Ditropan	3	(M)
	oxybutynin ER	1	Ditropan XL	3	(M)
			Enablex	2	(M)
			Oxytrol	3	(M)
	minirin	1	Stimate	3	
			Toviaz	3	(M)
			Vesicare	3	(M)





# appendix B

benefit riders



# ASH CHIROPRACTIC BENEFIT RIDER

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

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

## 1. DEFINITIONS.

This Benefit Rider uses the following capitalized defined terms in addition to Section 16—"Definitions" of the Contract. If there is a conflict between these terms and those in Section 16, these terms prevail.

### 1.1 Administrative Appeals.

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:

- a. Treatment plan was denied for not meeting authorization and/or claim timeframe requirements.
- b. Necessary information was not received from Provider according to ASH timelines.

### 1.2 ASH Quality Management and Improvement ("QI") Program.

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.

### 1.3 ASH Service Area.

The geographic area in which ASH arranges Chiropractic Services in Utah.

### 1.4 ASH Utilization Management ("UM") Program.

Those standards, protocols, policies, and procedures adopted by ASH regarding the management, review, and approval of the provision of Covered Chiropractic Services to you.

### 1.5 Chiropractic Appliances.

Chiropractic appliances are support-type devices prescribed by a Participating Chiropractor. Following are the only items that could be covered: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, 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.

### 1.6 Chiropractic Services.

The Services rendered or made available to you by a chiropractor for treatment or diagnosis of Neuromusculoskeletal Disorders.

### 1.7 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 Limitations.

- a. Examples of Clinical Appeals may include the following scenarios:
  - b. Treatment plan was denied or modified due to lack of Medical Necessity.
  - c. The number of visits requested by the Provider did not meet clinical criteria.

### 1.8 Covered Chiropractic Services.

The Chiropractic Services that ASH determines to be Medically Necessary, as limited by this Benefit Rider.

### 1.9 Emergency Chiropractic Services.

Services 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:

- a. 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;
- b. Serious impairment to bodily functions;
- c. Serious dysfunction of any bodily organ or part; or
- d. Decreasing the likelihood of maximum recovery.

### 1.10 Medical Necessity/Medically Necessary.

Chiropractic Services that are:

- a. 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;

- b. Directly applicable to the diagnosis and treatment of a covered condition;
- c. 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 your pre-illness/pre-injury daily functional status and activity);
- d. Rendered in a manner that appropriately assesses and manages your response to the clinical intervention;
- e. Rendered for the diagnosis and treatment of a covered condition;
- f. Rendered in accordance with the Clinical Services Management Program and Clinical Performance Management Program standards as published in the ASH Chiropractic Provider Operations Manual;
- g. Appropriate for the severity and complexity of symptoms and consistent with the covered condition (diagnosis) and appropriate for your response to care; and
- h. 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:
  - i. Preventive maintenance services;
  - ii. Wellness services;
  - iii. Services not necessary to return you to pre-illness/pre-injury functional status
  - iv. and activity; and
  - v. Services provided after you have reached maximum therapeutic benefit.

### 1.11 Neuromusculoskeletal Disorders.

Neuromusculoskeletal Disorders are conditions with associated signs and symptoms related to the nervous, muscular, and/or skeletal systems. Neuromusculoskeletal Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or 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), and related neurological manifestations or conditions.

### 1.12 Out-of-Area Services.

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 that are to be provided outside the ASH Service Area, and are arranged by ASH for assigned Members, are not considered Out-of-Area Services.

### 1.13 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.

## 2. USING YOUR CHIROPRACTIC BENEFITS.

Using your chiropractic Benefits is easy. Simply use a Participating Chiropractor listed in the Chiropractic Provider Directory.

You may receive Covered Chiropractic Services from any Participating Chiropractor without a referral. Except for Medically Necessary Emergency Chiropractic Services, ASH will not pay for Services received from any nonparticipating Chiropractor.

## 3. PREAUTHORIZATION/UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT.

After the initial examination, the Participating Chiropractor must obtain Preauthorization for any additional Covered Chiropractic Services that you receive. The Participating Chiropractor will be responsible for filing all claims with ASH. You must cooperate with ASH in the operation of its Utilization Management and Quality Improvement Programs.

## 4. 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 Chiropractor 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.

## 5. TYPES OF COVERED CHIROPRACTIC SERVICES.

Each office visit to a Participating Chiropractor, as described below, requires a Copay by you at the time Covered Chiropractic Services are provided. A maximum number of visits per calendar Year will apply to each Member as specified in your Member Payment Summary.

- a. A new patient examination is performed by a Participating Chiropractor to determine the nature of your problem, and if Covered Chiropractic Services appear warranted, a clinical treatment form of Services is prepared by the Participating Chiropractor. A new patient examination will be provided for each new patient. A Copay will be required.
- b. 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 reevaluation may be performed during a subsequent office visit or separately. If performed separately, a Copay is required.



- c. 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.
- d. Adjunctive therapy, as set forth in a clinical treatment form approved by ASH, may involve modalities such as ultrasound, hot packs, cold packs, electrical muscle stimulation, and other therapies.
- e. 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 and provided by a licensed chiropractic radiologist, medical radiologist, radiology group, or Hospital that has contracted with ASH to provide those services.
- f. Chiropractic appliances are payable up to a maximum of \$50.00 per year when prescribed by a Participating Chiropractor and approved by ASH.

## 6. CHIROPRACTIC EXCLUSIONS AND LIMITATIONS.

ASH will not pay for or otherwise cover the following:

- a. Any Services or treatments not authorized by ASH, except for a new patient examination and Emergency Chiropractic Services;
- b. Any Services or treatments not delivered by a Participating Chiropractor for the delivery of chiropractic care to you, except for Emergency Chiropractic Services;
- c. Services for examinations and/or treatments for conditions other than those related to Neuromusculoskeletal Disorder;
- d. Hypnotherapy, behavior training, sleep therapy, and weight programs;
- e. Thermography;
- f. Services, lab tests, x-rays, and other treatments not documented as Medically Necessary, as appropriate, or classified as Experimental and/or Investigational, or as being in the research stage, as determined in accordance with professionally recognized standards of practice;
- g. Services that are not documented as Medically Necessary;
- h. Magnetic resonance imaging (MRI), CAT scans, and any types of diagnostic radiology;
- i. Transportation costs including local ambulance charges;
- j. Education programs, nonmedical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing;
- k. Services or treatments for pre-employment physicals or vocational rehabilitation;

- l. Any services or treatments caused by or arising out of the course of employment or covered under any public liability insurance;
- m. 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;
- n. All chiropractic appliances or Durable Medical Equipment, except as specified herein;
- o. Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order;
- p. Services provided by a chiropractor practicing outside of Utah, except for Emergency Chiropractic Services.
- q. Hospitalization, anesthesia, manipulation under anesthesia, or other related services;
- r. All auxiliary aids and services, including interpreters, transcription services, written materials, telecommunication devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids;
- s. Adjunctive therapy not associated with spinal, muscle, or joint manipulation; and
- t. Vitamins, minerals, nutritional supplements, or other similar products.

## 7. THIS BENEFIT RIDER.

This Rider is subject to all provisions, Limitations, Exclusions, and agreements of the Certificate of Coverage and the Contract (available from your employer).

## 8. CLAIMS AND APPEALS.

ASH 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 Rider administered by ASH and that the provisions have been applied consistently with respect to similarly situated Claimants. This section uses the following additional (capitalized) defined terms:

### 8.1 Adverse Benefit Determination.

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, 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 Necessary or appropriate.

### 8.2 Authorized Representative.

Someone you have designated to represent you in the claims or appeals process. To designate an



Authorized Representative you must provide written authorization on a form provided by the ASH Member Services department or ASH Grievance and Appeals department. However, where an Urgent Preservice Claim is involved, a healthcare professional with knowledge of the medical condition will be permitted to act as your Authorized Representative without a prior written authorization. In this Benefit Rider, the words "you" and "your" include your Authorized Representative.

### 8.3 Benefit Determination.

The decision by ASH regarding the acceptance or denial of a claim for Benefits under this Rider.

### 8.4 Claimant.

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

### 8.5 Post-Service Claim.

Any claim related to care or treatment that has already been received by the Member.

### 8.6 Preservice Claim.

Any claim related to care or treatment that has not been received by the Member.

### 8.7 Urgent Preservice Claim.

Any Preservice Claim that if subject to the normal timeframes for determination could seriously jeopardize your life, health, or ability to regain maximum function or that, in the opinion of your treating chiropractor, would subject you to severe pain that could not adequately be managed without the requested Services. Whether a claim is an Urgent Preservice 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 Preservice Claim will be treated as such.

### 8.8 How to Make a Preservice Inquiry.

Preservice Inquiries should be directed to ASH Member Services at 1-800-678-9133.

### 8.9 How to File a Claim for Benefits.

You are responsible for submitting all Preservice, Urgent-Care, and Post-Service claims to ASH. Under certain circumstances provided by federal law, if you fail to follow the proper procedures for filing a claim, ASH will provide notice of the failure and describe the proper procedures to be followed. This notification will be provided as soon as reasonably possible, but not later than five days after the receipt of the claim and may be oral unless you specifically request it in writing.

### 8.10 Timing of Benefits Determinations.

ASH will make and notify your Provider and you, or your Authorized Representative, of its Benefits determinations as follows:

#### a. Urgent Preservice Claim.

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

#### b. Other Preservice 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, ASH may extend this period for up to an additional 15 days if ASH: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you with 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 an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information, and you will be given at least 45 days from your receipt of the notice to provide the requested information.

#### c. 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, ASH may extend this period for up to an additional 15 days if ASH: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30 day period, of the circumstances requiring the extension and the date by which 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 the required information, and you will be given at least 45 days from your receipt of the notice to provide the required information.



The applicable time period for the Benefit Determination begins when your claim is filed in accordance with ASH's procedures, even if you have not 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).

### 8.11 Notice of Adverse Benefit Determinations.

If your claim is subject to an Adverse Benefit Determination, you will receive a notification that includes:

- a. The specific reason(s) for the Adverse Benefit Determination;
- b. Reference to the specific provisions on which the Adverse Benefit Determination was based;
- c. A description of any additional information or material needed from you to complete the claim and explanation of why it is necessary;
- d. 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 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, guidelines, protocol, or other criterion will be provided upon request free of charge;
- e. If the Adverse Benefit Determination was based on a Medical Necessity, Experimental and/or Investigational treatment, or similar Exclusion or Limitation, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such an explanation will be provided upon request free of charge;
- f. If an Urgent Preservice Claim was denied, a description of the expedited review process applicable to the claim; and
- g. A description of ASH review or appeal procedures, including applicable time limits, and a statement of your right to bring suit under Employee Retirement Income Security Act (ERISA) Section 502(a) with respect to any claim denied after an appeal.

### 8.12 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 ASH Member Services at 800-678-9133.

### 8.13 Formal Appeals.

If you are not satisfied with the result of working with ASH Member Services, you may request a formal appeal either verbally or in writing of any Adverse Benefit Determination or the negative outcome of a Preservice Inquiry. 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.

- a. General Rules and Procedures. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, 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 appeal 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 Services are Experimental and/or Investigational or not Medically Necessary, ASH personnel 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 ASH in connection with the Adverse Benefit Determination, whether or not the advice was relied upon in making the Adverse Benefit Determination.

- b. Form and Timing. All requests for a formal appeal of an Adverse Benefit Determination (other than those involving an Urgent Preservice Claim) must be in writing and should include a copy of the Adverse Benefit Determination and any other pertinent information that you want 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 request a formal appeal of an Adverse Benefit Determination verbally by calling ASH at 800-678-9133.

If the request is made verbally, ASH will within 24 hours, send written confirmation acknowledging the receipt of your request.



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

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

- c. **Mandatory and Voluntary Appeal Levels.** As described below, the formal appeals process differs for Clinical and Administrative Preservice 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, Preservice Inquiries will be treated like Preservice Claims.

You must exhaust all mandatory levels of review before you may pursue civil action under ERISA Section 502(a). 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 ERISA Section 502(a). 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 effect on your rights to any other Benefits under the 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 Preservice Claims (both Clinical and Administrative) within 15 calendar days from receipt of the appeal request. ASH resolves the mandatory appeal review levels for Urgent Preservice Claims (both Clinical and Administrative) within 72 hours from receipt of the appeal request.

- i. **The Appeals Process for Clinical Appeals.** The formal process for appealing a clinical Adverse Benefits Determination consists of two mandatory review levels, two voluntary review levels, and the right to pursue civil action under ERISA Section 502(a).

**Mandatory Review—Level 1**

Upon receipt of your appeal request, a senior clinical services manager and at least one consumer representative conducts the first mandatory 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 mandatory appeal. You have 45 days from the date of the decision to file an additional appeal request.

**Mandatory Review—Level 2**

If you are dissatisfied with the outcome of the first mandatory level of appeal, the ASH director or senior clinician in the like specialty of the treating Provider and at least one consumer representative will conduct the second mandatory 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 mandatory 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 health care 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 1-800-778-7879. You will not be responsible for any charges or fees associated with voluntary dispute resolution options.

Any matter of 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 other recognized arbitrator, a copy of which is available on 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 mandatory review process, you may choose to pursue civil action under ERISA Section 502(a). Failure to properly pursue the mandatory appeals process may result in a waiver of the right to challenge ASH original decision.

- ii. **The Appeals Process for Administrative Appeals.** The formal process for appealing an Administrative Adverse Benefit Determination



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

**Mandatory 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 mandatory 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 mandatory appeal. You have 45 days from the date of the decision to file an additional appeal request.

**Mandatory Review—Level 2: Administrative Review Committee (ARC)**

If you are dissatisfied with the outcome of the first mandatory level of appeal, the ASH ARC, which consists of ASH officers, directors, employees, and at least one consumer representative, conducts the second mandatory level of appeal to administrative appeals. The ARC evaluates the appeal and renders a decision regarding the appeal and may 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 mandatory 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 regarding the appeal. 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 1-800-778-7879. 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 other recognized arbitrator, a

copy of which is available on 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 mandatory review process, you may choose to pursue civil action under ERISA Section 502(a). Failure to properly pursue the mandatory appeals process may result in a waiver of the right to challenge ASH original decision.

- d. Notification of Appeal Decision. At each applicable level of the appeals process described above, if your appeal is denied, ASH's written notification will include the following information:
- i. The specific reason(s) for the Adverse Benefit Determination;
  - ii. Reference to the specific provision(s) on which the Adverse Benefit Determination was based;
  - iii. 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;
  - iv. 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 upon request free of charge;
  - v. If the denied appeal was based on a Medical Necessity, Experimental and/or Investigation treatment, or a similar Exclusion or Limitation, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, or a statement that such an explanation will be provided upon request free of charge;
  - vi. A list of titles and qualifications or the individuals participating in the review; and
  - vii. A statement describing any additional mandatory or voluntary appeal levels either required or offered by ASH, including the opportunity for IRO assessment, if applicable, your right to obtain information about such procedures, and a statement of your right to bring suite under ERISA Section 502(a).
- e. Notification of the decision on an Urgent Preservice Claim may be provided verbally, but a follow-up written notification will be provided no later than three days after the verbal notice.





# MENTAL HEALTH/CHEMICAL DEPENDENCY BENEFIT RIDER

## 1. Your Mental Health Benefits

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

If you have any questions regarding any aspect of the Benefits described in this Benefit Rider, please call the Behavioral Health Advocates<sup>SM</sup> weekdays, from 8:00 a. m. to 6:00 p. m. at 801-442-1989 (Salt Lake area) or 800-876-1989.

## 2. Using Participating Mental Health Providers

Mental health Services will be covered only when rendered by a Participating Provider unless otherwise noted on your Member Payment Summary.

## 3. Services requiring Preauthorization

Preauthorization is required for the following mental health services:

- a. Inpatient psychiatric/detoxification admissions;
- b. Residential treatment (when indicated as a covered Benefit on your Member Payment Summary);
- c. Day treatment;
- d. Partial hospitalization; and
- e. Intensive outpatient treatment.

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

## 4. Exclusions

### 4.1 The following Services are not covered:

- a. Behavior modification;
- b. Biofeedback;
- c. 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;
- d. Education or training;
- e. Electrosleep or electronarcosis therapy;
- f. Family counseling and/or therapy;
- g. Long-term care;
- h. Marriage counseling and/or therapy;

- i. Methadone maintenance/therapy clinics or Services;
- j. Milieu therapy;
- k. Psychotherapy or psychoanalysis credited toward earning a degree or furthering your education or training;
- l. Residential treatment (except as otherwise indicated on your Member Payment Summary);
- m. Rest cures;
- n. Self-care or self-help training (nonmedical);
- o. Sensitivity training;
- p. Surgical procedures to remedy a condition diagnosed as psychological, emotional, or mental, including but not limited to transsexual or sex change treatment; and
- q. Neuropsychological testing for any of the following reasons:
  - i. Attention-deficit/hyperactivity disorder;
  - ii. Autism spectrum disorder/pervasive developmental disorder;
  - iii. Chronic fatigue syndrome;
  - iv. Learning disability;
  - v. Mental retardation;
  - vi. Tourette’s syndrome;
  - vii. When performed primarily for educational purposes; or
  - viii. When performed in association with vocational counseling or training.

### 4.2 In addition, Services for the following diagnoses are not covered:

- a. Adjustment disorder;
- b. Chronic organic brain syndrome;
- c. Conduct disorder;
- d. 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;
- e. Difficult life circumstance not part of treatment for a recognized mental illness;
- f. Marital or family problems;
- g. Mental retardation;
- h. Personality disorder;
- i. Psychosexual disorder such as transsexualism, psychosexual identity disorder, psychosexual dysfunction, or gender dysphoria;
- j. Problems with gambling, theft, or fire setting;
- k. Screening exams;



- l. Separation anxiety;
- m. Social, occupational, religious, or other social maladjustment; and
- n. Specific developmental disorder or learning disabilities such as autism, attention-deficit/hyperactivity disorder, and pervasive developmental disorder.





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