Regular Meeting of the

Board of Trustees of the Utah Transit Authority

Wednesday, June 5, 2019, 9:00 a.m.
Utah Transit Authority Headquarters
669 West 200 South, Salt Lake City, Utah
Golden Spike Conference Rooms

1.	**Call to Order & Opening Remarks**	**Chair Carlton Christensen**
2.	**Pledge of Allegiance**	**Chair Carlton Christensen**
3.	**Safety First Minute**	**Sheldon Shaw**
4.	**Public Comment Period**	**Bob Biles**
5.	**Approval of May 29, 2019 Board Meeting Minutes**	**Chair Carlton Christensen**
6.	**Agency Report**	**Steve Meyer**
7.	**Financial Report – April 2019**	**Bob Biles**
8.	**Contracts, Disbursements, and Grants**	
	a. Change Order: Employer Health Insurance (PEHP)	Kim Ulibarri
	b. Change Order: Employer Health Insurance (Select Health)	Kim Ulibarri
	c. Change Order: TIGER Phase 2 Amendment 8 – Midvale Crosswalk Improvement (Granite Construction)	Eddy Cumins
	d. Disbursement: Light Rail Inventory (Seimens)	Bob Biles
	e. Pre-procurement: Meadowbrook Building 8 Paint Booth Remodel	Steve Meyer
9.	**Discussion Items**	
	a. Salt Lake County 4th Quarter Allocation	Steve Meyer
10.	**Other Business**	**Chair Carlton Christensen**
	a. Next meeting: June 19, 2019 at 9:00 a.m.	

Website: https://www.rideuta.com/Board-of-Trustees
Live Streaming: https://www.youtube.com/results?search_query=utaride

11. Closed Session **Chair Carlton Christensen**

a. Strategy Session To Discuss Collective Bargaining

b. Discussion of the Character, Professional Competence, or Physical or Mental Health of an Individual.

12. Adjourn **Chair Carlton Christensen**

Public Comment: Members of the public are invited to provide comment during the public comment period. Comment may be provided in person or online through www.rideuta.com. In order to be considerate of time and the agenda, comments are limited to 2 minutes per individual or 5 minutes for a designated spokesperson representing a group. Comments may also be sent via e-mail to boardoftrustees@rideuta.com.

Special Accommodation: Information related to this meeting is available in alternate format upon request by contacting calldredge@rideuta.com or (801) 287-3536. Request for accommodations should be made at least two business days in advance of the scheduled meeting.

Website: https://www.rideuta.com/Board-of-Trustees
Live Streaming: https://www.youtube.com/results?search_query=utaride

You don't have eyes on the back of your head, be aware of your surroundings.

UTA
SAFETY & SECURITY

June 2019

Minutes of the Meeting
of the
Board of Trustees of the Utah Transit Authority (UTA)
held at UTA FrontLines Headquarters located at
669 West 200 South, Salt Lake City, Utah
May 29, 2019

Board Members Present:
Carlton Christensen, Chair
Beth Holbrook
Kent Millington

Also attending were members of UTA staff, as well as interested citizens.

Call to Order, Opening Remarks, and Pledge of Allegiance. Chair Christensen welcomed attendees and called the meeting to order at 9:02 a.m. with three board members present. Following Chair Christensen's opening remarks, the board and meeting attendees recited the Pledge of Allegiance.

Safety First Minute. Chair Christensen yielded the floor to Sheldon Shaw, UTA Safety Manager, for a brief safety message.

Public Comment Period. No public comment was given.

Consent Agenda. A motion to approve the consent agenda was made by Trustee Holbrook and seconded by Trustee Millington. The motion carried unanimously.

Agency Report.

Main Street Construction (Half Grand Union) Update. Mr. Meyer was joined by Eddy Cumins, UTA Chief Operating Officer, and Dave Hancock, UTA Director of Asset Management. Mr. Cumins provided an update on how work on the Main Street construction project is progressing. Discussion ensued. Questions on the selection of the endpoint for Green Line service during construction, media communications plans for project completion, construction challenges, and life expectancy of the work being performed were posed by the board and answered by staff.

R2019-05-03 Resolution Approving Title VI Program Report. Andrew Gray, UTA Civil Rights Compliance Officer for Title VI and Disadvantaged Business Enterprises, delivered a presentation on the Title VI program, including program objectives and program components. Mr. Gray reported on vehicle loads, vehicle headways, on-time performance, service availability, distribution of amenities, vehicle assignment, location of routes and facilities, and rider demographics. He noted that UTA performed well in all areas related to providing transit service to minority and low-income riders and there was no disparate impact found in any area of the Title VI program. Discussion ensued. Questions on public outreach to potentially impacted populations and analysis of the data by county were posed by the board and answered by Mr. Gray.

A motion to approve R2019-05-03 was made by Trustee Millington and seconded by Trustee Holbrook. The motion carried unanimously with aye votes from Trustee Millington, Trustee Holbrook, and Chair Christensen.

Change Orders, Pre-Procurements, and Grants.

Change Order: On-Call Maintenance Task Order #77 – Salt Lake Central Hub (Stacy and Witbeck). Mr. Cumins summarized the change order, which approves the installation of electric on-route bus charging equipment at the Salt Lake Central hub and preparation of a second location for a future charger. Discussion ensued. A question on the universality of the bus charging equipment was posed by the board and answered by Mr. Cumins.

A motion to approve the change order was made by Trustee Millington and seconded by Trustee Holbrook. The motion carried unanimously with aye votes from Trustee Millington, Trustee Holbrook, and Chair Christensen.

Change Order: On-Call Maintenance Task Order #78 – Delta Interlocking (Stacy and Witbeck). Mr. Cumins explained the change order, which authorizes removal and reconstruction of the light rail Delta interlocking. Discussion ensued. Questions on rail terminology, future interlocking upgrades, and dates of installation and associated service disruptions were posed by the board and answered by Mr. Cumins and Mr. Hancock.

A motion to approve the change order was made by Trustee Millington and seconded by Trustee Holbrook. The motion carried unanimously with aye votes from Trustee Millington, Trustee Holbrook, and Chair Christensen.

Change Order: On-Call Maintenance Task Order #70 Change Order #1 – 150 South Interlocking (Stacy and Witbeck). Mr. Cumins said a change order to Task Order #70 is needed to replace four switch heaters and cable for the 150 South interlocking. Discussion ensued. A question on anticipated problems with switch heaters on future interlocking maintenance projects was posed by the board and answered by Mr. Cumins and Mr. Hancock.

A motion to approve the change order was made by Trustee Holbrook and seconded by Trustee Millington. The motion carried unanimously with aye votes from Trustee Holbrook, Trustee Millington, and Chair Christensen.

Change Order: NoLo Electric Bus Charging Equipment (New Flyer). Mr. Cumins provided an overview of the change order, which approves the purchase of an on-route opportunity charging system as part of a $500,000 grant award from Rocky Mountain Power.

A motion to approve the change order was made by Trustee Holbrook and seconded by Trustee Millington. The motion carried unanimously with aye votes from Trustee Holbrook, Trustee Millington, and Chair Christensen.

Pre-Procurement: Coordinated and Comprehensive Specialized Transportation Plan. Mr. Meyer stated the agency will be issuing an RFP for a study to assess gaps in transportation services for seniors and persons with disabilities along the Wasatch Front. Discussion ensued. A question on the timeline was posed by the board and answered by Mr. Meyer.

Pre-Procurement: Provo Intermodal Center Buildings. Mr. Meyer spoke about the agency's intent to issue a procurement for two buildings at the Provo Intermodal Center. One building will house a police substation and the other will house a satellite

customer service office. Discussion ensued. A question on the anticipated cost of the buildings was posed by the board and answered by Mr. Meyer.

Grant: DHS Transit Security Grant Program – Interior FrontRunner Train Cameras. Mr. Meyer summarized the Department of Homeland Security (DHS) Transit Security Grant Program (TSGP) application for installation of cameras on the interior of FrontRunner passenger train cars. Discussion ensued. Questions on video retention and number of cameras included in the grant application were posed by the board and answered by Mr. Meyer.

Discussion Items.

Draft Board Procurement Policy. Todd Mills, UTA Senior Supply Chain Manager, presented the policy, which establishes the board responsibilities relative to contracting and procurement. Discussion ensued. A questions on how the policy addresses former UTA employees working with potential contractors was posed by the board and answered by Mr. Mills.

Draft Board Records Access and Management Policy. Auty Dahlquist, UTA Records Manager, provided an overview of the policy, which details board responsibilities relative to records access and management. Discussion ensued. Questions regarding UTA's fees for records requests, fee standards, and number of Government Records and Management Act (GRAMA) requests received by the agency were posed by the board and answered by Ms. Dahlquist. Trustee Millington suggested revising the fee structure for records requests.

Draft Revised Bylaws. Annette Royle, UTA Director of Strategic Board Operations, summarized proposed revisions to the UTA Bylaws, which change the name of the Advisory Board to Advisory Council, among other revisions.

Oquirrh View Planning. Wilf Sommerkorn and Jake Young with Salt Lake County delivered a presentation on the Oquirrh View planning process for the west bench of Salt Lake County. They discussed process phasing; the amount of developable land; population growth; job availability, migration, location, and density; street connectivity; trip length; housing; water availability; and parks. Discussion ensued. Questions on daily time patterns for job migration and housing segmentation were posed by the board and answered by Mr. Sommerkorn and Mr. Young.

Other Business.

Next Meeting. The next meeting of the board will be on Wednesday, June 5, 2019 at 9:00 a.m.

Adjournment. The meeting was adjourned at 10:41 a.m. by motion.

Transcribed by Cathie Griffiths
Executive Assistant to the Board Chair
Utah Transit Authority
cgriffiths@rideuta.com
801.237.1945

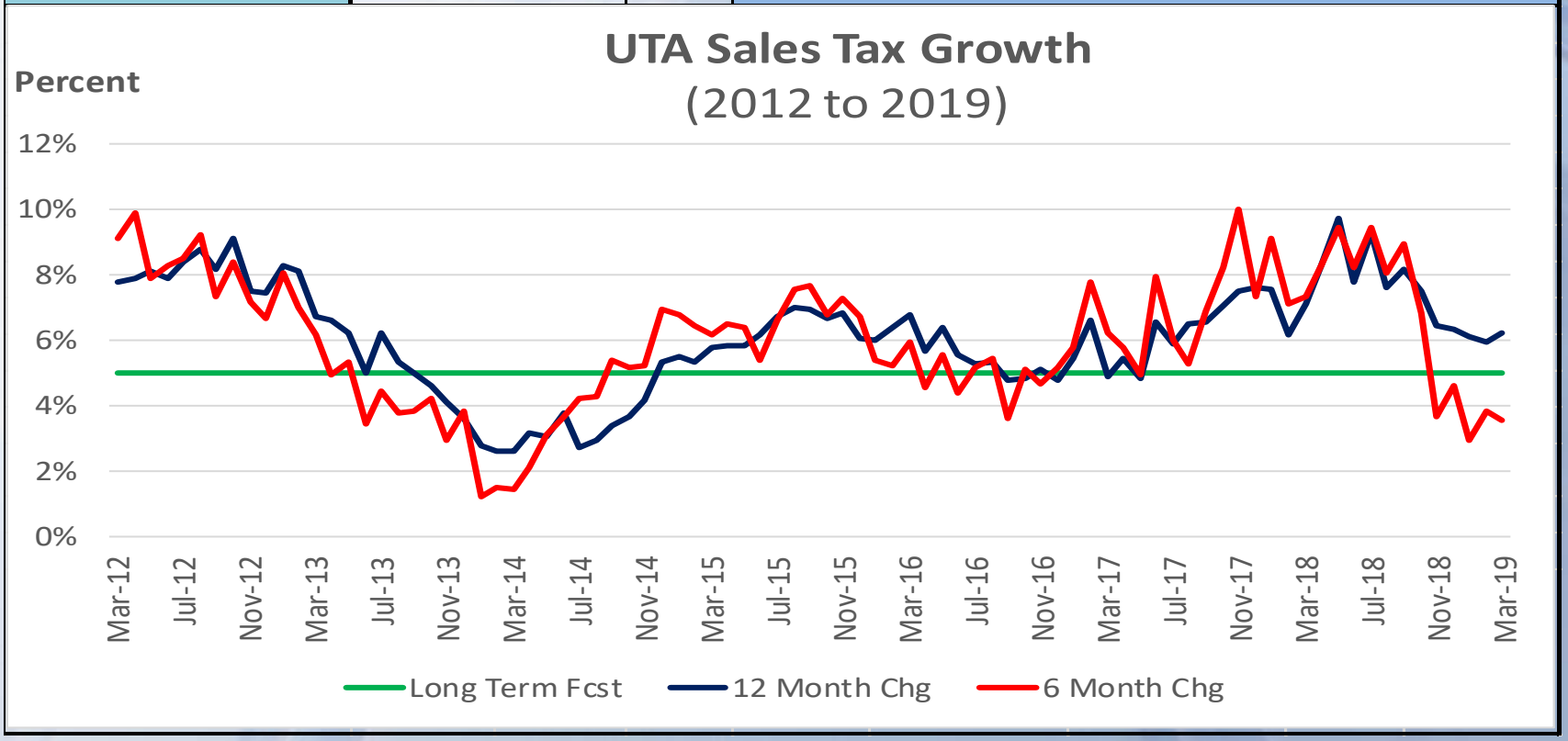
This document is not intended to serve as a full transcript as additional discussion may have taken place; please refer to the meeting materials, audio, or video located at https://www.utah.gov/pmn/sitemap/notice/536681.html for entire content.

This document along with the digital recording constitute the official minutes of this meeting.

UTA Board Dashboard

April 2019

Financial Metrics	Apr Actual	Apr Budget	Fav/ (Unfav)	%	YTD Actual	YTD Budget	Fav/ (Unfav)	%
Sales Tax (March '19 mm $)	$ 25.7	$ 27.7	$ (2.07)	-7.5%	$ 68.7	$ 69.4	$ (0.72)	-1.0%
Fare Revenue (mm)	$ 4.1	$ 4.4	$ (0.34)	-7.8%	$ 17.8	$ 17.9	$ (0.08)	-0.4%
Operating Exp (mm)	$ 23.8	$ 24.0	$ 0.19	0.8%	$ 93.1	$ 97.3	$ 4.17	4.3%
Subsidy Per Rider (SPR)	$ 5.22	$ 5.40	$ 0.18	3.3%	$ 5.08	$ 5.40	$ 0.32	5.9%
UTA Diesel Price ($/gal)	$ 2.29	$ 2.50	$ 0.21	8.3%	$ 2.00	$ 2.50	$ 0.50	19.9%
Operating Metrics	**Apr Actual**	**Apr-18**	**F/ (UF)**	**%**	**YTD Actual**	**YTD 2018**	**F/ (UF)**	**%**
Ridership (mm)	3.79	3.60	0.2	5.3%	14.85	14.58	0.3	1.8%
Alternative Fuels	CNG Price (Diesel Gal Equiv)		$ 1.84					



Utah Transit Authority

Financial Statement

(Unaudited)

April 30, 2019

KEY ITEM REPORT
(UNAUDITED)
As of April 30, 2019

EXHIBIT 1-1

		2019 YTD ACTUAL	2019 YTD BUDGET	VARIANCE FAVORABLE (UNFAVORABLE)	% FAVORABLE (UNFAVORABLE)
1	Sales Tax	$ 91,884,414	$ 91,199,157	$ 685,257	1%
2	Passenger Revenue	17,803,864	17,879,578	(75,714)	0%
3	Other Revenue	23,800,705	26,921,668	(3,120,963)	-12%
4	Total Revenue	133,488,983	136,000,403	(2,511,420)	-2%
5	Net Operating Expenses	(93,146,710)	(97,315,918)	4,169,208	4%
	Net Operating Income (Loss)	40,342,273	38,684,485	1,657,788	4%
6	Debt Service	46,557,752	46,575,545	17,793	0%
7	Other Non-Operating Expenses	1,482,989	2,011,660	528,671	26%
8	Sale of Assets	(896,094)	-	896,094	
9	Contribution to Capital Reserves	$ (6,802,374)	$ (9,902,720)	$ 3,100,346	
10	Bond Debt Service - Series 2016 UT COUNTY	671,898			
11	Amortization	(2,144,629)			
12	Depreciation	46,073,204			
13	Total Non-cash Items	$ 44,600,473			

GOALS

RIDERSHIP

	2018 Actual	April 2019	April 2018	Difference	2019 YTD	2018 YTD	Difference
14	44,200,955	3,794,939	3,602,655	192,284	14,845,823	14,584,794	261,029

OPERATING SUBSIDY PER RIDER -

			SPR
16	Net Operating Expense	$	93,146,710
17	Less: Passenger Revenue	-	(17,803,864)
18	Subtotal		75,342,846
19	Divided by: Ridership	÷	14,845,823
20	Subsidy per Rider	$	5.08

SUMMARY FINANCIAL DATA
(UNAUDITED)
As of April 30, 2019

EXHIBIT 1-2

BALANCE SHEET

		4/30/2019	4/30/2018
	CURRENT ASSETS		
1	Cash	$ 11,376,428	$ 12,142,212
2	Investments (Unrestricted)	93,618,489	90,460,045
3	Investments (Restricted)	141,697,337	172,139,016
4	Receivables	57,796,846	57,002,985
5	Receivables - Federal Grants	20,503,213	21,753,394
6	Inventories	37,166,255	35,018,195
7	Prepaid Expenses	1,678,984	1,263,583
8	TOTAL CURRENT ASSETS	$ 363,837,552	$ 389,779,430
9	Property, Plant & Equipment (Net)	3,054,897,675	3,037,844,400
10	Other Assets	148,781,843	146,417,846
11	TOTAL ASSETS	$3,567,517,070	$3,574,041,676
12	Current Liabilities	27,527,180	21,898,430
13	Other Liabilities	274,799,639	287,803,144
14	Net Pension Liability	131,069,664	100,876,554
15	Outstanding Debt	2,206,800,383	2,215,762,366
16	Equity	927,320,204	947,701,182
17	TOTAL LIABILITIES & EQUITY	$3,567,517,070	$3,574,041,676

RESTRICTED AND DESIGNATED CASH AND CASH EQUIVALENTS RECONCILIATION

	RESTRICTED RESERVES		
18	Debt Service Reserves	31,862,382	35,042,900
19	2018 Bond Proceeds	41,516,039	59,928,106
20	Debt Service Interest Payable	45,284,767	38,302,550
21	Risk Contingency	7,792,308	7,583,424
22	Box Elder County ROW (sales tax)	7,295,631	6,356,163
23	Mountain Accord	-	149,725
24	Joint Insurance Trust	4,332,372	4,044,096
25	UT County Bond Proceeds	-	10,292,901
26	Davis County Escrow	1,207,149	-
27	SL County Escrow (Streetcar Double Track)	578,649	-
28	Amounts held in escrow	1,828,040	10,439,151
29	TOTAL RESTRICTED RESERVES	$ 141,697,337	$ 172,139,016
	DESIGNATED OPERATING RESERVES		
30	Service Stabilization Reserve	$ 15,272,000	$ 13,916,046
31	Fuel Reserve	1,915,000	1,915,000
32	Parts Reserve	3,000,000	3,000,000
33	Operating Reserve	28,507,000	25,976,619
34	Early Debt Retirement Reserve	53,373,497	25,120,649
35	TOTAL DESIGNATED OPERATING RESERVES	$ 102,067,497	$ 69,928,314
36	TOTAL RESTRICTED AND DESIGNATED CASH AND EQUIVALENTS	$ 243,764,834	$ 242,067,330

SUMMARY FINANCIAL DATA
(UNAUDITED)
As of April 30, 2019

EXHIBIT 1-3

REVENUE & EXPENSES

		ACTUAL Apr-19	ACTUAL Apr-18	YTD 2019	YTD 2018
	REVENUE				
1	Passenger Revenue	$ 4,050,862	$ 4,855,621	$ 17,803,864	$ 17,422,141
2	Advertising Revenue	204,167	200,000	816,667	800,000
3	Investment Revenue	455,983	195,650	1,932,374	1,055,661
4	Sales Tax	21,459,791	22,905,858	91,884,414	88,761,071
5	Other Revenue	368,378	620,667	835,798	1,068,768
6	Fed Operations/Preventative Maint.	5,190,307	4,578,443	20,215,866	20,069,997
7	TOTAL REVENUE	$ 31,729,488	$ 33,356,239	$ 133,488,983	$ 129,177,638
	OPERATING EXPENSE				
8	Bus Service	$ 8,202,599	$ 7,379,255	$ 33,283,929	$ 30,379,762
9	Commuter Rail	1,966,465	2,138,347	7,539,469	7,640,149
10	Light Rail	2,879,895	1,990,592	12,592,107	11,673,500
11	Maintenance of Way	1,442,749	1,207,446	5,756,295	5,129,725
12	Paratransit Service	2,311,743	1,574,029	7,402,531	6,688,257
13	RideShare/Van Pool Services	267,760	218,290	1,003,960	802,061
14	Operations Support	4,041,024	3,755,745	15,782,003	14,845,541
15	Administration	2,737,188	2,295,196	9,786,416	9,372,629
16	TOTAL OPERATING EXPENSE	$ 23,849,423	$ 20,558,900	$ 93,146,710	$ 86,531,624
17	NET OPERATING INCOME (LOSS)	$ 7,880,065	$ 12,797,339	$ 40,342,273	$ 42,646,014
	NON-OPERATING EXPENSE (REVENUE)				
18	Planning & Development	$ 438,112	$ 364,884	$ 1,482,989	$ 1,381,419
19	Bond Principal	1,222,902	1,716,111	12,032,439	15,066,110
20	Bond Interest	7,964,238	8,179,016	31,856,949	30,854,973
21	Bond Cost of Issuance/Fees	8,000	-	9,500	1,060,484
22	Lease Cost	657,954	514,896	2,658,864	2,059,708
23	Sale of Assets	-	(278,644)	(896,094)	(4,047,197)
24	TOTAL NON-OPERATING EXPENSE	$ 10,291,206	$ 10,496,263	$ 47,144,647	$ 46,375,497
25	CONTRIBUTION TO CAPITAL RESERVES	$ (2,411,141)	$ 2,301,076	$ (6,802,374)	$ (3,729,483)
	OTHER EXPENSES (NON-CASH)				
26	Bond Debt Service - Series 2007A CAB	$ -	$ 53,816		$ 122,886
27	Bond Debt Service - Series 2016 UT COUNTY	$ 173,542		$ 671,898	
28	Bond Premium/Discount Amortization	(1,285,887)	(1,114,270)	(5,143,548)	(4,152,252)
29	Bond Refunding Cost Amortization	682,153	683,650	2,728,614	2,734,597
30	Future Revenue Cost Amortization	67,576	67,577	270,305	270,305
31	Depreciation	11,782,414	11,503,575	46,073,204	46,287,964
32	NET OTHER EXPENSES (NON-CASH)	$ 11,419,798	$ 11,194,348	$ 44,600,473	$ 45,263,500

ACTUAL REPORT
(UNAUDITED)
As of April 30, 2019

EXHIBIT 1-4

CURRENT MONTH

		ACTUAL Apr-19	BUDGET Apr-19	VARIANCE FAVORABLE (UNFAVORABLE)	% FAVORABLE (UNFAVORABLE)
	REVENUE				
1	Passenger Revenue	$ 4,050,862	$ 4,395,559	$ (344,697)	-8%
2	Advertising Revenue	204,167	204,167	-	0%
3	Investment Revenue	455,983	715,167	(259,184)	-36%
4	Sales Tax	21,459,791	21,792,501	(332,710)	-2%
5	Other Revenue	368,378	295,417	72,961	25%
6	Fed Operations/Preventative Maint.	5,190,307	5,515,667	(325,360)	-6%
7	TOTAL REVENUE	$ 31,729,488	$ 32,918,477	$ (1,188,989)	-4%
	OPERATING EXPENSE				
8	Bus Service	$ 8,202,599	$ 8,521,228	$ 318,629	4%
9	Commuter Rail	1,966,465	2,072,556	106,091	5%
10	Light Rail	2,879,895	2,990,132	110,237	4%
11	Maintenance of Way	1,442,749	1,517,261	74,512	5%
12	Paratransit Service	2,311,743	1,903,825	(407,918)	-21%
13	RideShare/Van Pool Services	267,760	268,420	660	0%
14	Operations Support	4,041,024	3,991,579	(49,445)	-1%
15	Administration	2,737,188	2,770,559	33,371	1%
16	TOTAL OPERATING EXPENSE	$ 23,849,423	$ 24,035,560	$ 186,137	1%
17	NET OPERATING INCOME (LOSS)	$ 7,880,065	$ 8,882,917	$ (1,002,852)	-11%
	NON-OPERATING EXPENSE (REVENUE)				
18	Planning & Development	$ 438,112	$ 502,915	$ 64,803	13%
19	Bond Principal	1,222,902	1,222,902	-	0%
20	Bond Interest	7,964,238	7,964,237	(1)	0%
21	Bond Cost of Issuance/Fees	8,000	7,000	(1,000)	-14%
22	Lease Cost	657,954	660,147	2,193	0%
23	Sale of Assets	-	-	-	
24	TOTAL NON-OPERATING EXPENSE	$ 10,291,206	$ 10,357,201	$ 65,995	1%
25	CONTRIBUTION TO CAPITAL RESERVES	$ (2,411,141)	$ (1,474,284)	$ (936,857)	-64%

	OTHER EXPENSES (NON-CASH)	
26	Bond Debt Service - Series 2007A CAB	$ -
27	Bond Debt Service - Series 2016 UT COUNTY	173,542
28	Bond Premium/Discount Amortization	(1,285,887)
29	Bond Refunding Cost Amortization	682,153
30	Future Revenue Cost Amortization	67,576
31	Depreciation	11,782,414
32	NET OTHER EXPENSES (NON-CASH)	$ 11,419,798

BUDGET TO ACTUAL REPORT
(UNAUDITED)
As of April 30, 2019

EXHIBIT 1-5

YEAR TO DATE

		ACTUAL Apr-19	BUDGET Apr-19	VARIANCE FAVORABLE (UNFAVORABLE)	% FAVORABLE (UNFAVORABLE)
	REVENUE				
1	Passenger Revenue	$ 17,803,864	$ 17,879,578	$ (75,714)	0%
2	Advertising Revenue	816,667	816,668	(1)	0%
3	Investment Revenue	1,932,374	2,860,667	(928,293)	-32%
4	Sales Tax	91,884,414	91,199,157	685,257	1%
5	Other Revenue	835,798	1,181,667	(345,869)	-29%
6	Fed Operations/Preventative Maint.	20,215,866	22,062,667	(1,846,801)	-8%
7	TOTAL REVENUE	$ 133,488,983	$ 136,000,403	$ (2,511,420)	-2%
	OPERATING EXPENSE				
8	Bus Service	$ 33,283,929	$ 34,357,117	$ 1,073,188	3%
9	Commuter Rail	7,539,469	8,093,247	553,778	7%
10	Light Rail	12,592,107	11,960,528	(631,579)	-5%
11	Maintenance of Way	5,756,295	5,975,991	219,696	4%
12	Paratransit Service	7,402,531	7,615,132	212,601	3%
13	RideShare/Van Pool Services	1,003,960	1,073,680	69,720	6%
14	Operations Support	15,782,003	16,020,680	238,677	1%
15	Administration	9,786,416	12,219,543	2,433,127	20%
16	TOTAL OPERATING EXPENSE	$ 93,146,710	$ 97,315,918	$ 4,169,208	4%
17	NET OPERATING INCOME (LOSS)	$ 40,342,273	$ 38,684,485	$ 1,657,788	4%
	NON-OPERATING EXPENSE (REVENUE)				
18	Planning & Development	$ 1,482,989	$ 2,011,660	$ 528,671	26%
19	Bond Principal	12,032,439	12,032,439	-	0%
20	Bond Interest	31,856,949	31,856,949	(0)	0%
21	Bond Cost of Issuance/Fees	9,500	25,100	15,600	62%
22	Lease Cost	2,658,864	2,661,057	2,193	0%
23	Sale of Assets	(896,094)	-	896,094	
24	TOTAL NON-OPERATING EXPENSE	$ 47,144,647	$ 48,587,205	$ 1,442,558	3%
25	CONTRIBUTION TO CAPITAL RESERVES	$ (6,802,374)	$ (9,902,720)	$ 3,100,346	31%

	OTHER EXPENSES (NON-CASH)	
26	Bond Debt Service - Series 2007A CAB	$ -
27	Bond Debt Service - Series 2016 UT COUNTY	$ 671,898
28	Bond Premium/Discount Amortization	(5,143,548)
29	Bond Refunding Cost Amortization	2,728,614
30	Future Revenue Cost Amortization	270,305
31	Depreciation	46,073,204
32	NET OTHER EXPENSES (NON-CASH)	$ 44,600,473

CAPITAL PROJECTS
(UNAUDITED)
As of April 30, 2019

EXHIBIT 1-6

		2019 ACTUAL	ANNUAL BUDGET	PERCENT
	EXPENSES			
1	REVENUE AND NON-REVENUE VEHICLES	$ 454,668	$ 10,290,000	4.4%
2	INFORMATION TECHNOLOGY	387,789	11,120,532	3.5%
3	FACILITIES, MAINTENANCE & ADMIN. EQUIP.	153,899	2,547,169	6.0%
4	CAPITAL PROJECTS	10,078,019	69,212,295	14.6%
5	PROVO OREM BRT	1,021,644	2,500,000	40.9%
6	AIRPORT STATION RELOCATION	168,905	2,650,000	6.4%
7	STATE OF GOOD REPAIR	4,208,538	28,046,172	15.0%
8	TIGER	238,663	15,012,832	1.6%
9	TOTAL	$ 16,712,125	$ 141,379,000	11.8%
	REVENUES			
10	GRANT	$ 4,970,306	$ 50,031,000	9.9%
11	PROVO-OREM TRIP	-	2,500,000	0.0%
12	LEASES (PAID TO DATE)	299,590	10,090,000	3.0%
13	BONDS	3,221,237	16,520,000	19.5%
14	LOCAL PARTNERS	47,872	15,686,000	0.3%
15	UTA FUNDING	8,173,120	46,552,000	17.6%
16	TOTAL	$ 16,712,125	$ 141,379,000	11.8%

FAREBOX RECOVERY & SPR
(UNAUDITED)
As of April 30, 2019

EXHIBIT 1-7

BY SERVICE

	CURRENT MONTH		YEAR TO DATE	
	Apr-19	Apr-18	2019	2018
UTA				
Fully Allocated Costs	23,849,424	20,588,900	93,146,711	86,561,624
Passenger Farebox Revenue	4,050,992	4,855,621	17,803,864	17,422,142
Passengers	3,794,939	3,602,655	14,845,823	14,584,794
Farebox Recovery Ratio	17.0%	23.6%	19.1%	20.1%
Actual Subsidy per Rider	$5.22	$4.37	$5.08	$4.74
BUS SERVICE				
Fully Allocated Costs	11,181,976	10,006,801	44,466,962	40,950,430
Passenger Farebox Revenue	1,462,885	1,861,007	7,472,983	6,964,873
Passengers	1,741,986	1,526,774	6,900,565	6,346,213
Farebox Recovery Ratio	13.1%	18.6%	16.8%	17.0%
Actual Subsidy per Rider	$5.58	$5.34	$5.36	$5.36
LIGHT RAIL SERVICE				
Fully Allocated Costs	6,363,367	5,033,060	26,011,089	24,085,984
Passenger Farebox Revenue	1,393,620	1,791,670	5,645,636	6,062,619
Passengers	1,452,738	1,503,610	5,583,415	5,940,102
Farebox Recovery Ratio	21.9%	35.6%	21.7%	25.2%
Actual Subsidy per Rider	$3.42	$2.16	$3.65	$3.03
COMMUTER RAIL SERVICE				
Fully Allocated Costs	3,332,167	3,349,891	12,776,095	12,534,298
Passenger Farebox Revenue	464,054	530,092	1,744,145	1,889,894
Passengers	431,522	395,714	1,704,773	1,602,841
Farebox Recovery Ratio	13.9%	15.8%	13.7%	15.1%
Actual Subsidy per Rider	$6.65	$7.13	$6.47	$6.64
PARATRANSIT				
Fully Allocated Costs	2,480,895	1,802,662	8,095,846	7,412,458
Passenger Farebox Revenue	407,688	346,261	1,577,564	1,197,786
Passengers	70,387	69,169	279,337	282,290
Farebox Recovery Ratio	16.4%	19.2%	19.5%	16.2%
Actual Subsidy per Rider	$29.45	$21.06	$23.33	$22.02
RIDESHARE				
Fully Allocated Costs	491,020	396,486	1,796,718	1,578,454
Passenger Farebox Revenue	322,746	326,592	1,363,536	1,306,970
Passengers	98,307	107,388	377,733	413,347
Farebox Recovery Ratio	65.7%	82.4%	75.9%	82.8%
Actual Subsidy per Rider	$1.71	$0.65	$1.15	$0.66

FAREBOX RECOVERY & SPR
(UNAUDITED)
As of April 30, 2019

EXHIBIT 1-8

BY TYPE

	CURRENT MONTH		YEAR TO DATE	
	Apr-19	Apr-18	2019	2018
FULLY ALLOCATED COSTS				
Bus Service	$11,181,976	$10,006,801	$44,466,962	$40,950,430
Light Rail Service	$6,363,367	$5,033,060	$26,011,089	$24,085,984
Commuter Rail Service	$3,332,167	$3,349,891	$12,776,095	$12,534,298
Paratransit	$2,480,895	$1,802,662	$8,095,846	$7,412,458
Rideshare	$491,020	$396,486	$1,796,718	$1,578,454
UTA	$23,849,424	$20,588,900	$93,146,711	$86,561,624
PASSENGER FAREBOX REVENUE				
Bus Service	$1,462,885	$1,861,007	$7,472,983	$6,964,873
Light Rail Service	$1,393,620	$1,791,670	$5,645,636	$6,062,619
Commuter Rail Service	$464,054	$530,092	$1,744,145	$1,889,894
Paratransit	$407,688	$346,261	$1,577,564	$1,197,786
Rideshare	$322,746	$326,592	$1,363,536	$1,306,970
UTA	$4,050,992	$4,855,621	$17,803,864	$17,422,142
PASSENGERS				
Bus Service	1,741,986	1,526,774	6,900,565	6,346,213
Light Rail Service	1,452,738	1,503,610	5,583,415	5,940,102
Commuter Rail Service	431,522	395,714	1,704,773	1,602,841
Paratransit	70,387	69,169	279,337	282,290
Rideshare	98,307	107,388	377,733	413,347
UTA	3,794,939	3,602,655	14,845,823	14,584,794
FAREBOX RECOVERY RATIO				
Bus Service	13.1%	18.6%	16.8%	17.0%
Light Rail Service	21.9%	35.6%	21.7%	25.2%
Commuter Rail Service	13.9%	15.8%	13.7%	15.1%
Paratransit	16.4%	19.2%	19.5%	16.2%
Rideshare	65.7%	82.4%	75.9%	82.8%
UTA	17.0%	23.6%	19.1%	20.1%
ACTUAL SUBSIDY PER RIDER				
Bus Service	$5.58	$5.34	$5.36	$5.36
Light Rail Service	$3.42	$2.16	$3.65	$3.03
Commuter Rail Service	$6.65	$7.13	$6.47	$6.64
Paratransit	$29.45	$21.06	$23.33	$22.02
Rideshare	$1.71	$0.65	$1.15	$0.66
UTA	$5.22	$4.37	$5.08	$4.74

SUMMARY OF ACCOUNTS RECEIVABLE
(UNAUDITED)
As of April 30, 2019

EXHIBIT 1-9

	Classification	Total	Current	31-60 Days	61-90 Days	90-120 Days	Over 120 Days
1	Federal Government [1]	$ 20,503,213	$ 20,503,213	$ -	$ -	$ -	$ -
2	Local Contributions [2]	48,776,501	48,776,501	-	-	-	-
3	Warranty Recovery	1,100,976	1,100,976	-	-	-	-
4	Product Sales and Development	1,035,914	828,075	121,395	46,226	66	40,152
5	Pass Sales	506,828	298,135	35,979	2,811	97,445	72,458
6	Property Management	96,182	51,152	15,987	9,690	-	19,353
7	Vanpool/Rideshare	132,710	15,235	10,517	(1,847)	3,776	105,029
8	Capital Development Agreements	922,704	-	-	438,137	420,600	63,967
9	Mobility Management	6,700	-	-	5,000	-	1,700
10	Paratransit	11,250	11,250	-	-	-	-
11	Other [3]	5,207,081	5,207,081	-	-	-	-
12	Total	$ 78,300,059	$ 76,791,618	$ 183,878	$ 500,017	$ 521,887	$ 302,659
	Percentage Due by Aging						
13	Federal Government [1]		100.0%	0.0%	0.0%	0.0%	0.0%
14	Local Contributions [2]		100.0%	0.0%	0.0%	0.0%	0.0%
15	Warranty Recovery		100.0%	0.0%	0.0%	0.0%	0.0%
16	Product Sales and Development		79.9%	11.7%	4.5%	0.0%	3.9%
17	Pass Sales		58.8%	7.1%	0.6%	19.2%	14.3%
18	Property Management		53.2%	16.6%	10.1%	0.0%	20.1%
19	Vanpool/Rideshare		11.5%	7.9%	-1.4%	2.8%	79.1%
20	Capital Development Agreements		0.0%	0.0%	47.5%	45.6%	6.9%
21	Mobility Management		0.0%	0.0%	74.6%	0.0%	25.4%
22	Paratransit		100.0%	0.0%	0.0%	0.0%	0.0%
23	Other		100.0%	0.0%	0.0%	0.0%	0.0%
24	Total		98.1%	0.2%	0.6%	0.7%	0.4%

[1] Federal preventive maintenance funds, federal RideShare funds, and federal interest subsidies for Build America Bonds

[2] Estimated sales tax to be distributed upon collection by the Utah State Tax Commission

[3] Build American Bond Tax Credits, fuel tax credit

SUMMARY OF APPROVED DISBURSEMENTS OVER $200,000
FROM APRIL 1, 2019 THROUGH APRIL 30, 2019
(UNAUDITED)

EXHIBIT 1-10

Contract # and Description		Contract Date	Vendor	Check #	Date	Check Total
17-2392PP	LONO ELECTRIC BUSES	7/30/2018	NEW FLYER OF AMERICA	344443	4/4/2019	$1,917,996.56
R2018-05-09			ROCKY MOUNTAIN POWER	344451	4/4/2019	222,995.11
14-1109TH	ADA PARATRANSIT AND ROUTE DEVIATION	9/1/2014	MV PUBLIC TRANSPORTATION	880874	4/11/2019	215,431.10
16-1846TP	ON-CALL MAINTENANCE	10/7/2016	STACEY AND WITBECK, INC.	880882	4/11/2019	1,109,668.04
R2018-05-09			ROCKY MOUNTAIN POWER	344786	4/18/2019	958,172.13
17-2392PP	LONO ELECTRIC BUSES	7/30/2018	NEW FLYER OF AMERICA	880906	4/18/2019	1,822,096.73
14-17TH	POSITIVE TRAIN CONTROL	10/6/2014	ROCKY MOUNTAIN SYSTEMS SERVICE	880910	4/18/2019	630,743.95

Detailed Contract Description & Purpose

Board Review Date:	6/5/2019	**Document Type:**	Change Order
Action Requested:	Motion to approve the contract or change order		
Criteria:	New total contract value is > $1,000,000 and Change-order is > 15% or $200,000		

Contract Title:	Employer Health Insurance - PEHP	**Contract #**	16-2067TP-1 & 16-2070TP-1
Project Manager:	Jacob Gomez	**Contract Administrator:**	Teressa Pickett
Impacted Areas:	All Employees	**Included in budget?**	Yes
Procurement method:	Best value (RFP)	**Contractor:**	PEHP
Sole-Source Reason:	N/A	**Original Contract Value**	$ 18,938,636
		Change Order Value	$ 10,000,000
		Total Contract Value	$ 28,938,636
Contract term (Months)	12	**Contract Start Date**	5/1/2019
Contract options (Months)	24	**Contract End Date:**	4/30/2020
Number of responding firms:	8	**$ Value of Next Lowest Bidder**	This is a best value procurement where technical and price were both evaluated. The next lowest bidder may not have been the most qualified.

General Description & Purpose:

The Utah Transit Authority offers a competitive benefits package to their eligible employees and eligible dependents. This includes a quality employer health insurance program. Employees are given a choice of two health care options. This program covers the benefits provided by Public Employees Health Program also known as PEHP.

This contract approval request is for two contracts with PEHP, one for Bargaining Unit employees ($7,000,000), and the other for Administrative employees ($3,000,000). This is the 3rd year of a 5 year contract, with no option years. The $10,000,000 is an estimate and will be determined by the amount of employees who sign up with PEHP vs Select Health.

Attachments:	Contract routing sheet attached?	Yes
	Other attachments? (list)	Administrative Emloyees Contract and Bargaining Unit Contract

Once approved, please forward to Contract Administrator

UTA

CONTRACT ROUTING SHEET

Agenda Item No.:
Board Review Date:

CONTRACT SECTION

1) Contract/P.O. No. **16-2070TP-1** *(Assigned by Purchasing)* Contract Administrator: **Teressa Pickett**
Project Manager: **Jacob Gomez**

2) Contract Type ☐ A. A&E/Design ☐ B. Blanket PO ☐ C. Construction ☐ D. Goods ☐ E. Modification ☑ E. Option ☐ F. Other _____ ☐ G. Renewal ☐ H. Services ☐ I. Task Orders

3) Procurement Method ☐ RFQ (Quote) ☐ IFB (Low Bid) ☐ RFQU (Qualification) ☑ RFP (Best-value) ☐ Sole source ☐ Other: _____

4) Contract Title **Employer Health Insurance Agreement - Administration**

5) Description / Purpose *(of contract or project)* **Employer Health Insurance Agreement between UTA and Public Employees' Health Program (PEHP) for Medical Healthcare Benefits.**

6) Contractor Name **Public Employees' Health Program (PEHP)**

7) Effective Dates Beginning: **05/01/19** Ending: **04/30/20**

8) Option to renew? ☑ Yes ☐ No Renewal terms: One year term (starting 5/1/17) with an option to renew every year up to a total of 5 years, ending 4/30/2022.

FINANCIAL SECTION

9) Total Board Approval Amount:

9a) Current Contract Value:	$	4,938,635.89
9b) Amendment Amount:	$	3,000,000.00
9d) New Contract Value (including all amendments)	$	7,938,635.89

9e) Is the amount an estimate? ☑ Yes ☐ No
(Estimate if per transaction cost)

9f) *If estimated, how was the estimate calculated?* The total amount is dependent on how many employees choose the PEHP program for their insurance.

10) Is the amount a one-time purchase or annual recurring purchase? ☐ One-time ☑ Recurring

11) Account Code **1.10411.PEHP** Capital Project Code

12) Budgeted? ☑ Yes ☐ No Budget amount: **$ 7,938,636.00**

13) Will this contract require support from another department? ☑ Yes ☐ No

14) If so, is the other department(s) aware of this contract and the required support? ☑ Yes ☐ No

15) If box 2a or 2c is checked, has the Qualified Heath Insurance Certificate been verified? N/A ☐ Yes ☐ No

SIGNATURE SECTION

	Route to?		Initials	
Contract Compliance	☑ Yes			Lisa Bohman
Accounting Review	☑ Yes	☐ No		Bryan Steele
IT Review (IT software or hardware)	☐ Yes	☑ No		N/A
Up to $10K Manager/Program Manager	☑ Yes	☐ No		Jacob Gomez
Up to $50K Dir, Sr. Mgr, RGM, or Chief/VP	☐ Yes	☑ No		N/A
Up to $100K Chief/VP, or Dir, Sr. Mgr, RGM (Capital, Maint., Ops. only)	☑ Yes	☐ No		Kimberly S. Ulibarri
Over $100K Executive Director	☑ Yes	☐ No		W. Steve Meyer
Over $200K Board Approval	☑ Yes	☐ No		Approval Date

If Yes, route to the Sr. Supply Chain Manager for board meeting agenda and approval

Once approved, please forward to Contract Administrator

UTA

CONTRACT ROUTING SHEET

Agenda Item No.:
Board Review Date:

CONTRACT SECTION

1) Contract/P.O. No. **16-2067TP-1** *(Assigned by Purchasing)* Contract Administrator: **Teressa Pickett**
Project Manager: **Jacob Gomez**

2) Contract Type ☐ A. A&E/Design ☐ B. Blanket PO ☐ C. Construction ☐ D. Goods ☐ E. Modification ☑ E. Option ☐ F. Other _____ ☐ G. Renewal ☐ H. Services ☐ I. Task Orders

3) Procurement Method ☐ RFQ (Quote) ☐ IFB (Low Bid) ☐ RFQU (Qualification) ☑ RFP (Best-value) ☐ Sole source ☐ Other: _____

4) Contract Title **Employer Health Insurance Agreement - Bargaining**

5) Description / Purpose *(of contract or project)* **Employer Health Insurance Agreement between UTA/ATU Joint Insurance Trust and Public Employees' Health Program (PEHP) for Medical Healthcare Benefits.**

6) Contractor Name **Public Employees' Health Program (PEHP)**

7) Effective Dates Beginning: **05/01/19** Ending: **04/30/20**

8) Option to renew? ☑ Yes ☐ No Renewal terms: One year term (starting 5/1/17) with an option to renew every year up to a total of 5 years, ending 4/30/2022.

FINANCIAL SECTION

9) **Total Board Approval Amount:**
- 9a) Current Contract Value: $ 14,000,000.00
- 9b) Amendment Amount: $ 7,000,000.00
- 9d) New Contract Value (including all amendments) $ 21,000,000.00
- 9e) Is the amount an estimate? ☑ Yes ☐ No
  (Estimate if per transaction cost)
- 9f) *If estimated, how was the estimate calculated?* The total amount is dependent on how many employees choose the PEHP program for their insurance.

10) Is the amount a one-time purchase or annual recurring purchase? ☐ One-time ☑ Recurring

11) Account Code **JIC** Capital Project Code

12) Budgeted? ☑ Yes ☐ No Budget amount: **$ 21,000,000.00**

13) Will this contract require support from another department? ☑ Yes ☐ No

14) If so, is the other department(s) aware of this contract and the required support? ☑ Yes ☐ No

15) If box 2a or 2c is checked, has the Qualified Heath Insurance Certificate been verified? N/A ☐ Yes ☐ No

SIGNATURE SECTION

	Route to?		Initials	
Contract Compliance	☑ Yes			Lisa Bohman
Accounting Review	☑ Yes	☐ No		Bryan Steele
IT Review (IT software or hardware)	☐ Yes	☑ No		N/A
Up to $10K Manager/Program Manager	☑ Yes	☐ No		Jacob Gomez
Up to $50K Dir, Sr. Mgr, RGM, or Chief/VP	☐ Yes	☑ No		N/A
Up to $100K Chief/VP, or Dir, Sr. Mgr, RGM (Capital, Maint., Ops. only)	☑ Yes	☐ No		Kimberly S. Ulibarri
Over $100K Executive Director	☑ Yes	☐ No		W. Steve Meyer
Over $200K Board Approval	☑ Yes	☐ No		Approval Date

If Yes, route to the Sr. Supply Chain Manager for board meeting agenda and approval

Employer Health Insurance Agreement

Between UTA/ATU Joint Insurance Trust
and
Utah Retirement Systems Public Employees' Health Program
May 1, 2019 through April 30, 2020

Table of Contents

SECTION 1 – INTRODUCTION

1.1 Contract

1.1.1 This Employer Health Insurance Agreement ("Agreement") is made and entered into, pursuant to Utah Code Annotated Title 49, Chapter 20, by and between __UTA/ATU Joint Insurance Trust____ ("Employer"), a body corporate and politic of the State of Utah, and the UTAH RETIREMENT SYSTEMS, by and through its Employer benefit and insurance division, the PUBLIC EMPLOYEES' HEALTH PROGRAM ("PEHP").

1.1.2 In exchange for Employer's payment of Rates, PEHP provides defined healthcare Benefits to Members. Any payment of Rates will constitute Employer's agreement to the terms of this Agreement, regardless of whether Employer has actually signed the Agreement.

1.1.3 NOW, THEREFORE, for and in consideration of the agreements and provisions hereinafter contained, the parties hereby agree and enter into this Agreement.

1.2 Scope of Agreement

1.2.1 PEHP will make available to Employer's Eligible Employees, , and Eligible dependents, the health and prescription drug plans listed in Appendix A. All terms, definitions, and conditions of the health and prescription drug plans are hereby incorporated into this Agreement.

1.2.2 Any and all other documents attached hereto are hereby made a part of this Agreement as fully as though detailed herein.

1.2.3 The parties acknowledge that for purposes of paying fees required by the Affordable Care Act, PEHP shall act as the plan sponsor of Employer's benefit plans. All programs and plans offered by PEHP are subject to change in order to adapt to the changes and trends in the health care industry. Further, the Benefits in this Agreement are not necessarily the benefits of the Employer's previous insurance carrier. This contract does not guarantee benefits payable under the previous carrier will be payable under PEHP.

1.2.4 No Member of PEHP has a vested right to any Benefits. Changes to the Agreement may be made without notification, consultation or the consent of Members. However, material mid-plan year changes to the Benefits must be made with approval of the Employer and with 60 days notice to the Members. The rights and interest of Members at any particular time depend on the Agreement terms in effect at that time.

1.2.5 PEHP may adopt reasonable policies, rules and procedures to help in the administration of the Agreement. Employer agrees to abide by all such reasonable policies, rules, and procedures that are not inconsistent with the Agreement.

1.2.6 PEHP has discretion to determine Eligibility for Benefits and to interpret the terms and conditions of the Benefit plan(s). PEHP's determinations under this Section do not prohibit or prevent a Member from seeking an appeal of claims or an administrative review by following the appeals procedure established by the Master Policy and Utah Code Ann. § 49-11-613.

SECTION 2 – ELIGIBILITY AND ENROLLMENT

2.1 Eligibility

2.1.1 PEHP shall provide coverage to those Eligible Employees and their Eligible Dependents in accordance with the terms of the Employer Eligibility Standard in Appendix B

2.1.2 In consultation with PEHP and within PEHP's stated Eligibility parameters, if Employer has 100 Subscribers or more, Employer shall decide which categories of Employees and Dependents are Eligible to become Members and establish related Eligibility requirements. Employer agrees to implement standards that are nondiscriminatory and is solely liable if any standards are determined to be discriminatory.

2.1.3 Employer has provided PEHP with its Eligibility standards. Employees returning from a leave of absence who have waived coverage due to the leave of absence are eligible to be reinstated to coverage on the first day of the month following their return to work.

2.1.4 Eligibility standards (including termination standards) determined by Employer must be reported to and approved by PEHP each plan year, at least ninety (90) days prior to the start of the plan year. **Employer shall inform PEHP of its eligibility standards on the PEHP Benefit Selection Form.** If Eligibility standards vary from plan year to plan year, PEHP may revise Rates correspondingly, in accordance with sound actuarial principles.

2.1.5 Employer may not change, extend, expand, or waive the Eligibility criteria without first obtaining the advance, written approval of an officer of PEHP. Eligibility standards may not be changed mid-plan year.

2.1.6 Employer's Eligibility parameters must meet PEHP's criteria which include the following:

- Eligible Employees with other coverage may waive coverage with the Employer under the Plan;
- At least 80% of Eligible individuals, who have not demonstrated proof of other coverage, must participate in the Plan, or, if Employer employs fewer than five (5) individuals, 100% of individuals must participate in the Plan;
- Independent contractors are not Eligible;

Only individuals who continuously satisfy the Eligibility criteria of the Agreement may be enrolled and continue as Members. Employer, Subscribers, and their Dependents are responsible for obtaining and submitting to PEHP evidence of Eligibility.

2.1.7 Notwithstanding this Section 2, PEHP reserves the right to deny coverage to an otherwise Eligible Employee and/or their Eligible Dependent(s), in accordance with the PEHP Master Policy, if that individual commits fraud upon PEHP, forges prescriptions, commits criminal acts associated with coverage, misuses or abuses Benefits or breaches the conditions of the PEHP Master Policy. Notwithstanding any other provision of this Agreement, if such an individual retains Coverage with PEHP at the request of an Employer after a recommendation by PEHP to address either the fraud, criminal acts associated with coverage, or a breach of the PEHP Master Policy, Employer shall be solely and completely responsible for all claims incurred for this individual. In such a circumstance, the individual's claims shall be adjudicated separately from the Employer's experience, and no claims for this individual, either in specific or aggregate, shall be eligible for payment by PEHP reinsurance.

2.2 Enrollment Requirements

2.2.1 In order for an Eligible individual to receive Benefits, Employer must enroll the individual, PEHP must accept the individual as a Member, and Employer must pay the applicable Rates. Employer agrees to limit enrollment to Eligible Employees and their Dependents.

2.2.2 Any Employee who does not enroll in the Employer Plan during their first 30 days of any applicable waiting period or during a special enrollment period through Employer's enrollment system, will not be Eligible to enroll until the next annual enrollment period.

2.2.3 Except as otherwise provided in this Agreement, enrollment and enrollment changes for existing Employees and their Dependents may only be made during an open enrollment period.

2.2.4 PEHP shall allow for a special enrollment period for specific circumstances listed in Section 2.2.5. The terms governing special enrollment for PEHP are also contained in the Master Policy attached hereto as part of Exhibit A.

2.2.5 Employer must notify PEHP within 60 days whenever there is a change in a Member's family and or employment status that may affect Eligibility or enrollment. Family or employment status includes the following events:

a) Adoption of a child, birth of a child, or gaining legal guardianship of a child;
b) Child loses Dependent status;
c) Death;
d) Divorce;
e) Marriage
f) Involuntary loss of other coverage;
g) Member called to active military duty;
h) Member receives a Qualified Medical Child Support Order (QMCSO);
i) Reduction in employment hours;
j) Member takes, returns from, or does not return from a leave of absence; and
k) Termination of employment.

2.2.6 If Employer fails to notify PEHP within 30 days of a Member's termination from employment or other family and/or employment change that results in the loss of a Member's Eligibility, Employer agrees to promptly pay PEHP any amounts paid as Benefits for such Member after the Member became ineligible and before PEHP was notified.

2.2.7 PEHP agrees to supply certification of creditable coverage to all terminated Subscribers and their Eligible Dependents losing coverage in accordance with federal law. The terms governing certification and disclosure are contained in the Master Policy attached hereto as part of Exhibit A.

2.2.8 Employer hereby agrees the Effective Date for new Employees is based upon the Employer's enrollment polices as stated on the Group Renewal Form.

2.2.9 PEHP will enroll Dependents as a result of a valid court order. Any requirement for the Plan to comply with court orders, including Qualified Medical Child Support Orders (QMCSOs) and/or Divorce Decrees is Employer's responsibility. When Employer directs PEHP to enroll an individual on the basis of a court order, PEHP reserves the right to review and confirm that the order is qualified.

2.2.10 PEHP may decline to enroll Employees, former Employees, or Dependents who do not satisfy the Eligibility criteria of the Agreement. Also, PEHP may initially decline to issue coverage if Employer fails to meet the minimum enrollment or minimum contribution requirements.

2.3 Continuation of Coverage (COBRA / Mini-COBRA) and Conversion Coverage

2.3.1 Employer's Members who lose coverage under a Plan made available by PEHP may be permitted to continue such Coverage in accordance with the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), or Utah mini-COBRA, Utah Code Ann. § 31A-22-722 (collectively, "Continuation Coverage").

2.3.2 Employer agrees to administer Continuation Coverage according to state and federal law.

2.3.3 PEHP and Employer agree that if this Agreement is terminated, Continuation Coverage with PEHP will terminate. Employer will be responsible for obtaining alternate coverage for those Members who are receiving Continuation Coverage.

2.3.4 PEHP agrees to bill and collect Rates from Members for Continuation Coverage.

2.3.5 PEHP agrees to provide COBRA Coverage for the minimum time and only to the minimum extent required by applicable state and federal law. PEHP will not provide Continuation Coverage if Employer or the Member fails to strictly comply with all applicable notice and other requirements and deadlines.

SECTION 3 – RESPONSIBILITIES OF EMPLOYER

3.1 In General

3.1.1 In addition to the responsibilities addressed throughout this Agreement, Employer agrees to the following responsibilities and obligations.

3.2 Rate Payments

3.2.1 Employer is responsible to collect and remit Rates to PEHP. By remitting Rates to PEHP, Employer certifies to PEHP that the Employer/Employee Rate share complies with the affordability standards of PPACA. Other than as required by state or federal law, nothing contained in this Agreement shall obligate the Employer to contribute any specific percentage of the contribution, nor to provide any specified credits for sick leave conversion, etc. to any Employee.

3.2.2 To the extent Employer requires its Employees to contribute to Rates, Employer agrees to collect those contributions from its Employees and remit the same to PEHP together with a copy of a remittance report. Such contributions and report will be submitted to PEHP monthly following the appropriate payroll dates. By remitting Rates, Employer certifies that all Employees meet the Eligibility requirements agreed upon under this Agreement.

3.2.3 Employer's obligation to pay the full Rates to PEHP is not contingent upon Employer's ability to collect any percentage of the Rates that Employer requires to be paid by Subscribers.

3.2.4 Rates will be considered late if received more than forty (40) days after the date of the corresponding invoice from PEHP.

3.2.5 Notwithstanding any other provision of this Agreement, if Employer is late in any required payment to PEHP, PEHP shall assess Employer a 5% penalty on late payments.

3.2.5 Notwithstanding any other provision of this Agreement, if Employer fails to pay a required invoice to PEHP within sixty (60) days after the date of the corresponding invoice from PEHP, PEHP shall immediately suspend payment of claims until payment is made in full; in such case, the Employer shall be responsible for any payment to Providers, including any late fees, as applicable; or immediately terminate this Agreement in accordance with Section 7.2.

3.3 Employment Verification and Status

3.3.1 To the extent Employer is responsible to determine Eligibility standards under this Agreement, Employer agrees to provide those standards to PEHP at least ninety (90) days prior to the start of the Plan Year, as provided in Section 2.1.

3.3.2 Employer agrees to verify employment status and date of employment information contained in any new applications filed by Employees, and Employer agrees to inform PEHP of any change in Employee or Dependent status or of the termination of coverage of any Employee or Dependent, including any COBRA Qualifying Events, on a semi-monthly basis, in accordance with Section 2.4.

3.3.3 It is the responsibility of the Employer to obtain and maintain updated, accurate records specifying enrollment information, Member files, Eligibility information, Effective Dates, and Employee status information. Employer agrees, to the extent requested by PEHP, to provide PEHP with current and updated copies of all completed enrollment forms and other documentation as deemed necessary by PEHP.

3.3.4 Payment of Rates shall constitute Employer's certification that Employer and all its Members meet the Eligibility standards as outlined in Utah Code Annotated Title 49, Chapter 20, and as established under this Agreement.

3.4 Compliance

3.4.1 Employer is responsible for its own compliance with applicable laws, rules, and regulations, including requirements to provide information to Members about their coverage. This includes all applicable requirements under PHSA, HIPAA, PPACA, COBRA, and any other state and federal requirements that apply to the Plan.

3.4.2 Employer agrees to notify PEHP when Employer receives Medicare secondary payer information.

3.4.3 Employer shall distribute to Employees all forms, documents, and notices as required by law (i.e. Summary of Benefits and Coverage, Benefit Summaries). In accordance with Section 4.4, PEHP may assist Employer in the production of such forms, documents and notices. Employer maintains sole responsibility to ensure compliance with federal law.

3.5 Miscellaneous

3.5.1 Employer certifies it is a political subdivision of the State of Utah and that both Employer and its Eligible Employees qualify to participate with PEHP, and Employer agrees to notify PEHP prior to its losing Eligibility to participate with PEHP.

3.5.2 It is Employer's responsibility to provide Subscribers a 30-day written notice of the Agreement's termination.

3.5.3 Except as modified in this Agreement, Employer shall be responsible for all tax consequences or penalties resulting from participation in the PEHP plans or programs.

SECTION 4 – RESPONSIBILITIES OF PEHP

4.1 Plan Services

4.1.1 Employer hereby agrees that it is the sole responsibility and right of PEHP to contract with, negotiate policies, procedures, and plan provisions, in reference to physicians, hospitals, facilities, corporations, or other service Providers. PEHP agrees to establish and maintain its usual hospital and physician relations activities, Subscriber service activities, investigative and claim review procedures, legal review and defense services, and shall take all reasonable measures to prevent the allowance and payment of improper claims for Employer.

4.1.2 PEHP shall provide Employer with all administrative services provided by PEHP to its other policy holders. A monthly fee for administrative services shall be included in the Rate amount, on a Per Member Per Month ("PMPM") basis, at the Rate specified in Appendix A.

4.1.3 PEHP shall provide Reinsurance coverage as provided for in Section 5. PEHP will charge a monthly reinsurance fee, on a PMPM basis, at the Rate specified in Appendix A. The reinsurance fee is included in the Employer Rate.

4.1.4 At Employer's request, PEHP may facilitate an on site medical clinic for Employer's employees in accordance with the terms in Appendix B.

4.1.5 PEHP shall make available to Members an electronic enrollment process via the www.pehp.org website. PEHP shall also furnish to the Employer appropriate enrollment forms for distribution to new Eligible Employees. Upon receipt and processing of enrollment information, PEHP will distribute identification/prescription cards and Benefit brochures to Subscribers.

4.2 Reporting

4.2.1 These reporting provisions are subject to the confidentiality provisions of Section 6.

4.2.2 PEHP shall provide Employer with regular reports of the total amount paid to Providers in Employer's risk pool.

4.2.3 If Employer employs over 100 Subscribers, PEHP shall provide Employer with Employer-specific quarterly utilization reports. These Employers may request additional ad hoc reports as needed. However, to the extent that any specific requested reports may be unique and costly to produce, Employer agrees to pay PEHP the reasonable cost of assembling and preparing such additional information and reports, so long as the cost of any such report has been made available to Employer in advance and Employer has agreed in writing to pay such costs. PEHP may decline to produce reports if PEHP determines that doing so would violate state or federal law.

4.2.4 If Employer employs over 100 Subscribers, Employer and/or its designated Business Associates, as defined by HIPAA, shall be entitled, upon written request from Employer, to receive a copy of individual data pertaining to Employer in accordance with Utah Code Ann. § 49-11-618 and applicable Board resolutions for the sole purpose of reviewing claims and utilization experience for individuals covered by the program. PEHP shall not provide diagnosis information unless specifically requested by Employer, and Employer has demonstrated to the satisfaction of PEHP that the individual diagnosis is essential to the review process, in which case, PEHP may require a separate release statement. Employer hereby agrees to never share or otherwise divulge this individual data to any other person or unit of government, unless subpoenaed by a court or governmental entity having proper jurisdictional authority. When requesting this data, Employer will designate an officer or employee responsible for receipt and custody of the data and hereby agrees to indemnify and hold PEHP harmless against any claims, loss, damage, injury or other liability resulting from the disclosure of confidential medical data by any officer or employee of Employer.

4.2.5 Subject to the foregoing provisions, PEHP may provide specialized or additional reports to Employer, at Employer's request. PEHP may charge a fee to Employer for such special reporting requests as negotiated between the parties.

4.3 Record Retention and Review

4.3.1 PEHP shall maintain, or cause to be maintained, records covering claims submitted to PEHP hereunder as well as payment disbursed by it. The records shall be maintained for the same period of time that PEHP retains like records in connection with its claims administration.

4.4 Claims Payment, Customer Service and Appeals

4.4.1 PEHP shall adjudicate claims within forty-five (45) days upon receipt of all information necessary to accurately make a claim determination pursuant to PEHP's policies and procedures. Necessary information to adjudicate claims shall include, but is not limited to, information regarding coordination of benefits ("COB") from the primary insurance carrier, if applicable.

4.4.2 PEHP shall notify Members of paid or rejected claims and the reason for the rejection through an explanation of benefits, which shall be sent within one (1) week of PEHP's adjudication of the claim.

4.4.3 PEHP shall advise and aid claimants in meeting requirements for additional information and proper completion of claim forms.

4.4.4 PEHP shall maintain customer service staff and telephone numbers to provide information and response to inquiries of Members regarding program coverage and Benefits as well as specific information concerning claims, such as: status of claim, date paid/denied, amount, and Provider.

4.4.5 PEHP shall provide a website with general Plan information, specific claims information, and cost tools for evaluating and finding Providers.

4.4.6 PEHP shall discuss claims, where applicable, with physicians and other Providers of services.

4.4.7 PEHP shall obtain and furnish information, as necessary, regarding non-duplication of payment or COB.

4.4.8 PEHP will correct payment of claim errors for up to 12 months following the adjudication of a claim. For claims involving COB, PEHP will have up to 15 months following the adjudication of such claims to make adjustments. These time frames will not apply in instances where PEHP determines that the claims were paid due to fraud.

4.4.9 PEHP shall provide a claims adjudication and appeals process to resolve any disputes regarding Benefits under this Agreement. Members and Providers are required to cooperate with this process in any dispute with PEHP as outlined in the Master Policy attached in Appendix A.

4.4.10 PEHP shall provide additional Member Services, including Case Management, Disease Management, and Wellness Programs.

4.4.11 If Employer requests for correctly-paid claims to be reprocessed, Employer agrees to pay the administrative costs of reprocessing in accordance with PEHP's policies and procedures.

4.5 Information for Members

4.5.1 Employer, with cooperation from PEHP, shall produce any required forms or documents required by law to be distributed to Employees. Employer shall bear the responsibility to distribute such documents, in accordance with Section 3.4. PEHP may assist Employer with creation and production of documents, as specified in this Section.

4.5.2 PEHP shall assist Employer in its distribution by making available Plan-specific Benefits Summaries, Master Policies, Rates, forms and documents online at www.pehp.org, which will include the ability for Members to check status of claims and other information.

SECTION 5 – FUNDING

5.1 Self-Funded Status

5.1.1 Employer acknowledges and agrees that through this Agreement Employer participates in a self-insured plan, and that plan is part of a self-insured risk pool. Employer maintains the financial risk associated with that plan and the risk pool. Such risk includes, but is not limited to claims expenses for covered Benefits and any interest required to be paid.

5.1.2 Risk pool reserves held by PEHP are owned by, returned to, and credited for interest earnings to Employer in accordance with Section 5.3 and Appendix A.

5.2 Establishment of Rates

5.2.1 PEHP shall have sole discretion to determine Rates, which are set forth in Appendix A. The Rates will remain the same until the end of the plan year. However, upon notice to Employer, PEHP may reasonably modify the Rates mid-year if federal or state laws or regulations mandate an adjustment of Benefits under the Agreement, or if contingency reserves fall below the level required by the PEHP actuary.

5.2.2 It is understood and agreed that Appendix A outlines the Rates to be paid by Employer for the Plan(s) in which Employer participates during the current term. Rates include administrative fees and reinsurance fees as determined necessary by PEHP, and as listed in Appendix A. The PEHP rate setting process takes into account all of the health experience of the Employer, including but not limited to, the health experience of Employees, Dependents, Early Retirees, LTD Participants, and other Members covered under active, early retiree, and/or COBRA Coverage.

5.2.3 It is further understood and agreed that PEHP will provide notice to Employer of estimated regular Rate changes ninety (90) days prior to the end of the contract term, with the Rate change to be effective on the date of renewal of the plan year.

5.2.4 Notice of Rate increases relating to Medicare Supplement programs offered by PEHP will be provided by PEHP unless Medicare benefits change information has not yet been made available to PEHP by the Medicare authorities. All changes will become effective on January 1 of each year.

5.3 Reserves

5.3.1 Pursuant to Utah Code Annotated § 49-20-301, PEHP plans "shall be maintained on a financially and actuarially sound basis by payments from covered employers and covered individuals." Utah Code Annotated § 49-20-402(1) provides, "The reserves in a risk pool in a given fiscal year shall be maintained at the level recommended by the program's consulting actuary and approved or ratified by the Board. If the reserves drop below that level, covered employers in the risk pool are required to cure any deficiency in the reserve."

5.3.2 PEHP shall provide Employer with reserve recommendations from its consulting actuary upon request from Employer. PEHP shall provide Employer with financial statements regarding the level of reserves in Employer's risk pool.

5.3.3 If the reserves in Employer's risk pool drop below the recommendation of the consulting actuary, Employer shall be responsible to pay the difference (or the pro-rata difference if Employer is in a multi-Employer risk pool) to PEHP within fifteen (15) days following the request. In the case of a deficit in reserves, Employer agrees to pay PEHP interest of 1% per month for each month after the end of the month in which Employer maintains a deficit.

5.3.4 PEHP, upon recommendation of its consulting actuary, shall determine when “substantial excess reserves” have been accrued in accordance with Utah Code Annotated § 49-20-402. In such a case, and upon Board approval, PEHP shall refund reserves to Employer (on a pro-rata basis if Employer is in a multi-Employer risk pool) in a manner approved by the Board.

5.4 Claims Reinsurance

5.4.1 All Employers participating in PEHP health plans shall participate in a self-funded PEHP Reinsurance Risk Pool governed by the Utah State Retirement Board (the "Board"), as described in Appendix A.

5.4.2 The reinsurance fee associated with the PEHP Reinsurance Risk Pool is included within the Employer’s Rate and includes both a specific stop loss and aggregate reinsurance cost. The Reinsurance fee is set forth in Appendix A. Reinsurance fees are not self-insured, and the Employer shall have no recourse to recover any of these amounts paid.

5.5 Administrative Costs

5.5.1 Employer is responsible to pay its share of administrative costs on a PMPM basis. The administrative fee is included in the Employer Rate, according to the schedule in Appendix A. Administrative fees are not self-insured, and Employer shall have no recourse to recover any of these amounts paid.

SECTION 6 – CONFIDENTIALITY

6.1 HIPAA. The parties agree that the acts, duties and obligations required by this Agreement shall be performed in compliance with the Privacy and Security Rules as promulgated under HIPAA.

6.2 Utah Law. Employer understands that under Utah Code Annotated § 49-11-618, “All data in the possession of [PEHP] is confidential, and may not be divulged by [PEHP] except as permitted by board action.” Employer acknowledges and agrees that this Agreement is subject to this rule of confidentiality.

6.3 Definition of Data. For the purpose of this Agreement, "data" means any information pertaining to Employer’s participation with PEHP, Plan Rates, this Agreement, PEHP or its business practices, or the personal health information (as defined by federal law) of any individual participating in the Plan administered by PEHP.

SECTION 7 – TERM AND TERMINATION

7.1 Term of Agreement

7.1.1 Unless sooner terminated as herein provided, this Agreement shall be effective for a one year term and pertain to claims incurred during the period May 1, 2017 through April 30, 2018.

7.1.2 This Agreement shall be renewed automatically for one year terms unless Employer notifies PEHP of its intent to terminate as provided herein.

7.2 Termination

7.2.1 This Agreement, and coverage for all Members under this Agreement, can terminate for the reasons listed below.

7.2.2 This Agreement may be terminated by Employer by providing PEHP with written notice prior to the Employer's open enrollment period for the next one year term. PEHP will not accept retroactive termination dates.

7.2.3 PEHP may immediately terminate Employer's coverage upon written notice if PEHP determines that Employer is in breach of this Agreement. The following circumstances constitute a breach:

a. Employer fails to pay the required Rates in accordance with this Agreement;
b. Partial payment will be treated as nonpayment unless PEHP, at its sole discretion, indicates otherwise in writing;
c. Employer performs an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact under the terms of the coverage;
d. Employer's status changes to an entity that is not a political subdivision of the State of Utah;
e. Employer's membership in an entity through which this Agreement was made available ceases; or
f. Employer fails to satisfy the minimum Employer participation requirements in Section 2.1.6 of this Agreement.

7.2.4 Employer agrees that if proper written notice of termination is not given within the designated time parameters, a penalty of up to one percent (1%) of total annual Rate may be assessed on Employer at the sole discretion of PEHP.

7.2.5 It is Employer's responsibility to provide Subscribers a 30-day written notice of the Agreement's termination. PEHP will provide a sample notice upon request.

7.2.6 Upon termination or expiration of this Agreement, PEHP shall continue to process and pay claims for services obtained or charges incurred by Employer's Members prior to the date of termination or expiration of this Agreement for a period of 12 months after the date of termination ("Run-Out Period"). PEHP shall not pay for Services obtained or charges incurred after the date of termination, regardless of when a condition arose and despite care or treatment anticipated or already in progress.

7.2.7 If Employer breaches this Agreement in accordance with Section 7.2.3 of this Agreement, which results in termination of this Agreement, PEHP shall pay no further claims, regardless of the date incurred. Employer shall be responsible for any such claims. Employer shall be responsible to pay

PEHP for all reinsurance and administrative costs due prior to the date of termination, regardless of any other provision in this Agreement.

7.2.8 Upon termination of this Agreement, Employer shall be responsible for any deficits in the risk pool as determined by PEHP.

SECTION 8 – GENERAL TERMS

8.1 Interpretation. The attached Appendices are complementary to this Agreement and what is called for by any one of them shall be binding as if called for by all. In the event of any inconsistency between the provisions of the Agreement and the documents accompanying this Agreement, the inconsistency shall be resolved by giving precedence first to the Appendices and then to this Agreement. This Agreement will be interpreted and enforced according to the laws and regulations of the State of Utah and any applicable federal laws or regulations. If an inconsistency exists between the Agreement and any applicable law, this Agreement will be construed to include the minimum requirements of the applicable law.

8.2 Indemnification. PEHP agrees to indemnify Employer from and against any claims or other liability, including attorney fees, based upon PEHP's failure to comply with its obligations under the Agreement. Employer agrees to indemnify PEHP from and against any claims or other liability, including attorney fees, based upon Employer's failure to comply with its obligations under the Agreement.

8.3 Amendment and Assignment. As benefits under this Agreement may be modified from year to year, this Agreement may be modified or amended unilaterally by PEHP within 30 days prior to a new plan year by providing Employer with written notice of the Amendment. If Employer objects to any unilateral amendments, Employer shall inform PEHP in writing to its objection within 30 days of receipt of the amendment. At all other times of the plan year, and for all other amendments or modifications to this Agreement, this Agreement shall be amended only by a written instrument executed by duly authorized officers of the parties hereto. This Agreement may not be assigned by either party without the written consent of the other party.

8.4 Default. If either party defaults in the performance of this Agreement or any of its obligations hereunder, the defaulting party shall pay all costs and expenses, including reasonable attorney's fees, which may arise or accrue from enforcing the Agreement or from pursuing any remedy provided hereunder.

8.5 Force Majeure. Neither party will be responsible for a delay in performing its obligations under the Agreement due to circumstances reasonably beyond its control, such as natural disaster, epidemic, riot, war, terrorism, or nuclear release.

8.6 Dispute Resolution. This Agreement is entered into in the State of Utah and shall be governed by the laws of said state, notwithstanding any conflicts of laws principles. Any dispute arising out of this

Agreement will be subject to the exclusive jurisdiction of the administrative hearing process found in Utah Code Annotated § 49-11-613.

8.7 Conflict of Interest. PEHP represents that it has not knowingly influenced, and hereby promises that it will not knowingly influence, an Employer officer or employee, or former Employer officer or employee, to breach any ethical standards applicable to Employer. Employer represents that it has not knowingly influenced, and hereby promises that it will not knowingly influence any PEHP officer or employee or former PEHP officer or employee to breach any ethical standard applicable to PEHP.

8.8 Severance. In the event any portion of this Agreement is determined to be unconstitutional, unlawful or otherwise unenforceable in the State of Utah, only the unconstitutional portion of the Agreement will be severed and the remaining portion of the Agreement will continue in effect and be binding on the Parties, provided that such holding of invalidity or unenforceability does not materially affect the essence of the Agreement.

8.9 Notice.

8.9.1 Any notice required herein of PEHP shall be addressed to Employer at the address listed in Appendix A, and when required of Employer, shall be addressed to PEHP, Marketing Department, Public Employees' Health Program, 560 East 200 South, Salt Lake City, Utah 84102-2004, or kurt.murray@pehp.org (or current Marketing Manager).

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

8.9.3 Any notice PEHP is required to send will be sufficient if:

a. For notice to Employer, notice is sent to the address listed in Appendix A;
b. For notice to a Subscriber, notice is sent to the address PEHP has on record; and
c. For notice to a Dependent, notice is sent to the Subscriber.

8.9.4 Any notice Employer is required to send will be sufficient if sent to the address listed above.

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

8.11 Workers' Compensation Insurance. The Agreement does not provide or replace workers' compensation coverage for Employer's Employees. Employment-related injuries are not covered under the Agreement.

8.12 Relationship of the Parties. This Agreement is a contract for services and does not create an agency relationship. Employer does not have the authority to act as PEHP's agent. PEHP is not Employer's agent for any purpose.

SECTION 9 – DEFINITIONS

9.0 In General. This Agreement 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.

9.1 Adult Designee. If Employer accepts Adult Designees as Dependents, the qualifications agreed upon by Employer and PEHP will be included in Appendix A.

9.2 Agreement. This Employer Health Insurance Agreement, including the Employer Application and all other documents expressly referred to and incorporated by reference.

9.3 Benefit(s). The payments and privileges to which Members are entitled by this Agreement.

9.4 Continuation or COBRA Coverage. Coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and/or coverage allowed under Utah Code Annotated § 31A-22-722 (Mini-COBRA).

9.5 Conversion Coverage. Coverage provided under Utah Code Annotated § 31A-22-723.

9.6 Dependent(s). An Employee's lawful spouse (or Adult Designee if allowed by Employer) and any child who meets the Eligibility criteria under this Agreement.

9.7 Effective Date. The date on which coverage for a Member begins.

9.8 Employee. An individual employed by Employer.

9.9 Employer Plan (or "Plan(s)"). The group health and/or other Benefit plan(s) elected and sponsored by Employer under this Agreement and attached in Appendix A.

9.10 Eligible, Eligibility. The criteria or standards, established by Employer and/or PEHP under this Agreement and Appendix A, in order to participate in a PEHP health plan.

9.11 HIPAA. The Health Insurance Portability and Accountability Act found at 45 C.F.R. §§ 160 and 164, as amended.

9.12 Master Policy. The document(s), considered part of this Agreement, which describe(s) the terms and conditions of the health insurance Benefits with PEHP, including the Benefit Summary, and which is available online at the address listed in Appendix A, or by request.

9.13 Member. As defined in the Master Policy attached in Appendix A, a Subscriber, including an Employee, Early Retiree, LTD Participant, COBRA Participant, Conversion Coverage Participant, and any Dependent, when properly enrolled in the Plan and accepted by PEHP.

9.14 PHSA. The Public Health Service Act of 1944, codified in United States Code, Title 42, as amended.

9.15 PPACA. The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, including the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, as amended.

9.16 Provider. A vendor of healthcare Services as defined in the Master Policy.

9.17 Rate(s). The amount paid periodically by Employer and/or Subscribers to PEHP as consideration for providing Benefits under the Plan. The Contribution rate is specified in Appendix A.

9.18 Service(s). Services provided by a Provider, including medical practices or care, treatment, tests, supplies, equipment, devices, or drugs.

9.19 Subscriber. An Employee that enrolls with PEHP, as defined in the Master Policy.

SECTION 10 – SIGNATURE PAGE

EXECUTED this _____day of _____, 20__.

UTAH RETIREMENT SYSTEMS
PUBLIC EMPLOYEES HEALTH PROGRAM

By_____
Chet Loftis
Director, Public Employees Health Program

EXECUTED this _____day of _____, 20__.

[Employer Name]

By _____
[Name] Kim S. Ulibarri
[Title] Chief People Officer

By _____
[Name]
[Title]

By _____
[Name]
[Title]

Legally Sufficient

_____
Michael Bell, Assistant Attorney General

APPENDIX A

Plan Year: May 1, 2019 to April 30, 2020

A-1 Benefits

A Employer Plans/Programs

Master Policy & Benefit Grid – members can access at www.pehp.org or on Employer's website. Benefit Grids are attached.
Summary of Benefits & Coverage (SBC) – members can access at www.pehp.org or on Employer's website.
Provider Directory - Provider directories for the Employer plans are found online at www.pehp.org. Provider directories are subject to change without notice. PEHP shall make reasonable efforts, as determined by PEHP, to inform Employer and Members if a material disruption shall occur to provider networks during the term of this Agreement.

Wellness Programs

PEHP offers the Healthy Utah wellness program for Employer. If Employer elects to offer additional wellness programs to employees, Employer shall be solely responsible for any federal law compliance related to such additional program, included taxability of rebates and tracking applicable wellness limits for employees.

Legal Guardianship

Employer has elected to allow children under guardianship to remain covered by PEHP between ages 19-26 like natural born children. In order to continue enrollment, the guardian child must have been enrolled on the Employer's coverage prior to being 18 years of age and otherwise have met the qualifications for coverage as a guardian child. PEHP shall inform the Employer if a guardian child over the age of 19 has enrolled with PEHP on the monthly bill to Employer. The Employer understands that it may need to impute income to the employee if the guardian child does not qualify as a tax dependent under federal law. Employer acknowledges that it shall be solely liable for any tax consequences related to coverage of a guardian child over the age of 19, and that PEHP maintains no responsibility of any kind for any taxes which may be owed as a result of this coverage.

LTD Premium Waiver or Stipend

Employer has elected not to provide this benefit.

B Vesting Standards for LGRP

1. Employer hereby acknowledges that it participates in the Local Governments Risk Pool ("LGRP") sponsored by PEHP, which is a multi-employer self-funded risk pool. Participation in the LGRP requires meeting PEHP's vesting requirement, which include:
    a. An Employer is vested with PEHP when either:
        i. the Employer provides two years of specific plan benefits and claims costs to PEHP to appropriately determine rates; or
        ii. the Employer continuously participates with PEHP in the LGRP for three years.
    b. If an Employer is vested with PEHP, the Employer may terminate this agreement with no further obligation to LGRP. At the time of termination, the Employer shall not receive any LGRP reserve funds, and shall not pay any deficits incurred or paid by Employer to LGRP.
    c. If Employer is not vested with PEHP and terminates this Agreement before becoming vested, Employer will immediately pay PEHP for any deficits incurred during its participation with LGRP. Deficits mean the difference between claims paid by PEHP, including administrative costs, and the rates paid by Employer, including all Employer allocated investment earnings or deficits. Deficits shall be solely determined by PEHP. Any calculations regarding deficits will include Employer's claims presented and paid by PEHP over the 12 months following Employer's termination of this Agreement.
    d. Any surpluses attributable to the Employer (when rates exceed premiums), whether vested or non-vested, will remain with PEHP for the benefit of the Employers participating in the LGRP.

2. Employer IS deemed vested by PEHP.

C Reinsurance

1. Each Employer shall participate in the PEHP Reinsurance Risk Pool and pay the applicable fees for such services. Reinsurance fees are included in the Employer's Rate, as outlined in Appendix Section A-2. The PEHP Reinsurance Risk Pool covers for the Employer:
    a. Medical and pharmacy claims eligible under this Agreement and the Master Policy, according to the following limits and subject to the exclusions herein;
    b. Large claims exceeding $100,000 annually, calculated on an incurred in 12 months and paid in 15 months basis (specific stop loss coverage);
    c. Aggregate risk pool claims that total between 120% to 135% of expected risk pool claims (aggregate stop loss coverage); and
    d. Other purposes that PEHP and the Board may approve.

2. The PEHP Reinsurance Risk Pool specifically excludes coverage for any claims incurred:
    a. Outside of the eligibility standards of this agreement or the Master Policy;
    b. For benefits not specifically covered by the Master Policy;
    c. That are excluded by PEHP's commercial reinsurance carrier;
    d. By an Employee or Eligible Dependent who has committed fraud, criminal acts, or other breach of the Master Policy, as described in Section 2.1.7 of this Agreement; or
    e. That are approved by Employer for processing and payment, despite being ineligible for payment under this Agreement, the Master Policy or the Employer plan benefit documents that have been approved by PEHP.

3. If the Employer approves claims or benefits not covered by this Agreement or the Master Policy, the Employer shall be responsible for all claims expenses associated with such charges. Notwithstanding any other provision of this Agreement, PEHP shall have no liability to pay any claims, benefits or make other payments that are not specifically stated in this Agreement or the Master Policy.

4. PEHP shall evaluate claims and pay reinsurance amounts on a monthly basis.

D. IRS Reporting

1. Employer has determined to calculate and file ACA reports as required by federal law.

A-2 Rates

Summit Exclusive Traditional	**SINGLE**	**DOUBLE**	**FAMILY**
	$562.06	$1,386.16	$1,967.39

A-3 Additional Terms

A Following termination of this Agreement, PEHP shall pay claims incurred prior to termination of this Agreement for 12 months.

B Conflict of Interest – Employer acknowledges that PEHP is a public employer, and that no employee or officer is related to any employee or officer of PEHP within two degrees of consanguinity except as has been previously disclosed to PEHP.

C Additional Reporting Requests - PEHP shall provide regular reports to Employer as described in the Agreement. PEHP may provide additional reports to Employer as negotiated between Employer and PEHP. If such additional reports are agreed upon and authorized by PEHP, Employer agrees to pay PEHP the reasonable costs of producing such reports at the rate of $20/hour and $.10/page for printed reports. In accordance with Section 4.2.4, PEHP may provide personal health information of Employees or Dependents to another Covered Entity at the written request of the Employer as allowed by HIPAA. PEHP may provide personal health information of Employees or Dependents to Employer's Business Associates at Employer's written request in accordance with Section 4.2.4 of this Agreement.

Notwithstanding the payment schedule above, Employer has requested and PEHP has agreed to provide identifiable claims data to Employer's medical data warehouse vendors for health care and on-site clinic predictive modeling and utilization review. Such data shall be provided on a monthly basis by the 5th day of each month for the previous month. For such reports, vendor shall provide specific data parameters to PEHP at least 30 days prior to the first report being provided. PEHP shall notify Employer of the data parameters. Upon PEHP's receipt of a valid Business Associate Agreements between Employer and vendors, PEHP will begin to prepare the data reports to send to vendors .

D Notice to Employer – Address: 669 W. 200 S. SLC, UT 84101

A-4 Employer Portal –

The PEHP Employer Portal through the website pehp.org if available for Employers 24 hours per day, seven days a week at no additional administrative charge to Employer. PEHP may temporarily suspend PEHP Employer Portal access and services at its discretion for maintenance or other quality control issues.

Employer will use PEHP Employer Portal in a manner consistent with applicable laws. Employer is solely responsible for all use of Employer's PEHP Portal website account and for any violation of the terms of this section.

For purposes of this section, Employer's "use"

(a) means

(i) use by Employer's employees, agents or contractors;

(ii) use by Employer's employees, agents or contractors, who following their separation from employment or engagement from Employer were enabled by the use of Employer's signature obtained in their employment or engagement;

(iii) use by any person who obtains Employer's signature because of Employer's negligence; and

(iv) use by any person who obtains Employer's signature from any person described in (i), (ii) or (iii) above; and

(b) specifically excludes the unauthorized use of Employer's PEHP Employer Portal website account by any person who is not described in (a)(i) – (iv) above or who accesses or uses Employer's signature without authorization from Employer."

Appendix B

The Effective Date is the first day of the month following the Employer Waiting Period. Employees classified as Operators have a 30-day orientation period. Upon completion of the orientation period, the Employer Waiting Period begins and lasts for 30 days.

Once approved, please forward to Contract Administrator

UTA

CONTRACT ROUTING SHEET

Agenda Item No.:
Board Review Date:

CONTRACT SECTION

1) Contract/P.O. No. **16-2067TP-1** *(Assigned by Purchasing)* Contract Administrator: **Teressa Pickett**
Project Manager: **Jacob Gomez**

2) Contract Type ☐ A. A&E/Design ☐ B. Blanket PO ☐ C. Construction ☐ D. Goods ☐ E. Modification ☑ E. Option ☐ F. Other _____ ☐ G. Renewal ☐ H. Services ☐ I. Task Orders

3) Procurement Method ☐ RFQ (Quote) ☐ IFB (Low Bid) ☐ RFQU (Qualification) ☑ RFP (Best-value) ☐ Sole source ☐ Other: _____

4) Contract Title **Employer Health Insurance Agreement - Bargaining**

5) Description / Purpose *(of contract or project)* **Employer Health Insurance Agreement between UTA/ATU Joint Insurance Trust and Public Employees' Health Program (PEHP) for Medical Healthcare Benefits.**

6) Contractor Name **Public Employees' Health Program (PEHP)**

7) Effective Dates Beginning: **05/01/19** Ending: **04/30/20**

8) Option to renew? ☑ Yes ☐ No Renewal terms: One year term (starting 5/1/17) with an option to renew every year up to a total of 5 years, ending 4/30/2022.

FINANCIAL SECTION

9) **Total Board Approval Amount:**
- 9a) Current Contract Value: $ 14,000,000.00
- 9b) Amendment Amount: $ 7,000,000.00
- 9d) New Contract Value (including all amendments) $ 21,000,000.00
- 9e) Is the amount an estimate? ☑ Yes ☐ No
  (Estimate if per transaction cost)
- 9f) *If estimated, how was the estimate calculated?* The total amount is dependent on how many employees choose the PEHP program for their insurance.

10) Is the amount a one-time purchase or annual recurring purchase? ☐ One-time ☑ Recurring

11) Account Code **JIC** Capital Project Code

12) Budgeted? ☑ Yes ☐ No Budget amount: **$ 21,000,000.00**

13) Will this contract require support from another department? ☑ Yes ☐ No

14) If so, is the other department(s) aware of this contract and the required support? ☑ Yes ☐ No

15) If box 2a or 2c is checked, has the Qualified Heath Insurance Certificate been verified? N/A ☐ Yes ☐ No

SIGNATURE SECTION

	Route to?		Initials	
Contract Compliance	☑ Yes			Lisa Bohman
Accounting Review	☑ Yes	☐ No		Bryan Steele
IT Review (IT software or hardware)	☐ Yes	☑ No		N/A
Up to $10K Manager/Program Manager	☑ Yes	☐ No		Jacob Gomez
Up to $50K Dir, Sr. Mgr, RGM, or Chief/VP	☐ Yes	☑ No		N/A
Up to $100K Chief/VP, or Dir, Sr. Mgr, RGM (Capital, Maint., Ops. only)	☑ Yes	☐ No		Kimberly S. Ulibarri
Over $100K Executive Director	☑ Yes	☐ No		W. Steve Meyer
Over $200K Board Approval	☑ Yes	☐ No		Approval Date

If Yes, route to the Sr. Supply Chain Manager for board meeting agenda and approval

Employer Health Insurance Agreement

Between UTA/ATU Joint Insurance Trust
and
Utah Retirement Systems Public Employees' Health Program
May 1, 2019 through April 30, 2020

Table of Contents

SECTION 1 – INTRODUCTION

1.1 Contract

1.1.1 This Employer Health Insurance Agreement ("Agreement") is made and entered into, pursuant to Utah Code Annotated Title 49, Chapter 20, by and between __UTA/ATU Joint Insurance Trust____ ("Employer"), a body corporate and politic of the State of Utah, and the UTAH RETIREMENT SYSTEMS, by and through its Employer benefit and insurance division, the PUBLIC EMPLOYEES' HEALTH PROGRAM ("PEHP").

1.1.2 In exchange for Employer's payment of Rates, PEHP provides defined healthcare Benefits to Members. Any payment of Rates will constitute Employer's agreement to the terms of this Agreement, regardless of whether Employer has actually signed the Agreement.

1.1.3 NOW, THEREFORE, for and in consideration of the agreements and provisions hereinafter contained, the parties hereby agree and enter into this Agreement.

1.2 Scope of Agreement

1.2.1 PEHP will make available to Employer's Eligible Employees, , and Eligible dependents, the health and prescription drug plans listed in Appendix A. All terms, definitions, and conditions of the health and prescription drug plans are hereby incorporated into this Agreement.

1.2.2 Any and all other documents attached hereto are hereby made a part of this Agreement as fully as though detailed herein.

1.2.3 The parties acknowledge that for purposes of paying fees required by the Affordable Care Act, PEHP shall act as the plan sponsor of Employer's benefit plans. All programs and plans offered by PEHP are subject to change in order to adapt to the changes and trends in the health care industry. Further, the Benefits in this Agreement are not necessarily the benefits of the Employer's previous insurance carrier. This contract does not guarantee benefits payable under the previous carrier will be payable under PEHP.

1.2.4 No Member of PEHP has a vested right to any Benefits. Changes to the Agreement may be made without notification, consultation or the consent of Members. However, material mid-plan year changes to the Benefits must be made with approval of the Employer and with 60 days notice to the Members. The rights and interest of Members at any particular time depend on the Agreement terms in effect at that time.

1.2.5 PEHP may adopt reasonable policies, rules and procedures to help in the administration of the Agreement. Employer agrees to abide by all such reasonable policies, rules, and procedures that are not inconsistent with the Agreement.

1.2.6 PEHP has discretion to determine Eligibility for Benefits and to interpret the terms and conditions of the Benefit plan(s). PEHP's determinations under this Section do not prohibit or prevent a Member from seeking an appeal of claims or an administrative review by following the appeals procedure established by the Master Policy and Utah Code Ann. § 49-11-613.

SECTION 2 – ELIGIBILITY AND ENROLLMENT

2.1 Eligibility

2.1.1 PEHP shall provide coverage to those Eligible Employees and their Eligible Dependents in accordance with the terms of the Employer Eligibility Standard in Appendix B

2.1.2 In consultation with PEHP and within PEHP's stated Eligibility parameters, if Employer has 100 Subscribers or more, Employer shall decide which categories of Employees and Dependents are Eligible to become Members and establish related Eligibility requirements. Employer agrees to implement standards that are nondiscriminatory and is solely liable if any standards are determined to be discriminatory.

2.1.3 Employer has provided PEHP with its Eligibility standards. Employees returning from a leave of absence who have waived coverage due to the leave of absence are eligible to be reinstated to coverage on the first day of the month following their return to work.

2.1.4 Eligibility standards (including termination standards) determined by Employer must be reported to and approved by PEHP each plan year, at least ninety (90) days prior to the start of the plan year. **Employer shall inform PEHP of its eligibility standards on the PEHP Benefit Selection Form.** If Eligibility standards vary from plan year to plan year, PEHP may revise Rates correspondingly, in accordance with sound actuarial principles.

2.1.5 Employer may not change, extend, expand, or waive the Eligibility criteria without first obtaining the advance, written approval of an officer of PEHP. Eligibility standards may not be changed mid-plan year.

2.1.6 Employer's Eligibility parameters must meet PEHP's criteria which include the following:

- Eligible Employees with other coverage may waive coverage with the Employer under the Plan;
- At least 80% of Eligible individuals, who have not demonstrated proof of other coverage, must participate in the Plan, or, if Employer employs fewer than five (5) individuals, 100% of individuals must participate in the Plan;
- Independent contractors are not Eligible;

Only individuals who continuously satisfy the Eligibility criteria of the Agreement may be enrolled and continue as Members. Employer, Subscribers, and their Dependents are responsible for obtaining and submitting to PEHP evidence of Eligibility.

2.1.7 Notwithstanding this Section 2, PEHP reserves the right to deny coverage to an otherwise Eligible Employee and/or their Eligible Dependent(s), in accordance with the PEHP Master Policy, if that individual commits fraud upon PEHP, forges prescriptions, commits criminal acts associated with coverage, misuses or abuses Benefits or breaches the conditions of the PEHP Master Policy. Notwithstanding any other provision of this Agreement, if such an individual retains Coverage with PEHP at the request of an Employer after a recommendation by PEHP to address either the fraud, criminal acts associated with coverage, or a breach of the PEHP Master Policy, Employer shall be solely and completely responsible for all claims incurred for this individual. In such a circumstance, the individual's claims shall be adjudicated separately from the Employer's experience, and no claims for this individual, either in specific or aggregate, shall be eligible for payment by PEHP reinsurance.

2.2 Enrollment Requirements

2.2.1 In order for an Eligible individual to receive Benefits, Employer must enroll the individual, PEHP must accept the individual as a Member, and Employer must pay the applicable Rates. Employer agrees to limit enrollment to Eligible Employees and their Dependents.

2.2.2 Any Employee who does not enroll in the Employer Plan during their first 30 days of any applicable waiting period or during a special enrollment period through Employer's enrollment system, will not be Eligible to enroll until the next annual enrollment period.

2.2.3 Except as otherwise provided in this Agreement, enrollment and enrollment changes for existing Employees and their Dependents may only be made during an open enrollment period.

2.2.4 PEHP shall allow for a special enrollment period for specific circumstances listed in Section 2.2.5. The terms governing special enrollment for PEHP are also contained in the Master Policy attached hereto as part of Exhibit A.

2.2.5 Employer must notify PEHP within 60 days whenever there is a change in a Member's family and or employment status that may affect Eligibility or enrollment. Family or employment status includes the following events:

a) Adoption of a child, birth of a child, or gaining legal guardianship of a child;
b) Child loses Dependent status;
c) Death;
d) Divorce;
e) Marriage
f) Involuntary loss of other coverage;
g) Member called to active military duty;
h) Member receives a Qualified Medical Child Support Order (QMCSO);
i) Reduction in employment hours;
j) Member takes, returns from, or does not return from a leave of absence; and
k) Termination of employment.

2.2.6 If Employer fails to notify PEHP within 30 days of a Member's termination from employment or other family and/or employment change that results in the loss of a Member's Eligibility, Employer agrees to promptly pay PEHP any amounts paid as Benefits for such Member after the Member became ineligible and before PEHP was notified.

2.2.7 PEHP agrees to supply certification of creditable coverage to all terminated Subscribers and their Eligible Dependents losing coverage in accordance with federal law. The terms governing certification and disclosure are contained in the Master Policy attached hereto as part of Exhibit A.

2.2.8 Employer hereby agrees the Effective Date for new Employees is based upon the Employer's enrollment polices as stated on the Group Renewal Form.

2.2.9 PEHP will enroll Dependents as a result of a valid court order. Any requirement for the Plan to comply with court orders, including Qualified Medical Child Support Orders (QMCSOs) and/or Divorce Decrees is Employer's responsibility. When Employer directs PEHP to enroll an individual on the basis of a court order, PEHP reserves the right to review and confirm that the order is qualified.

2.2.10 PEHP may decline to enroll Employees, former Employees, or Dependents who do not satisfy the Eligibility criteria of the Agreement. Also, PEHP may initially decline to issue coverage if Employer fails to meet the minimum enrollment or minimum contribution requirements.

2.3 Continuation of Coverage (COBRA / Mini-COBRA) and Conversion Coverage

2.3.1 Employer's Members who lose coverage under a Plan made available by PEHP may be permitted to continue such Coverage in accordance with the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), or Utah mini-COBRA, Utah Code Ann. § 31A-22-722 (collectively, "Continuation Coverage").

2.3.2 Employer agrees to administer Continuation Coverage according to state and federal law.

2.3.3 PEHP and Employer agree that if this Agreement is terminated, Continuation Coverage with PEHP will terminate. Employer will be responsible for obtaining alternate coverage for those Members who are receiving Continuation Coverage.

2.3.4 PEHP agrees to bill and collect Rates from Members for Continuation Coverage.

2.3.5 PEHP agrees to provide COBRA Coverage for the minimum time and only to the minimum extent required by applicable state and federal law. PEHP will not provide Continuation Coverage if Employer or the Member fails to strictly comply with all applicable notice and other requirements and deadlines.

SECTION 3 – RESPONSIBILITIES OF EMPLOYER

3.1 In General

3.1.1 In addition to the responsibilities addressed throughout this Agreement, Employer agrees to the following responsibilities and obligations.

3.2 Rate Payments

3.2.1 Employer is responsible to collect and remit Rates to PEHP. By remitting Rates to PEHP, Employer certifies to PEHP that the Employer/Employee Rate share complies with the affordability standards of PPACA. Other than as required by state or federal law, nothing contained in this Agreement shall obligate the Employer to contribute any specific percentage of the contribution, nor to provide any specified credits for sick leave conversion, etc. to any Employee.

3.2.2 To the extent Employer requires its Employees to contribute to Rates, Employer agrees to collect those contributions from its Employees and remit the same to PEHP together with a copy of a remittance report. Such contributions and report will be submitted to PEHP monthly following the appropriate payroll dates. By remitting Rates, Employer certifies that all Employees meet the Eligibility requirements agreed upon under this Agreement.

3.2.3 Employer's obligation to pay the full Rates to PEHP is not contingent upon Employer's ability to collect any percentage of the Rates that Employer requires to be paid by Subscribers.

3.2.4 Rates will be considered late if received more than forty (40) days after the date of the corresponding invoice from PEHP.

3.2.5 Notwithstanding any other provision of this Agreement, if Employer is late in any required payment to PEHP, PEHP shall assess Employer a 5% penalty on late payments.

3.2.5 Notwithstanding any other provision of this Agreement, if Employer fails to pay a required invoice to PEHP within sixty (60) days after the date of the corresponding invoice from PEHP, PEHP shall immediately suspend payment of claims until payment is made in full; in such case, the Employer shall be responsible for any payment to Providers, including any late fees, as applicable; or immediately terminate this Agreement in accordance with Section 7.2.

3.3 Employment Verification and Status

3.3.1 To the extent Employer is responsible to determine Eligibility standards under this Agreement, Employer agrees to provide those standards to PEHP at least ninety (90) days prior to the start of the Plan Year, as provided in Section 2.1.

3.3.2 Employer agrees to verify employment status and date of employment information contained in any new applications filed by Employees, and Employer agrees to inform PEHP of any change in Employee or Dependent status or of the termination of coverage of any Employee or Dependent, including any COBRA Qualifying Events, on a semi-monthly basis, in accordance with Section 2.4.

3.3.3 It is the responsibility of the Employer to obtain and maintain updated, accurate records specifying enrollment information, Member files, Eligibility information, Effective Dates, and Employee status information. Employer agrees, to the extent requested by PEHP, to provide PEHP with current and updated copies of all completed enrollment forms and other documentation as deemed necessary by PEHP.

3.3.4 Payment of Rates shall constitute Employer's certification that Employer and all its Members meet the Eligibility standards as outlined in Utah Code Annotated Title 49, Chapter 20, and as established under this Agreement.

3.4 Compliance

3.4.1 Employer is responsible for its own compliance with applicable laws, rules, and regulations, including requirements to provide information to Members about their coverage. This includes all applicable requirements under PHSA, HIPAA, PPACA, COBRA, and any other state and federal requirements that apply to the Plan.

3.4.2 Employer agrees to notify PEHP when Employer receives Medicare secondary payer information.

3.4.3 Employer shall distribute to Employees all forms, documents, and notices as required by law (i.e. Summary of Benefits and Coverage, Benefit Summaries). In accordance with Section 4.4, PEHP may assist Employer in the production of such forms, documents and notices. Employer maintains sole responsibility to ensure compliance with federal law.

3.5 Miscellaneous

3.5.1 Employer certifies it is a political subdivision of the State of Utah and that both Employer and its Eligible Employees qualify to participate with PEHP, and Employer agrees to notify PEHP prior to its losing Eligibility to participate with PEHP.

3.5.2 It is Employer's responsibility to provide Subscribers a 30-day written notice of the Agreement's termination.

3.5.3 Except as modified in this Agreement, Employer shall be responsible for all tax consequences or penalties resulting from participation in the PEHP plans or programs.

SECTION 4 – RESPONSIBILITIES OF PEHP

4.1 Plan Services

4.1.1 Employer hereby agrees that it is the sole responsibility and right of PEHP to contract with, negotiate policies, procedures, and plan provisions, in reference to physicians, hospitals, facilities, corporations, or other service Providers. PEHP agrees to establish and maintain its usual hospital and physician relations activities, Subscriber service activities, investigative and claim review procedures, legal review and defense services, and shall take all reasonable measures to prevent the allowance and payment of improper claims for Employer.

4.1.2 PEHP shall provide Employer with all administrative services provided by PEHP to its other policy holders. A monthly fee for administrative services shall be included in the Rate amount, on a Per Member Per Month ("PMPM") basis, at the Rate specified in Appendix A.

4.1.3 PEHP shall provide Reinsurance coverage as provided for in Section 5. PEHP will charge a monthly reinsurance fee, on a PMPM basis, at the Rate specified in Appendix A. The reinsurance fee is included in the Employer Rate.

4.1.4 At Employer's request, PEHP may facilitate an on site medical clinic for Employer's employees in accordance with the terms in Appendix B.

4.1.5 PEHP shall make available to Members an electronic enrollment process via the www.pehp.org website. PEHP shall also furnish to the Employer appropriate enrollment forms for distribution to new Eligible Employees. Upon receipt and processing of enrollment information, PEHP will distribute identification/prescription cards and Benefit brochures to Subscribers.

4.2 Reporting

4.2.1 These reporting provisions are subject to the confidentiality provisions of Section 6.

4.2.2 PEHP shall provide Employer with regular reports of the total amount paid to Providers in Employer's risk pool.

4.2.3 If Employer employs over 100 Subscribers, PEHP shall provide Employer with Employer-specific quarterly utilization reports. These Employers may request additional ad hoc reports as needed. However, to the extent that any specific requested reports may be unique and costly to produce, Employer agrees to pay PEHP the reasonable cost of assembling and preparing such additional information and reports, so long as the cost of any such report has been made available to Employer in advance and Employer has agreed in writing to pay such costs. PEHP may decline to produce reports if PEHP determines that doing so would violate state or federal law.

4.2.4 If Employer employs over 100 Subscribers, Employer and/or its designated Business Associates, as defined by HIPAA, shall be entitled, upon written request from Employer, to receive a copy of individual data pertaining to Employer in accordance with Utah Code Ann. § 49-11-618 and applicable Board resolutions for the sole purpose of reviewing claims and utilization experience for individuals covered by the program. PEHP shall not provide diagnosis information unless specifically requested by Employer, and Employer has demonstrated to the satisfaction of PEHP that the individual diagnosis is essential to the review process, in which case, PEHP may require a separate release statement. Employer hereby agrees to never share or otherwise divulge this individual data to any other person or unit of government, unless subpoenaed by a court or governmental entity having proper jurisdictional authority. When requesting this data, Employer will designate an officer or employee responsible for receipt and custody of the data and hereby agrees to indemnify and hold PEHP harmless against any claims, loss, damage, injury or other liability resulting from the disclosure of confidential medical data by any officer or employee of Employer.

4.2.5 Subject to the foregoing provisions, PEHP may provide specialized or additional reports to Employer, at Employer's request. PEHP may charge a fee to Employer for such special reporting requests as negotiated between the parties.

4.3 Record Retention and Review

4.3.1 PEHP shall maintain, or cause to be maintained, records covering claims submitted to PEHP hereunder as well as payment disbursed by it. The records shall be maintained for the same period of time that PEHP retains like records in connection with its claims administration.

4.4 Claims Payment, Customer Service and Appeals

4.4.1 PEHP shall adjudicate claims within forty-five (45) days upon receipt of all information necessary to accurately make a claim determination pursuant to PEHP's policies and procedures. Necessary information to adjudicate claims shall include, but is not limited to, information regarding coordination of benefits ("COB") from the primary insurance carrier, if applicable.

4.4.2 PEHP shall notify Members of paid or rejected claims and the reason for the rejection through an explanation of benefits, which shall be sent within one (1) week of PEHP's adjudication of the claim.

4.4.3 PEHP shall advise and aid claimants in meeting requirements for additional information and proper completion of claim forms.

4.4.4 PEHP shall maintain customer service staff and telephone numbers to provide information and response to inquiries of Members regarding program coverage and Benefits as well as specific information concerning claims, such as: status of claim, date paid/denied, amount, and Provider.

4.4.5 PEHP shall provide a website with general Plan information, specific claims information, and cost tools for evaluating and finding Providers.

4.4.6 PEHP shall discuss claims, where applicable, with physicians and other Providers of services.

4.4.7 PEHP shall obtain and furnish information, as necessary, regarding non-duplication of payment or COB.

4.4.8 PEHP will correct payment of claim errors for up to 12 months following the adjudication of a claim. For claims involving COB, PEHP will have up to 15 months following the adjudication of such claims to make adjustments. These time frames will not apply in instances where PEHP determines that the claims were paid due to fraud.

4.4.9 PEHP shall provide a claims adjudication and appeals process to resolve any disputes regarding Benefits under this Agreement. Members and Providers are required to cooperate with this process in any dispute with PEHP as outlined in the Master Policy attached in Appendix A.

4.4.10 PEHP shall provide additional Member Services, including Case Management, Disease Management, and Wellness Programs.

4.4.11 If Employer requests for correctly-paid claims to be reprocessed, Employer agrees to pay the administrative costs of reprocessing in accordance with PEHP's policies and procedures.

4.5 Information for Members

4.5.1 Employer, with cooperation from PEHP, shall produce any required forms or documents required by law to be distributed to Employees. Employer shall bear the responsibility to distribute such documents, in accordance with Section 3.4. PEHP may assist Employer with creation and production of documents, as specified in this Section.

4.5.2 PEHP shall assist Employer in its distribution by making available Plan-specific Benefits Summaries, Master Policies, Rates, forms and documents online at www.pehp.org, which will include the ability for Members to check status of claims and other information.

SECTION 5 – FUNDING

5.1 Self-Funded Status

5.1.1 Employer acknowledges and agrees that through this Agreement Employer participates in a self-insured plan, and that plan is part of a self-insured risk pool. Employer maintains the financial risk associated with that plan and the risk pool. Such risk includes, but is not limited to claims expenses for covered Benefits and any interest required to be paid.

5.1.2 Risk pool reserves held by PEHP are owned by, returned to, and credited for interest earnings to Employer in accordance with Section 5.3 and Appendix A.

5.2 Establishment of Rates

5.2.1 PEHP shall have sole discretion to determine Rates, which are set forth in Appendix A. The Rates will remain the same until the end of the plan year. However, upon notice to Employer, PEHP may reasonably modify the Rates mid-year if federal or state laws or regulations mandate an adjustment of Benefits under the Agreement, or if contingency reserves fall below the level required by the PEHP actuary.

5.2.2 It is understood and agreed that Appendix A outlines the Rates to be paid by Employer for the Plan(s) in which Employer participates during the current term. Rates include administrative fees and reinsurance fees as determined necessary by PEHP, and as listed in Appendix A. The PEHP rate setting process takes into account all of the health experience of the Employer, including but not limited to, the health experience of Employees, Dependents, Early Retirees, LTD Participants, and other Members covered under active, early retiree, and/or COBRA Coverage.

5.2.3 It is further understood and agreed that PEHP will provide notice to Employer of estimated regular Rate changes ninety (90) days prior to the end of the contract term, with the Rate change to be effective on the date of renewal of the plan year.

5.2.4 Notice of Rate increases relating to Medicare Supplement programs offered by PEHP will be provided by PEHP unless Medicare benefits change information has not yet been made available to PEHP by the Medicare authorities. All changes will become effective on January 1 of each year.

5.3 Reserves

5.3.1 Pursuant to Utah Code Annotated § 49-20-301, PEHP plans "shall be maintained on a financially and actuarially sound basis by payments from covered employers and covered individuals." Utah Code Annotated § 49-20-402(1) provides, "The reserves in a risk pool in a given fiscal year shall be maintained at the level recommended by the program's consulting actuary and approved or ratified by the Board. If the reserves drop below that level, covered employers in the risk pool are required to cure any deficiency in the reserve."

5.3.2 PEHP shall provide Employer with reserve recommendations from its consulting actuary upon request from Employer. PEHP shall provide Employer with financial statements regarding the level of reserves in Employer's risk pool.

5.3.3 If the reserves in Employer's risk pool drop below the recommendation of the consulting actuary, Employer shall be responsible to pay the difference (or the pro-rata difference if Employer is in a multi-Employer risk pool) to PEHP within fifteen (15) days following the request. In the case of a deficit in reserves, Employer agrees to pay PEHP interest of 1% per month for each month after the end of the month in which Employer maintains a deficit.

5.3.4 PEHP, upon recommendation of its consulting actuary, shall determine when “substantial excess reserves” have been accrued in accordance with Utah Code Annotated § 49-20-402. In such a case, and upon Board approval, PEHP shall refund reserves to Employer (on a pro-rata basis if Employer is in a multi-Employer risk pool) in a manner approved by the Board.

5.4 Claims Reinsurance

5.4.1 All Employers participating in PEHP health plans shall participate in a self-funded PEHP Reinsurance Risk Pool governed by the Utah State Retirement Board (the "Board"), as described in Appendix A.

5.4.2 The reinsurance fee associated with the PEHP Reinsurance Risk Pool is included within the Employer’s Rate and includes both a specific stop loss and aggregate reinsurance cost. The Reinsurance fee is set forth in Appendix A. Reinsurance fees are not self-insured, and the Employer shall have no recourse to recover any of these amounts paid.

5.5 Administrative Costs

5.5.1 Employer is responsible to pay its share of administrative costs on a PMPM basis. The administrative fee is included in the Employer Rate, according to the schedule in Appendix A. Administrative fees are not self-insured, and Employer shall have no recourse to recover any of these amounts paid.

SECTION 6 – CONFIDENTIALITY

6.1 HIPAA. The parties agree that the acts, duties and obligations required by this Agreement shall be performed in compliance with the Privacy and Security Rules as promulgated under HIPAA.

6.2 Utah Law. Employer understands that under Utah Code Annotated § 49-11-618, “All data in the possession of [PEHP] is confidential, and may not be divulged by [PEHP] except as permitted by board action.” Employer acknowledges and agrees that this Agreement is subject to this rule of confidentiality.

6.3 Definition of Data. For the purpose of this Agreement, "data" means any information pertaining to Employer’s participation with PEHP, Plan Rates, this Agreement, PEHP or its business practices, or the personal health information (as defined by federal law) of any individual participating in the Plan administered by PEHP.

SECTION 7 – TERM AND TERMINATION

7.1 Term of Agreement

7.1.1 Unless sooner terminated as herein provided, this Agreement shall be effective for a one year term and pertain to claims incurred during the period May 1, 2017 through April 30, 2018.

7.1.2 This Agreement shall be renewed automatically for one year terms unless Employer notifies PEHP of its intent to terminate as provided herein.

7.2 Termination

7.2.1 This Agreement, and coverage for all Members under this Agreement, can terminate for the reasons listed below.

7.2.2 This Agreement may be terminated by Employer by providing PEHP with written notice prior to the Employer's open enrollment period for the next one year term. PEHP will not accept retroactive termination dates.

7.2.3 PEHP may immediately terminate Employer's coverage upon written notice if PEHP determines that Employer is in breach of this Agreement. The following circumstances constitute a breach:

a. Employer fails to pay the required Rates in accordance with this Agreement;
b. Partial payment will be treated as nonpayment unless PEHP, at its sole discretion, indicates otherwise in writing;
c. Employer performs an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact under the terms of the coverage;
d. Employer's status changes to an entity that is not a political subdivision of the State of Utah;
e. Employer's membership in an entity through which this Agreement was made available ceases; or
f. Employer fails to satisfy the minimum Employer participation requirements in Section 2.1.6 of this Agreement.

7.2.4 Employer agrees that if proper written notice of termination is not given within the designated time parameters, a penalty of up to one percent (1%) of total annual Rate may be assessed on Employer at the sole discretion of PEHP.

7.2.5 It is Employer's responsibility to provide Subscribers a 30-day written notice of the Agreement's termination. PEHP will provide a sample notice upon request.

7.2.6 Upon termination or expiration of this Agreement, PEHP shall continue to process and pay claims for services obtained or charges incurred by Employer's Members prior to the date of termination or expiration of this Agreement for a period of 12 months after the date of termination ("Run-Out Period"). PEHP shall not pay for Services obtained or charges incurred after the date of termination, regardless of when a condition arose and despite care or treatment anticipated or already in progress.

7.2.7 If Employer breaches this Agreement in accordance with Section 7.2.3 of this Agreement, which results in termination of this Agreement, PEHP shall pay no further claims, regardless of the date incurred. Employer shall be responsible for any such claims. Employer shall be responsible to pay

PEHP for all reinsurance and administrative costs due prior to the date of termination, regardless of any other provision in this Agreement.

7.2.8 Upon termination of this Agreement, Employer shall be responsible for any deficits in the risk pool as determined by PEHP.

SECTION 8 – GENERAL TERMS

8.1 Interpretation. The attached Appendices are complementary to this Agreement and what is called for by any one of them shall be binding as if called for by all. In the event of any inconsistency between the provisions of the Agreement and the documents accompanying this Agreement, the inconsistency shall be resolved by giving precedence first to the Appendices and then to this Agreement. This Agreement will be interpreted and enforced according to the laws and regulations of the State of Utah and any applicable federal laws or regulations. If an inconsistency exists between the Agreement and any applicable law, this Agreement will be construed to include the minimum requirements of the applicable law.

8.2 Indemnification. PEHP agrees to indemnify Employer from and against any claims or other liability, including attorney fees, based upon PEHP's failure to comply with its obligations under the Agreement. Employer agrees to indemnify PEHP from and against any claims or other liability, including attorney fees, based upon Employer's failure to comply with its obligations under the Agreement.

8.3 Amendment and Assignment. As benefits under this Agreement may be modified from year to year, this Agreement may be modified or amended unilaterally by PEHP within 30 days prior to a new plan year by providing Employer with written notice of the Amendment. If Employer objects to any unilateral amendments, Employer shall inform PEHP in writing to its objection within 30 days of receipt of the amendment. At all other times of the plan year, and for all other amendments or modifications to this Agreement, this Agreement shall be amended only by a written instrument executed by duly authorized officers of the parties hereto. This Agreement may not be assigned by either party without the written consent of the other party.

8.4 Default. If either party defaults in the performance of this Agreement or any of its obligations hereunder, the defaulting party shall pay all costs and expenses, including reasonable attorney's fees, which may arise or accrue from enforcing the Agreement or from pursuing any remedy provided hereunder.

8.5 Force Majeure. Neither party will be responsible for a delay in performing its obligations under the Agreement due to circumstances reasonably beyond its control, such as natural disaster, epidemic, riot, war, terrorism, or nuclear release.

8.6 Dispute Resolution. This Agreement is entered into in the State of Utah and shall be governed by the laws of said state, notwithstanding any conflicts of laws principles. Any dispute arising out of this

Agreement will be subject to the exclusive jurisdiction of the administrative hearing process found in Utah Code Annotated § 49-11-613.

8.7 Conflict of Interest. PEHP represents that it has not knowingly influenced, and hereby promises that it will not knowingly influence, an Employer officer or employee, or former Employer officer or employee, to breach any ethical standards applicable to Employer. Employer represents that it has not knowingly influenced, and hereby promises that it will not knowingly influence any PEHP officer or employee or former PEHP officer or employee to breach any ethical standard applicable to PEHP.

8.8 Severance. In the event any portion of this Agreement is determined to be unconstitutional, unlawful or otherwise unenforceable in the State of Utah, only the unconstitutional portion of the Agreement will be severed and the remaining portion of the Agreement will continue in effect and be binding on the Parties, provided that such holding of invalidity or unenforceability does not materially affect the essence of the Agreement.

8.9 Notice.

8.9.1 Any notice required herein of PEHP shall be addressed to Employer at the address listed in Appendix A, and when required of Employer, shall be addressed to PEHP, Marketing Department, Public Employees' Health Program, 560 East 200 South, Salt Lake City, Utah 84102-2004, or kurt.murray@pehp.org (or current Marketing Manager).

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

8.9.3 Any notice PEHP is required to send will be sufficient if:

a. For notice to Employer, notice is sent to the address listed in Appendix A;
b. For notice to a Subscriber, notice is sent to the address PEHP has on record; and
c. For notice to a Dependent, notice is sent to the Subscriber.

8.9.4 Any notice Employer is required to send will be sufficient if sent to the address listed above.

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

8.11 Workers' Compensation Insurance. The Agreement does not provide or replace workers' compensation coverage for Employer's Employees. Employment-related injuries are not covered under the Agreement.

8.12 Relationship of the Parties. This Agreement is a contract for services and does not create an agency relationship. Employer does not have the authority to act as PEHP's agent. PEHP is not Employer's agent for any purpose.

SECTION 9 – DEFINITIONS

9.0 In General. This Agreement 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.

9.1 Adult Designee. If Employer accepts Adult Designees as Dependents, the qualifications agreed upon by Employer and PEHP will be included in Appendix A.

9.2 Agreement. This Employer Health Insurance Agreement, including the Employer Application and all other documents expressly referred to and incorporated by reference.

9.3 Benefit(s). The payments and privileges to which Members are entitled by this Agreement.

9.4 Continuation or COBRA Coverage. Coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and/or coverage allowed under Utah Code Annotated § 31A-22-722 (Mini-COBRA).

9.5 Conversion Coverage. Coverage provided under Utah Code Annotated § 31A-22-723.

9.6 Dependent(s). An Employee's lawful spouse (or Adult Designee if allowed by Employer) and any child who meets the Eligibility criteria under this Agreement.

9.7 Effective Date. The date on which coverage for a Member begins.

9.8 Employee. An individual employed by Employer.

9.9 Employer Plan (or "Plan(s)"). The group health and/or other Benefit plan(s) elected and sponsored by Employer under this Agreement and attached in Appendix A.

9.10 Eligible, Eligibility. The criteria or standards, established by Employer and/or PEHP under this Agreement and Appendix A, in order to participate in a PEHP health plan.

9.11 HIPAA. The Health Insurance Portability and Accountability Act found at 45 C.F.R. §§ 160 and 164, as amended.

9.12 Master Policy. The document(s), considered part of this Agreement, which describe(s) the terms and conditions of the health insurance Benefits with PEHP, including the Benefit Summary, and which is available online at the address listed in Appendix A, or by request.

9.13 Member. As defined in the Master Policy attached in Appendix A, a Subscriber, including an Employee, Early Retiree, LTD Participant, COBRA Participant, Conversion Coverage Participant, and any Dependent, when properly enrolled in the Plan and accepted by PEHP.

9.14 PHSA. The Public Health Service Act of 1944, codified in United States Code, Title 42, as amended.

9.15 PPACA. The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, including the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, as amended.

9.16 Provider. A vendor of healthcare Services as defined in the Master Policy.

9.17 Rate(s). The amount paid periodically by Employer and/or Subscribers to PEHP as consideration for providing Benefits under the Plan. The Contribution rate is specified in Appendix A.

9.18 Service(s). Services provided by a Provider, including medical practices or care, treatment, tests, supplies, equipment, devices, or drugs.

9.19 Subscriber. An Employee that enrolls with PEHP, as defined in the Master Policy.

SECTION 10 – SIGNATURE PAGE

EXECUTED this _____day of _____, 20__.

UTAH RETIREMENT SYSTEMS
PUBLIC EMPLOYEES HEALTH PROGRAM

By_____
Chet Loftis
Director, Public Employees Health Program

EXECUTED this _____day of _____, 20__.

[Employer Name]

By _____
[Name] Kim S. Ulibarri
[Title] Chief People Officer

By _____
[Name]
[Title]

By _____
[Name]
[Title]

Legally Sufficient

_____
Michael Bell, Assistant Attorney General

APPENDIX A

Plan Year: May 1, 2019 to April 30, 2020

A-1 Benefits

A Employer Plans/Programs

Master Policy & Benefit Grid – members can access at www.pehp.org or on Employer's website. Benefit Grids are attached.
Summary of Benefits & Coverage (SBC) – members can access at www.pehp.org or on Employer's website.
Provider Directory - Provider directories for the Employer plans are found online at www.pehp.org. Provider directories are subject to change without notice. PEHP shall make reasonable efforts, as determined by PEHP, to inform Employer and Members if a material disruption shall occur to provider networks during the term of this Agreement.

Wellness Programs

PEHP offers the Healthy Utah wellness program for Employer. If Employer elects to offer additional wellness programs to employees, Employer shall be solely responsible for any federal law compliance related to such additional program, included taxability of rebates and tracking applicable wellness limits for employees.

Legal Guardianship

Employer has elected to allow children under guardianship to remain covered by PEHP between ages 19-26 like natural born children. In order to continue enrollment, the guardian child must have been enrolled on the Employer's coverage prior to being 18 years of age and otherwise have met the qualifications for coverage as a guardian child. PEHP shall inform the Employer if a guardian child over the age of 19 has enrolled with PEHP on the monthly bill to Employer. The Employer understands that it may need to impute income to the employee if the guardian child does not qualify as a tax dependent under federal law. Employer acknowledges that it shall be solely liable for any tax consequences related to coverage of a guardian child over the age of 19, and that PEHP maintains no responsibility of any kind for any taxes which may be owed as a result of this coverage.

LTD Premium Waiver or Stipend

Employer has elected not to provide this benefit.

B Vesting Standards for LGRP

1. Employer hereby acknowledges that it participates in the Local Governments Risk Pool ("LGRP") sponsored by PEHP, which is a multi-employer self-funded risk pool. Participation in the LGRP requires meeting PEHP's vesting requirement, which include:
    a. An Employer is vested with PEHP when either:
        i. the Employer provides two years of specific plan benefits and claims costs to PEHP to appropriately determine rates; or
        ii. the Employer continuously participates with PEHP in the LGRP for three years.
    b. If an Employer is vested with PEHP, the Employer may terminate this agreement with no further obligation to LGRP. At the time of termination, the Employer shall not receive any LGRP reserve funds, and shall not pay any deficits incurred or paid by Employer to LGRP.
    c. If Employer is not vested with PEHP and terminates this Agreement before becoming vested, Employer will immediately pay PEHP for any deficits incurred during its participation with LGRP. Deficits mean the difference between claims paid by PEHP, including administrative costs, and the rates paid by Employer, including all Employer allocated investment earnings or deficits. Deficits shall be solely determined by PEHP. Any calculations regarding deficits will include Employer's claims presented and paid by PEHP over the 12 months following Employer's termination of this Agreement.
    d. Any surpluses attributable to the Employer (when rates exceed premiums), whether vested or non-vested, will remain with PEHP for the benefit of the Employers participating in the LGRP.

2. Employer IS deemed vested by PEHP.

C Reinsurance

1. Each Employer shall participate in the PEHP Reinsurance Risk Pool and pay the applicable fees for such services. Reinsurance fees are included in the Employer's Rate, as outlined in Appendix Section A-2. The PEHP Reinsurance Risk Pool covers for the Employer:
    a. Medical and pharmacy claims eligible under this Agreement and the Master Policy, according to the following limits and subject to the exclusions herein;
    b. Large claims exceeding $100,000 annually, calculated on an incurred in 12 months and paid in 15 months basis (specific stop loss coverage);
    c. Aggregate risk pool claims that total between 120% to 135% of expected risk pool claims (aggregate stop loss coverage); and
    d. Other purposes that PEHP and the Board may approve.

2. The PEHP Reinsurance Risk Pool specifically excludes coverage for any claims incurred:
    a. Outside of the eligibility standards of this agreement or the Master Policy;
    b. For benefits not specifically covered by the Master Policy;
    c. That are excluded by PEHP's commercial reinsurance carrier;
    d. By an Employee or Eligible Dependent who has committed fraud, criminal acts, or other breach of the Master Policy, as described in Section 2.1.7 of this Agreement; or
    e. That are approved by Employer for processing and payment, despite being ineligible for payment under this Agreement, the Master Policy or the Employer plan benefit documents that have been approved by PEHP.

3. If the Employer approves claims or benefits not covered by this Agreement or the Master Policy, the Employer shall be responsible for all claims expenses associated with such charges. Notwithstanding any other provision of this Agreement, PEHP shall have no liability to pay any claims, benefits or make other payments that are not specifically stated in this Agreement or the Master Policy.

4. PEHP shall evaluate claims and pay reinsurance amounts on a monthly basis.

D. IRS Reporting

1. Employer has determined to calculate and file ACA reports as required by federal law.

A-2 Rates

Summit Exclusive Traditional	**SINGLE**	**DOUBLE**	**FAMILY**
	$562.06	$1,386.16	$1,967.39

A-3 Additional Terms

A Following termination of this Agreement, PEHP shall pay claims incurred prior to termination of this Agreement for 12 months.

B Conflict of Interest – Employer acknowledges that PEHP is a public employer, and that no employee or officer is related to any employee or officer of PEHP within two degrees of consanguinity except as has been previously disclosed to PEHP.

C Additional Reporting Requests - PEHP shall provide regular reports to Employer as described in the Agreement. PEHP may provide additional reports to Employer as negotiated between Employer and PEHP. If such additional reports are agreed upon and authorized by PEHP, Employer agrees to pay PEHP the reasonable costs of producing such reports at the rate of $20/hour and $.10/page for printed reports. In accordance with Section 4.2.4, PEHP may provide personal health information of Employees or Dependents to another Covered Entity at the written request of the Employer as allowed by HIPAA. PEHP may provide personal health information of Employees or Dependents to Employer's Business Associates at Employer's written request in accordance with Section 4.2.4 of this Agreement.

Notwithstanding the payment schedule above, Employer has requested and PEHP has agreed to provide identifiable claims data to Employer's medical data warehouse vendors for health care and on-site clinic predictive modeling and utilization review. Such data shall be provided on a monthly basis by the 5th day of each month for the previous month. For such reports, vendor shall provide specific data parameters to PEHP at least 30 days prior to the first report being provided. PEHP shall notify Employer of the data parameters. Upon PEHP's receipt of a valid Business Associate Agreements between Employer and vendors, PEHP will begin to prepare the data reports to send to vendors .

D Notice to Employer – Address: 669 W. 200 S. SLC, UT 84101

A-4 Employer Portal –

The PEHP Employer Portal through the website pehp.org if available for Employers 24 hours per day, seven days a week at no additional administrative charge to Employer. PEHP may temporarily suspend PEHP Employer Portal access and services at its discretion for maintenance or other quality control issues.

Employer will use PEHP Employer Portal in a manner consistent with applicable laws. Employer is solely responsible for all use of Employer's PEHP Portal website account and for any violation of the terms of this section.

For purposes of this section, Employer's "use"

(a) means

(i) use by Employer's employees, agents or contractors;

(ii) use by Employer's employees, agents or contractors, who following their separation from employment or engagement from Employer were enabled by the use of Employer's signature obtained in their employment or engagement;

(iii) use by any person who obtains Employer's signature because of Employer's negligence; and

(iv) use by any person who obtains Employer's signature from any person described in (i), (ii) or (iii) above; and

(b) specifically excludes the unauthorized use of Employer's PEHP Employer Portal website account by any person who is not described in (a)(i) – (iv) above or who accesses or uses Employer's signature without authorization from Employer."

Appendix B

The Effective Date is the first day of the month following the Employer Waiting Period. Employees classified as Operators have a 30-day orientation period. Upon completion of the orientation period, the Employer Waiting Period begins and lasts for 30 days.

Detailed Contract Description & Purpose

Board Review Date:	6/5/2019	**Document Type:**	Change Order
Action Requested:	Motion to approve the contract or change order		
Criteria:	New total contract value is > $1,000,000 and Change-order is > 15% or $200,000		

Contract Title:	Employer Health Insurance - Select Health	**Contract #**	16-2070TP-4 & 16-2067TP-4
Project Manager:	Jacob Gomez	**Contract Administrator:**	Teressa Pickett
Impacted Areas:	All Employees	**Included in budget?**	Yes
Procurement method:	Best value (RFP)	**Contractor:**	Select Health
Sole-Source Reason:	N/A	**Original Contract Value**	$ 41,832,884
		Change Order Value	$ 21,800,000
		Total Contract Value	$ 63,632,884
Contract term (Months)	12	**Contract Start Date**	5/1/2019
Contract options (Months)	24	**Contract End Date:**	4/30/2020
Number of responding firms:	8	**$ Value of Next Lowest Bidder**	This is a best value procurement where technical and price were both evaluated. The next lowest bidder may not have been the most qualified.

General Description & Purpose:

The Utah Transit Authority offers a competitive benefits package to their eligible employees and eligible dependents. This includes a quality employer health insurance program. Employees are given a choice of two health care options. This program covers the benefits provided by Select Health

This contract approval request is for two contracts with Select Health, one for Bargaining Unit employees ($12,500,000), and the other for Administrative employees ($9,300,000). This is the 3rd year of a 5 year contract, with no option years. The $21,800,000 is an estimate and will be determined by the amount of employees who sign up with Select Health vs PEHP.

Attachments:	Contract routing sheet attached?	Yes
	Other attachments? (list)	Administrative Employee Contract and Bargaining Unit Contract

Once approved, please forward to Contract Administrator

UTA

CONTRACT ROUTING SHEET

Agenda Item No.:
Board Review Date:

CONTRACT SECTION

1) Contract/P.O. No. **16-2070TP-4** *(Assigned by Purchasing)* Contract Administrator: **Teressa Pickett**
Project Manager: **Jacob Gomez**

2) Contract Type ☐ A. A&E/Design ☐ B. Blanket PO ☐ C. Construction ☐ D. Goods ☐ E. Modification ☑ E. Option ☐ F. Other ____ ☐ G. Renewal ☐ H. Services ☐ I. Task Orders

3) Procurement Method ☐ RFQ (Quote) ☐ IFB (Low Bid) ☐ RFQU (Qualification) ☑ RFP (Best-value) ☐ Sole source ☐ Other: ____

4) Contract Title **Employer Health Insurance Agreement - Administration**

5) Description / Purpose *(of contract or project)* **Employer Health Insurance Agreement between UTA and SelectHealth for Medical Healthcare Benefits.**

6) Contractor Name **SelectHealth**

7) Effective Dates Beginning: **05/01/19** Ending: **04/30/20**

8) Option to renew? ☑ Yes ☐ No Renewal terms: One year term (starting 5/1/17) with an option to renew every year up to a total of 5 years, ending 4/30/2022.

FINANCIAL SECTION

9) Total Board Approval Amount:

9a) Current Contract Value:	$ 16,832,884.16
9b) Amendment Amount:	$ 9,300,000.00
9d) New Contract Value (including all amendments)	$ 26,132,884.16

9e) Is the amount an estimate? ☑ Yes ☐ No

(Estimate if per transaction cost)

9f) *If estimated, how was the estimate calculated?* The total amount is dependent on how many employees choose the Select Health program for their insurance.

10) Is the amount a one-time purchase or annual recurring purchase? ☐ One-time ☑ Recurring

11) Account Code **1.10411.IHC** Capital Project Code

12) Budgeted? ☑ Yes ☐ No Budget amount: **$ 26,132,885.00**

13) Will this contract require support from another department? ☑ Yes ☐ No

14) If so, is the other department(s) aware of this contract and the required support? ☑ Yes ☐ No

15) If box 2a or 2c is checked, has the Qualified Heath Insurance Certificate been verified? N/A ☐ Yes ☐ No

SIGNATURE SECTION

	Route to?		Initials	
Contract Compliance	☑ Yes			*Lisa Bohman*
Accounting Review	☑ Yes	☐ No		*Bryan Steele*
IT Review (IT software or hardware)	☐ Yes	☑ No		*N/A*
Up to $10K Manager/Program Manager	☑ Yes	☐ No		*Jacob Gomez*
Up to $50K Dir, Sr. Mgr, RGM, or Chief/VP	☐ Yes	☑ No		*N/A*
Up to $100K Chief/VP, or Dir, Sr. Mgr, RGM (Capital, Maint., Ops. only)	☑ Yes	☐ No		*Kimberly S. Ulibarri*
Over $100K Executive Director	☑ Yes	☐ No		*W. Steve Meyer*
Over $200K Board Approval	☑ Yes	☐ No		*Approval Date*

If Yes, route to the Sr. Supply Chain Manager for board meeting agenda and approval

Once approved, please forward to Contract Administrator

UTA

CONTRACT ROUTING SHEET

Agenda Item No.:
Board Review Date:

CONTRACT SECTION

1) Contract/P.O. No. **16-2067TP-4** *(Assigned by Purchasing)* Contract Administrator: **Teressa Pickett**
Project Manager: **Jacob Gomez**

2) Contract Type ☐ A. A&E/Design ☐ B. Blanket PO ☐ C. Construction ☐ D. Goods ☐ E. Modification ☑ E. Option ☐ F. Other _____ ☐ G. Renewal ☐ H. Services ☐ I. Task Orders

3) Procurement Method ☐ RFQ (Quote) ☐ IFB (Low Bid) ☐ RFQU (Qualification) ☑ RFP (Best-value) ☐ Sole source ☐ Other: _____

4) Contract Title **Employer Health Insurance Agreement - Bargaining**

5) Description / Purpose *(of contract or project)* **Employer Health Insurance Agreement between UTA/ATU Joint Insurance Trust and SelectHealth for Medical Healthcare Benefits.**

6) Contractor Name **SelectHealth**

7) Effective Dates Beginning: **05/01/19** Ending: **04/30/20**

8) Option to renew? ☑ Yes ☐ No Renewal terms: **One year term (starting 5/1/17) with an option to renew every year up to a total of 5 years, ending 4/30/2022.**

FINANCIAL SECTION

9) Total Board Approval Amount:

9a) Current Contract Value:	$ 25,000,000.00
9b) Amendment Amount:	$ 12,500,000.00
9d) New Contract Value (including all amendments)	$ 37,500,000.00

9e) Is the amount an estimate? ☑ Yes ☐ No
(Estimate if per transaction cost)

9f) *If estimated, how was the estimate calculated?* The total amount is dependent on how many employees choose the Select Health program for their insurance.

10) Is the amount a one-time purchase or annual recurring purchase? ☐ One-time ☑ Recurring

11) Account Code ~~4-10410-IHC~~ JIC Capital Project Code

12) Budgeted? ☑ Yes ☐ No Budget amount: **$ 37,500,000.00**

13) Will this contract require support from another department? ☑ Yes ☐ No

14) If so, is the other department(s) aware of this contract and the required support? ☑ Yes ☐ No

15) If box 2a or 2c is checked, has the Qualified Heath Insurance Certificate been verified? N/A ☐ Yes ☐ No

SIGNATURE SECTION

	Route to?		Initials	
Contract Compliance	☑ Yes			Lisa Bohman
Accounting Review	☑ Yes	☐ No		Trey Billings for Bryan Steele
IT Review (IT software or hardware)	☐ Yes	☑ No		N/A
Up to $10K Manager/Program Manager	☑ Yes	☐ No		Jacob Gomez
Up to $50K Dir, Sr. Mgr, RGM, or Chief/VP	☐ Yes	☑ No		N/A
Up to $100K Chief/VP, or Dir, Sr. Mgr, RGM (Capital, Maint., Ops. only)	☑ Yes	☐ No		Kimberly S. Ulibarri
Over $100K Executive Director	☑ Yes	☐ No		W. Steve Meyer
Over $200K Board Approval	☑ Yes	☐ No		Approval Date

If Yes, route to the Sr. Supply Chain Manager for board meeting agenda and approval

2019

Medical Contract

UTA-ATU / Joint Insurance Trust

selecthealth.

GROUP APPLICATION

Product	Select Med PLUS
Employer	UTA-ATU/Joint Insurance Trust
Employer Contact	Heather Austin
Employer Address	669 W 200 S
	SALT LAKE CITY, UT 84101

Affiliated Businesses/Subsidiaries Covered by this Application

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

1. Monthly Premiums.

On or before the first day of each month, employer shall pay the following Premiums to SelectHealth:

$ 517.14	for each single party enrollment
$ 1292.38	for each Subscriber plus spouse enrollment
$ 1292.38	for each Subscriber plus child enrollment
$ 1809.52	for each Subscriber plus children enrollment
$ 1809.52	for each family enrollment

2. Eligibility, Prepayment and Enrollment Criteria.

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

2.1 Scheduled hours of work per week.

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

2.2 Portion of Premium Subscriber must contribute.

Wellness program	No Wellness	
$92.00	$117.08	for each single party enrollment
$227.55	$290.68	for each two party enrollment
$321.47	$410.79	for each family enrollment

2.3 Limiting Age.

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

2.4 Retirees.

Retirees are not covered.

2.5 Domestic Partners.

Domestic partners are not covered.

2.6 Leave of Absence.

Eligible employees may be granted up to a 60 day leave of absence by employer or up to the time allowed for a qualifying leave under the Family Medical Leave Act. Leave time can only be accrued and used by the employee using the leave time. Leave banks beyond what is required by the FMLA, i.e. where employees share or purchase leave time from other employees, are not allowed.

2.7 Initial Eligibility Period.

The Initial Eligibility Period is 31 days.

2.8 Waiting Period.

The Employer Waiting Period for employees classified as Operator is 60 days and the Effective Date is the first day of the next calendar month following the Employer Waiting Period. The Employer Waiting Period for all other employees is 30 days and the Effective Date is the first day of the next calendar month following the Employer Waiting Period.

2.9 Other employees.

Leased employees and independent contractors are not Eligible for coverage by SelectHealth.

2.10 Termination.

Coverage will terminate on the end of the calendar month in which Subscriber and/or Dependents lose Eligibility. When a loss of Eligibility is not reported in a timely fashion as required by the Contract and federal or state law prevents SelectHealth from retroactively terminating coverage, SelectHealth has the discretion to determine the prospective date of termination. SelectHealth also has the discretion to determine the date of termination for Rescissions.

3. Duration of Contract.

This Contract is effective on May 1, 2019 to April 30, 2020, for a term of 12 months.

4. Additional Terms.

4.1 Additional Eligibility.

Eligible participants shall also include full time officials of the Amalgamated Transit Union, Local 382 ("Union"), who are on leave of absence for the Authority in order to serve as elected officials of the Union.

An eligible employee who waives COBRA continuation coverage or enrolls on COBRA at any time while on a medical leave of absence of up to one year will remain eligible for reinstatement upon return to work on a full-time basis within the one-year period.

In Section 2.3 "Grace Period" of the contract LE-CONTRACT 01/01/19, the grace period has been extended from thirty (30) days to forty five (45) days.

Product: Select Med PLUS

Effective Date: May 1, 2019

Acknowledged and agreed:

Employer: UTA-ATU Joint Insurance Trust

By: _____

Printed Name: Kim S Ulibarri

Title: Chief People Officer

Date: 5-23-19

By: _____

Printed Name: _____

Title: _____

Date: _____

Legally Sufficient, Lee Bell, Assistant Attorney General

SelectHealth:

By: _____

Printed Name: Patricia R. Richards

Title: President / Chief Executive Officer

Date: 3/14/2019

LE-GROUP APP 01/01/15

medical
contract

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SECTION 1 INTRODUCTION

1.1 Contract

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

1.2 SelectHealth

SelectHealth is an HMO licensed by the State of Utah located at 5381 Green Street, Murray, Utah 84123. We are affiliated with Intermountain Healthcare, but are 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 for our obligations or actions.

1.3 Agency

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

1.4 Administration of Contract

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

1.5 ERISA and SelectHealth's Authority

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

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

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

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

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

SECTION 2 PREMIUM

2.1 Employer Responsibility

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

2.2 Premium Rates

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

2.3 Grace Period

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

2.4 Refund of Premium

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

SECTION 3 COVERAGE

3.1 Certificate of Coverage

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

3.2 Administrative Processes

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

3.3 No Vested Rights

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

SECTION 4 ELIGIBILITY AND ENROLLMENT

4.1 Eligibility

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

4.2 Changes in Member Information or Eligibility

You must notify us within 31 days whenever there is a change in a Member's situation that may affect Eligibility or enrollment. This includes the following events:

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

b. Child loses Dependent status;

c. Death;

d. Divorce;

e. Marriage;

f. Involuntary loss of other coverage;

g. Member called to active military duty;

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

i. Reduction in employment hours;

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

k. Termination of employment; and

l. Other events as required by federal law.

If you fail to notify us within 31 days of a Member's termination from employment or other event that results in the loss of a Member's Eligibility, you agree to promptly pay us any amounts paid as Benefits for such Member before we were notified.

4.3 Enrollment

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

4.4 Enrolling a Dependent Because of a Court Order

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

4.5 COBRA or Utah mini-COBRA Coverage (Continuation Coverage)

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

4.5.1 Minimum Extent

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

4.5.2 Documentation

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

4.6 Right to Decline Enrollment

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

SECTION 5 RESPONSIBILITIES OF THE PARTIES

5.1 Compliance

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

5.2 Indemnification

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

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

5.3 Reports

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

5.4 Internal Revenue Code (IRC) Section 6055 Reporting

You agree to request the Social Security Numbers of your Employees and their Dependents, and provide this information to us, in the time and manner required by IRC Section 6055.

5.5 Summary of Benefits and Coverage (SBC)

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

SECTION 6 TERMINATION

6.1 Reasons for Termination

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

6.1.1 Termination by Employer

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

6.1.2 Termination of Employer Group by SelectHealth

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

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

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

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

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

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

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

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

6.1.3 Employer Notice of Termination to Subscribers

It is your responsibility to provide Subscribers a 30-day written notice of the Contract's termination. We will provide you a sample notice upon request.

6.2 Rescission

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

6.3 Liability for Services After Termination

We do not cover Services obtained after the date of termination, regardless of when a condition arose and despite care or treatment anticipated or already in progress.

SECTION 7 GENERAL

7.1 Binding Effect

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

7.2 Partial Invalidity

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

7.3 Non-Assignability

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

7.4 Choice of Law

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

7.5 Right to Audit Employer Records

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

7.6 Term

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

7.7 Circumstances Beyond Control

Neither party will be responsible for a delay in performing its obligations under the Contract due to circumstances reasonably beyond its control, such as natural disaster, epidemic, riot, war, terrorism, or nuclear release.

7.8 Workers' Compensation Insurance

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

7.9 No Waiver

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

7.10 Notices

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

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

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

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

d. We do not provide COBRA notification services.

SECTION 8 DEFINITIONS

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

8.1 Affordable Care Act (ACA)

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

8.2 Benefit(s)

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

8.3 Certificate of Coverage (Certificate)

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

8.4 COBRA Coverage

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

8.5 Continuation Coverage

COBRA Coverage and/or Utah mini-COBRA coverage.

8.6 Contract

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

8.7 Covered Services

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

8.8 Dependents

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

8.9 Effective Date

The date on which coverage for a Member begins.

8.10 Eligible, Eligibility

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

8.11 Employer Waiting Period

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

8.12 Employer Plan

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

8.13 ERISA

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

8.14 Exclusion(s)

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

8.15 Facility

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

8.16 Group Application

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

8.17 Grace Period

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

8.18 Limitation(s)

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

8.19 Member

A Subscriber and any Dependents, when properly enrolled in the Plan and accepted by us.

8.20 Member Payment Summary

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

8.21 Optional Benefit

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

8.22 Plan

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

8.23 Plan Sponsor

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

8.24 Premium(s)

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

8.25 Provider

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

8.26 Qualified Medical Child Support Order

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

8.27 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.

8.28 Service Area

As defined in the Certificate(s) of Coverage.

8.29 Service(s)

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

8.30 Subscriber

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

8.31 Utah mini-COBRA

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

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MED NETWORK

MEMBER PAYMENT SUMMARY	PARTICIPATING *(In-Network)* When using participating providers, you are responsible to pay the amounts in this column.	NONPARTICIPATING *(Out-of-Network)* When using nonparticipating providers, you are responsible to pay the amounts in this column.
CONDITIONS AND LIMITATIONS		
Lifetime Maximum Plan Payment - *Per Person*	None	
Pre-Existing Conditions (PEC)	None	
Benefit Accumulator Period	plan year	
Maximum Annual Out-of-Network Payment - (per plan year)	None	None
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5]	**PARTICIPATING**	**NONPARTICIPATING**
Self Only Coverage, 1 person enrolled - per plan year		
Deductible	$1,000	$2,000
Out-of-Pocket Maximum	$3,000	$6,000
Family Coverage, 2 or more enrolled - per plan year		
Deductible - per person/family	$1000/$3000	$2000/$6000
Out-of-Pocket Maximum - per person/family	$3000/$6000	$6000/$12000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)		
INPATIENT SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Medical, Surgical and Hospice[4]	20% after deductible	40% after deductible
Skilled Nursing Facility[4] - Up to 60 days per plan year	20% after deductible	40% after deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	20% after deductible	40% after deductible
Up to 40 days per plan year for all therapy types combined		
PROFESSIONAL SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP)[1]	$25	40% after deductible
Secondary Care Provider (SCP)[1]	$35	40% after deductible
Allergy Tests	See Office Visits Above	Not Covered
Allergy Treatment and Serum	20%	Not Covered
Major Surgery	20%	40% after deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after deductible	40% after deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**PARTICIPATING**	**NONPARTICIPATING**
Primary Care Provider (PCP)[1]	Covered 100%	Not Covered
Secondary Care Provider (SCP)[1]	Covered 100%	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Not Covered
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	Not Covered
Diagnostic Tests: Minor	Covered 100%	Not Covered
Other Preventive Services	Covered 100%	Not Covered
VISION SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Preventive Eye Exams	Covered 100%	Not Covered
All Other Eye Exams	$35	40% after deductible
OUTPATIENT SERVICES[4]	**PARTICIPATING**	**NONPARTICIPATING**
Outpatient Facility and Ambulatory Surgical	20% after deductible	40% after deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after deductible	See Participating Benefit
Emergency Room - *(Participating facility)*	$300 after deductible	See Participating Benefit
Emergency Room - *(Nonparticipating facility)*	$300 after deductible	See Participating Benefit
Intermountain InstaCare® Facilities, Urgent Care Facilities	$40	40% after deductible
Intermountain KidsCare® Facilities	$25	Not Available
Intermountain Connect Care®	$10	Not Available
Chemotherapy, Radiation and Dialysis	20% after deductible	40% after deductible
Diagnostic Tests: Minor[3]	Covered 100%	40% after deductible
Diagnostic Tests: Major[3]	20% after deductible	40% after deductible
Home Health, Hospice, Outpatient Private Nurse	20% after deductible	40% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational	$35 after deductible	40% after deductible

See other side for additional benefits

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MED NETWORK

	MEMBER PAYMENT SUMMARY	
	PARTICIPATING *(In-Network)*	**NONPARTICIPATING** *(Out-of-Network)*
MISCELLANEOUS SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Durable Medical Equipment (DME)[4]	20% after deductible	40% after deductible
Miscellaneous Medical Supplies (MMS)[3]	20% after deductible	40% after deductible
Maternity and Adoption[4,6]	See Professional, Inpatient or Outpatient	40% after deductible
Cochlear Implants[4]	See Professional, Inpatient or Outpatient	Not Covered
Infertility - *Select Services* *(Max Plan Payment $1,500/ plan year; $5,000 lifetime)*	*50% after deductible	Not Covered
Donor Fees for Covered Organ Transplants[4]	20% after deductible	Not Covered
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient	Not Covered
OPTIONAL BENEFITS	**PARTICIPATING**	**NONPARTICIPATING**
Mental Health and Chemical Dependency[4]		
Office Visits	$25	40% after deductible
Inpatient	20% after deductible	40% after deductible
Outpatient	20%	40% after deductible
Residential Treatment[2]	20% after deductible	40% after deductible
Chiropractic - 800-678-9133	$20 (up to 15 visits per plan year)	Not Covered
Injectable Drugs and Specialty Medications[4]	20% after deductible	40% after deductible
PRESCRIPTION DRUGS		
Pharmacy Deductible - Per Person per plan year	$100	
Prescription Drug List (formulary)	RxSelect®	
Prescription Drugs - *Up to 30 Day Supply of Covered Medications* [4]		
Tier 1	$10	
Tier 2	25% after pharmacy deductible (minimum $25 maximum $75)	
Tier 3	50% after pharmacy deductible (minimum $50 maximum $150)	
Tier 4	20% after pharmacy deductible	
Maintenance Drugs - *90 Day Supply (Mail-Order, Retail90 ®)-selected drugs* [4]		
Tier 1	$10	
Tier 2	25% after pharmacy deductible (minimum $50 maximum $150)	
Tier 3	50% after pharmacy deductible (minimum $100 maximum $300)	
Generic Substitution Required	Generic required or must pay copay plus cost difference between name brand and generic	

To remain compliant with state and federal regulations including the Affordable Care Act (ACA), these benefits are subject to change.

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

2 Refer to your Certificate of Coverage for more information.

3 Frequency and/or quantity limitations apply to some preventive care and MMS services.

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

5 All deductible/copay/coinsurance amounts are based on the allowed amounts and not on the providers billed charges. Nonparticipating Providers or Facilities have not agreed to accept the Allowed Amount for Covered Services. When this occurs, you are responsible to pay for any charges that exceed the amount that SelectHealth pays for Covered Services. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

6 SelectHealth provides a $4000 adoption indemnity as outlined by the state of Utah. Medical deductible, copay, or coinsurance listed under the benefit applies and may exhaust the benefits prior to any plan payments.

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

All covered services obtained outside the United States, except for routine, urgent, or emergency conditions require preauthorization.

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

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

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Non-Discrimination Notice

SelectHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide free aid and services to people with disabilities to help them communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). We also provide free language services to people whose primary language is not English, such as qualified interpreters and member materials written in other languages.

If you need these services, please call SelectHealth Member Services at **1-800-538-5038**. Any member or other person who believes he/she may have been subject to discrimination may file a complaint or grievance by calling the SelectHealth 504/Civil Rights Coordinator at **1-844-208-9012** or the Compliance Hotline at **1-800-442-4845** (TTY Users: 711). You may also call the Office for Civil Rights at **1-800-368-1019** (TTY Users: **1-800-537-7697**).

selecthealth.

Language Access Services

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a SelectHealth: **1-800-538-5038**.

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 SelectHealth: **1-800-538-5038**. 。

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số SelectHealth: **1-800-538-5038**.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. SelectHealth: **1-800-538-5038**.

번으로 전화해 주십시오.

Navajo

Díí baa akó nínízin: Díí saad bee yáníltí̀go Diné Bizaad, saad bee áká̀ánída̓áwo̓dę́ę́'', t̓áá jiik̀eh, éí ná hóló', koj̨į̀ hódíílnih SelectHealth: **1-800-538-5038**.

Nepali

ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नमि्ति भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । SelectHealth: **1-800-538-5038** मा फोन गर्नुहोस्।

Tongan

FAKATOKANGA̓I: Kapau ʻoku ke lea fakatonga, ko e kau fakatonu lea te nau tokoni atu ta̓etotongi, pea te ke lava ʻo ma̓u ia. Telefoni ki he SelectHealth: **1-800-538-5038**.

Serb-Croatian

ОБАВЕШТЕЊЕ: Ако говорите српски језик, услуге језичке помоћи доступне су вам бесплатно. Позовите SelectHealth: **1-800-538-5038**.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa SelectHealth: **1-800-538-5038**.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: SelectHealth: **1-800-538-5038**.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните SelectHealth: **1-800-538-5038**

Arabic

ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم SelectHealth: **1-800-538-5038**.

Mon-khmer, Cambodian

សម្គាល់៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ សូវៅជំនួយផ្នែកភាសា ជាយមិនគិតថ្លៃ គឺអាចមានសវាប អ្នក។ សូមទូរស័ព្ទមក SelectHealth: **1-800-538-5038** ។

French

ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez SelectHealth: **1-800-538-5038**.

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。SelectHealth: **1-800-538-5038**. まで、お電話にてご連絡ください。

SECTION 1 INTRODUCTION

1.1 This Certificate

This Certificate of Coverage describes the terms and conditions of the health insurance Benefits provided under the Group Health Insurance Contract. 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, Inc.

SelectHealth is an HMO licensed by and **domiciled in the State of Utah and is located at 5381 Green Street, Murray, Utah 84123**. 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 the obligations or actions of SelectHealth.

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) agree 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 the principal office of SelectHealth. 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 the SelectHealth complaint resolution system.

1.10 Questions

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

1.11 Benefit Changes

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

a. In the event of a discrepancy between information given by a SelectHealth employee and the written terms of the Contract, the terms of the Contract will control.

b. Any changes or modifications that would increase your Benefits must be provided in writing and signed by the president, vice president, or medical director of 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. Eligibility may not be established retroactively.

2.3.2 Children

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

2.3.3 Disabled Children

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

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

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

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

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 26th birthday.

2.3.4 Incarcerated Dependents

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

2.4 Court-Ordered Dependent Coverage

When you or your lawful spouse are required by a court or administrative order to provide health insurance coverage for a child, the child will be enrolled in your family coverage according to SelectHealth guidelines and only to the minimum extent required pursuant to Utah Code Annotated 31A-22-610 through 611, and 718. If you are not enrolled for coverage at the time the court or administrative order becomes effective, only you and the affected Dependent will be allowed to enroll for coverage. 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:

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

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

c. The period to which the order applies.

2.4.2 National Medical Support Notice (NMSN)

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

2.4.3 Eligibility and Enrollment

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

2.4.4 Duration of Coverage

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

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 an Application accepted 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 an 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 an Annual Open Enrollment will take effect on the day the Contract is effective.

3.3.2 Newly Eligible Employees

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

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

3.3.3 Court or Administrative Order

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

a. The start date indicated in the order;

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

c. The date SelectHealth receives the order.

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 an Annual Open Enrollment if each of the following conditions are 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). One exception to this rule exists: if a Dependent is enrolled on another group health plan and the Annual Open Enrollment periods of the two plans do not coincide, the Dependent may voluntarily drop coverage under their health plan's open enrollment and a special enrollment period will be permitted under the Plan in order to avoid a gap in coverage; and

c. You and/or your Dependents who lost the other coverage must enroll in the Plan within 31 days after the date the other coverage is lost.

Proof of loss of the other 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:

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 guardianship court order or testamentary appointment 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 60 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.

3.4.5 As Required by State or Federal Law

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

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

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

a. If enrolling the child requires additional Premium, you must enroll the child within 31 days of the child's birth, adoption, or placement for adoption or under legal guardianship.

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 an Annual Open Enrollment or if you experience an event that creates a Special Enrollment Right.

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 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.

4.1.2 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 the minimum group participation and/or employer contribution requirements of SelectHealth;

e. No employees 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 Termination Date

If you and/or your enrolled Dependents lose Eligibility, then coverage will terminate either on the date Eligibility is lost or the end of the month in which Eligibility is lost, as specified in the Group Application. However, when a Dependent child ceases to be a Dependent, coverage will terminate at the end of the month in which Dependent status is lost. When a loss of Eligibility is not reported in a timely fashion as required by the Contract, and federal or state law prevents SelectHealth from retroactively terminating coverage, SelectHealth has the discretion to determine the prospective date of termination. SelectHealth also has the discretion to determine the date of termination for Rescissions.

4.2.2 Fraud or Misrepresentation

a. Made During Enrollment:

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

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

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

b. Made After Enrollment: Coverage for you and/or your Dependents may be terminated or Rescinded if you or they commit fraud or make an intentional misrepresentation of material fact in connection with Benefits or Eligibility. At the discretion of SelectHealth, the Rescission may be effective retroactively to the date of the fraud or misrepresentation.

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

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 an 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.

4.2.6 Court or Administrative Order

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

4.3 Member Receiving Treatment at Termination

All Benefits under the Plan terminate when the Contract terminates, including coverage for Members hospitalized or otherwise within a course of care or treatment. 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 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 or Utah mini-COBRA (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.

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:

a. Notify persons entitled to Continuation Coverage;

b. Notify SelectHealth of such individuals; and

c. 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 Minimum Extent

Continuation Coverage will only be provided for the minimum time and only to the minimum extent required by applicable federal law or pursuant to Utah Code Annotated 31A-22-722. 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.

6.1.1 Participating Providers and Facilities

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

6.1.2 Nonparticipating Providers and Facilities

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

6.1.3 Other Networks

For Dependent children residing and receiving care outside of the Service Area, Participating Benefits apply for Services received from Providers on the Select Med network in Utah, SelectHealth network in Idaho, and MultiPlan/PHCS Providers outside of Utah or Idaho. Contact Member Services for additional information.

6.2 Access to Healthcare Providers

You may be entitled to coverage for healthcare Services from the following Nonparticipating Providers if you live or reside within 30 paved road miles of the listed Providers, or if you live or reside in closer proximity to the listed Providers than to your Participating Providers:

Independent Hospital(s)
Brigham City Community Hospital, Brigham City, Box Elder County, Utah

Federally Qualified Health Centers
Beaver Medical Clinic, Beaver, Beaver County, Utah
Blanding Family Practice/Blanding Medical Center, Blanding, Utah
Bryce Valley Clinic, Cannonville, Utah
Carbon Medical Services, Carbon, Carbon County, Utah
Circleview Clinic, Circleview, Piute County, Utah
Duchesne Valley Medical Clinic, Duchesne, Duchesne County, Utah
Emery Medical Center, Castledale, Emery County, Utah
Enterprise Valley Medical Clinic, Enterprise, Washington County, Utah
Garfield Memorial Clinic, Panguitch, Garfield County, Utah
Green Valley/River Clinic, Green River, Emery/Grand Counties, Utah
Halchita Clinic, San Juan County, Utah
Hurricane Family Practice Clinic, Hurricane, Washington County, Utah
Kamas Health Center, Kamas, Summit County, Utah
Kazan Memorial Clinic, Escalante, Garfield County, Utah
Long Valley Medical, Kane County, Utah
Milford Valley Clinic, Milford, Beaver County, Utah
Montezuma Creek Health Center, Montezuma Creek, San Juan County, Utah
Monument Valley Health Center, Monument Valley, Utah
Navajo Mountain Health Center, San Juan County, Utah
Wayne County Medical Clinic, Bicknell, Wayne County, Utah

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

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

6.3 Providers and Facilities not Agents/Employees of 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.

6.4 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.

6.4.1 Incentives

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

6.4.2 Payments to Members

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

6.5 Provider/Patient Relationship

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

6.6 Continuity of Care

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

If you or your Dependent is under the care of a Provider when 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 the Allowed Amount as payment in full;

b. Follow SelectHealth's Healthcare Management Program 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

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, Limitations on the use of Nonparticipating Providers and Facilities, and expenses that do not count against your Out-of-Pocket Maximum.

7.3 Identification (ID) Cards

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

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

7.4 Medical Necessity

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

7.5 Benefit Changes

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

7.6 Calendar-Year or Plan-Year Basis

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

7.7 Lifetime Maximums

Your Member Payment Summary will specify any applicable Lifetime Maximums.

7.8 Two Benefit Levels

7.8.1 Participating Benefits

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

7.8.2 Nonparticipating Benefits

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

7.9 Emergency Conditions

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

If you or your Dependent is hospitalized for an emergency:

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

b. If you are in a Nonparticipating Facility, once the 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 Out-of-Area Benefits and Services

Other than for Emergency Conditions and Urgent Conditions, as described above, Nonparticipating Benefits apply for Covered Services rendered by Nonparticipating Providers or Facilities outside of SelectHealth's Service Area.

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

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

b. Visit selecthealth.org;

c. Refer to your Provider & Facility Directory; or

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

8.1 Facility Services

8.1.1 Educational Training

Only when rendered by a Participating Provider for a covered diagnosis.

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

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

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

8.1.5 Outpatient Facility and Ambulatory Surgical Facility

Outpatient surgical and medical Services.

8.1.6 Skilled Nursing Facility

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

8.1.7 Urgent Care Facility

8.2 Provider Services

8.2.1 After-Hours Visits

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

8.2.2 Anesthesia

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

8.2.3 Dental Services

Only:

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

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

   i. Maxillary and/or mandibular procedures;

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

   iii. Orthognathic Services; or

   iv. Services for Congenital Oligodontia/Anodontia.

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

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

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

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

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

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

8.2.4 Dietary Products

Only in the following limited circumstances:

a. For hereditary metabolic disorders when:

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

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

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

b. Certain enteral formulas according to SelectHealth policy.

8.2.5 Genetic Counseling

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

8.2.6 Genetic Testing

Only in the following circumstances and according to SelectHealth criteria or as required by state or federal law:

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

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

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

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

8.2.7 Home Visits

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

8.2.8 Infertility

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

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

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

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

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

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

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

8.2.11 Medical/Surgical

In an inpatient, outpatient, or Ambulatory Surgical Facility.

8.2.12 Maternity Services

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

8.2.13 Office Visits

For consultation, diagnosis, and treatment.

8.2.14 Preventive Services

8.2.15 Sleep Studies

Only when provided by:

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

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

8.2.16 Sterilization Procedures

8.3 Miscellaneous Services

8.3.1 Adoption Indemnity Benefit

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

If you adopt more than one child from the same birth (e.g., twins), only one adoption indemnity Benefit applies. If you and/or your spouse are covered by multiple plans, 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 Ambulance/Transportation Services

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

8.3.3 Approved Clinical Trials

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

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

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

c. Either:

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

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

8.3.4 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.

8.3.6 Durable Medical Equipment (DME)

Only:

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

   i. Prescribed by a Provider;

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

   iii. Required for Activities of Daily Living;

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

   v. Not attached to a home or vehicle.

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

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

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. Injectable drugs and specialty medications must be provided by a Participating Provider unless otherwise approved in writing in advance by SelectHealth. You may be required to receive the drug or medication in your Provider's office. Some Injectable Drugs and Specialty Medications may only be obtained from certain drug distributors. Call Member Services to determine if this is the case and to obtain information on participating drug vendors.

8.3.10 Miscellaneous Medical Supplies (MMS)

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

8.3.11 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. Patients with Parkinson's Disease;

d. Stroke patients undergoing formal rehabilitation; and

e. Post-traumatic-brain-injury patients.

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

8.3.12 Organ Transplants

a. Only if:

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

b. And only the following:

i. Bone marrow as outlined in SelectHealth criteria;

ii. Combined heart/lung;

iii. Combined pancreas/kidney;

iv. Cornea;

v. Heart;

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

vii. Liver;

viii. Pancreas after kidney; and

ix. Single or double lung.

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

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

8.3.13 Orthotics and Other Corrective Appliances for the Foot

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

8.3.14 Osteoporosis Screening

Only central bone density testing (DEXA scan)

8.3.15 Private Duty Nursing

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

8.3.16 Rehabilitation Therapy

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

8.3.17 Temporomandibular Joint (TMJ)

8.3.18 TeleHealth

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

8.3.19 Vision Aids

Only:

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

b. Monofocal intraocular lenses after cataract surgery.

8.4 Prescription Drug Services

Refer to Section 9 Prescription Drug Benefits for details.

SECTION 9 PRESCRIPTION DRUG BENEFITS

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

9.1 Prescription Drug Benefit Resources

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

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

b. Visit selecthealth.org/pharmacy;

c. Refer to your Provider & Facility Directory; or

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

9.2 Use Participating Pharmacies

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

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

9.3 Tiered Benefits

There are tiers (or levels) of covered prescriptions listed on your ID card and 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.

9.4 Filling Your Prescription

9.4.1 Copay/Coinsurance

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

9.4.2 Quantity and Day Supply

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

9.4.3 Refills

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

9.5 Generic Drug Substitution Required

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

9.6 Maintenance Drugs

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

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

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

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

Maintenance drugs are identified by the letter (M) on the Prescription Drug List. You have two options when filling prescriptions under the maintenance drug Benefit: (1) Retail90SM, 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.

9.7 Preauthorization of Prescription Drugs

There are certain drugs that require Preauthorization by your Provider 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 drug is prescribed in excess of the Plan limits (quantity, duration of use, maximum dose, etc.). The most current information can be found at the SelectHealth website.

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

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

9.8 Step Therapy

Certain drugs require your Provider to first prescribe an alternative drug preferred by 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. The letters (ST) appear next to each drug that requires step therapy.

9.9 Coordination of Benefits (COB)

If you have other health insurance that is your primary coverage, claims must be submitted first to your primary insurance carrier before being submitted to 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 drugs.

a. These drugs include:
   i. Narcotic analgesics;
   ii. Other addictive or potentially addictive drugs; and
   iii. Drugs prescribed in quantities, dosages, or usages that are outside the usual standard of care for the medication in question.

b. These drugs are not covered when they are prescribed:
   i. Outside the usual standard of care for the practitioner prescribing the drug;
   ii. In a manner inconsistent with accepted medical practice; or
   iii. For indications that are Experimental and/or Investigational.

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

9.11 Prescription Drug Benefit Abuse

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

a. Obtain prescriptions in limited dosages and supplies;

b. Obtain prescriptions only from a specified Provider;

c. Fill your prescriptions at a specified pharmacy;

d. Participate in specified treatment for any underlying medical problem (such as a pain management program);

e. Complete a drug treatment program; or

f. Adhere to any other specified limitation or program designed to reduce or eliminate drug abuse or dependence.

If you seek to obtain drugs in amounts in excess of what is Medically Necessary, such as making repeated emergency room/urgent care visits to obtain drugs, 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, such as by intentionally misrepresenting your condition, other medications, healthcare encounters, or other medically relevant information. At the discretion of SelectHealth, you may be permitted to retain your coverage if you comply with specified conditions.

9.12 Pharmacy Injectable Drugs and Specialty Medications

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

9.13 Prescription Drug List (PDL)

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

9.14 Exceptions Process

If your Provider believes that you require a certain drug that is not on your Formulary, normally requires step therapy, or exceeds a Quantity Limit, he or she may request an exception through the Preauthorization process.

9.15 Prescriptions Dispensed in a Provider's Office

Prescriptions dispensed in a Provider's office are not covered unless expressly approved by SelectHealth.

9.16 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 A Optional Benefits, the following Limitations and Exclusions apply.

10.1 Abortions/Termination of Pregnancy

Abortions are not covered except:

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

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

Medical complications resulting from an abortion 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 Administrative 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. Rebuck Skin Window Test;

   viii. Rinkel Test;

   ix. Subcutaneous Provocative Food and Chemical Test; and

   x. Sublingual Provocative Food and Chemical Test.

b. The following allergy treatments are not covered:

   i. Allergoids;

   ii. Autogenous urine immunization;

   iii. LEAP therapy;

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

   v. Neutralization therapy;

   vi. Photo-inactivated extracts; and

   vii. Polymerized extracts.

10.5 Anesthesia

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

10.6 Bariatric Surgery

Surgery, including any revision or reversal of such surgery, to facilitate weight loss is not covered. This Exclusion does not apply if your Member Payment Summary indicates that your Plan includes the Bariatric Surgery Optional Benefit.

10.7 Biofeedback/Neurofeedback

Biofeedback/neurofeedback is not covered.

10.8 Birthing Centers and Home Childbirth

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

10.9 Certain Cancer Therapies

Neutron beam therapy is not covered.

Proton beam therapy is not covered except in the following limited circumstances:

a. Chordomas or chondrosarcomas arising at the base of the skull or along the axial skeleton without distant metastases;

b. Other central nervous system tumors located near vital structures;

c. Pituitary neoplasms;

d. Uveal melanomas confined to the globe (not distant metastases); or

e. In accordance with SelectHealth medical policy.

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

10.10 Certain Illegal Activities

Subject to the nondiscrimination provisions of the Health Insurance Portability and Accountability Act (HIPAA), Services for an illness, condition, accident, or injury related directly to voluntary participation in an illegal activity are not covered. This exclusion does not apply for any injuries sustained from an act of domestic violence or a medical condition.

10.11 Chiropractic Services

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

10.12 Claims After One Year

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

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

10.13 Complementary and Alternative Medicine (CAM)

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

10.14 Custodial Care

Custodial Care is not covered.

10.15 Debarred Providers

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

10.16 Dental Anesthesia

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

a. You or your Dependent is developmentally delayed, regardless of his or her chronological age;

b. You or your Dependent, regardless of age, has a congenital cardiac or neurological condition and documentation is provided that the dental anesthesia is needed to closely monitor the condition; or

c. You or your Dependent is younger than five years of age and:

   i. The proposed dental work involves three or more teeth;

   ii. The diagnosis is nursing bottle-mouth syndrome or extreme enamel hypoplasia; and

   iii. The proposed procedures are restoration or extraction for rampant decay.

10.17 Dry Needling

Dry needling procedures are not covered.

10.18 Duplication of Coverage

The following are not covered:

a. Services that are covered by, or would have been covered, if you or your Dependents had enrolled and maintained coverage in automobile insurance, including no-fault type coverage up to the minimum amount required by law. In the event of a claim, you should provide a copy of the Personal Injury Protection (PIP) documentation from the automobile insurance carrier.

b. Services that are covered by, or would have been covered, if your employer had enrolled and maintained coverage in, Workers' Compensation insurance.

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

d. Services received by you or one of your Dependents while incarcerated in a prison, jail, or other correctional facility at the time Services are provided, including care provided outside of a correctional facility to a person who has been arrested or is under a court order of incarceration.

10.19 Exercise Equipment or Fitness Training

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

10.20 Experimental and/or Investigational Services

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

10.21 Eye Surgery, Refractive

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

10.22 Food Supplements

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

10.23 Hearing Aids

Except for cochlear implants, as described in Section 8 Covered Services, and unless otherwise noted in your Member Payment Summary, 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.

10.24 Home Health Aides

Services provided by a home health aide are not covered.

10.25 Immunizations

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

10.26 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 Optional Benefit.

10.27 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.

10.28 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.

10.29 Prescription Drugs/Injectable Drugs and Specialty Medications

The following are not covered:

a. Appetite suppressants and weight loss drugs;

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

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

d. Compound drugs when alternative products are available commercially;

e. Cosmetic health and beauty aids;

f. Drugs not on your Formulary;

g. Drugs purchased from Nonparticipating Providers over the Internet;

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

i. Flu symptom drugs, except when approved by an expert panel of Physicians and SelectHealth;

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

k. Infertility drugs;

l. Medical foods;

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

   i. Food and Drug Administration (FDA) approval;

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

   iii. Nationally recognized compendium sources currently utilized by SelectHealth;

   iv. National Comprehensive Cancer Network (NCCN); or

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

n. Drugs used for infertility purposes;

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

p. New drugs approved by the FDA after the previous May 1st, unless approved for coverage by SelectHealth;

q. Non-Sedating Antihistamines;

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

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

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

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

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

t. Prescription Drugs used for cosmetic purposes;

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

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

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

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

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

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

10.30 Reconstructive, Corrective, and Cosmetic Services

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

i. To improve form or appearance;

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

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

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

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

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

i. Congenital cleft lip except for treatment rendered within 12 months of birth, or a planned, staged series of Services (as specifically documented in you or your Dependent's medical record) is initiated, or when congenital cleft lip surgery is performed as part of a cleft palate repair; or

ii. Treatment for venous telangiectasias (spider veins).

10.31 Related Provider Services

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

10.32 Respite Care

Respite Care is not covered.

10.32 Robot-Assisted Surgery

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

10.33 Sexual Dysfunction

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

10.34 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.

10.35 Specific Services

The following Services are not covered:

a. Anodyne infrared device for any indication;

b. Auditory brain implantation;

c. Automated home blood pressure monitoring equipment;

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

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

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

g. Computer-assisted navigation for orthopedic procedures;

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

i. Extracorporeal shock wave therapy for musculoskeletal indications;

j. Freestanding/home cervical traction;

k. Home anticoagulation or hemoglobin A1C testing;

l. Infrared light coagulation for the treatment of hemorrhoids;

m. Interferential/neuromuscular stimulators;

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

o. Magnetic Source Imaging (MSI);

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

q. Mole mapping;

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

s. Nucleoplasty or other forms of percutaneous disc decompression;

t. Oncofertility;

u. Pediatric/infant scales;

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

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

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

y. Prolotherapy;

z. Radiofrequency ablation for lateral epicondylitis;

aa. Radiofrequency ablation of the dorsal root ganglion;

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

cc. Whole body scanning.

10.36 Telephone/E-mail Consultations

Except for TeleHealth Services, as described in Section 8 Covered Services, charges for Provider telephone, e-mail, or other electronic consultations are not covered.

10.37 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.

10.38 Travel-related Expenses

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

10.39 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. Preauthorization requirements for Prescription Drugs are also found in Section 9 – Prescription Drug Benefits.

11.1.1 Services Requiring Preauthorization

Preauthorization is required for the following Services:

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

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

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

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

e. Joint replacement;

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

g. Pain management/pain clinic Services;

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

i. Certain genetic testing;

j. Certain ultrasounds;

k. Certain radiation therapies;

l. Certain sleep studies;

m. Certain medical oncology drugs;

n. Continuous glucose monitors;

o. Hysterectomy;

p. Tonsillectomy;

q. Adenoidectomy;

r. Vision rehabilitation therapy;

s. Outpatient Rehabilitative, Habilitative, and Chiropractic-therapy Services after 10 visits;

t. The following Durable Medical Equipment:

   i. Insulin pumps;

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

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

iv. Motorized or customized wheelchairs; and

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

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

In addition to these Services, Participating Providers must Preauthorize other Services as specified in SelectHealth medical policy.

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.

11.1.3 How to request Preauthorization

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

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

11.1.4 Penalties

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

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

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

11.2 Case Management

If you have certain serious or chronic conditions (such as spinal cord injuries, diabetes, asthma, or premature births), 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 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 do not supersede the express provisions of this Certificate. Coverage decisions are subject to all terms and conditions of the applicable Plan, including specific Exclusions and Limitations. Because medical policies are based on constantly changing science, they are periodically reviewed and updated by SelectHealth. For questions about SelectHealth's medical policies, call Member Services at 800-538-5038.

SECTION 12 CLAIMS AND APPEALS

12.1 Administrative Consistency

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

12.2 Claims and Appeals Definitions

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

12.2.1 Adverse Benefit Determination

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

12.2.2 Appeal(s)

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 Appeals process.

12.2.9 Independent Review Organization (IRO)

An entity that conducts independent External Reviews.

12.2.10 Postservice Appeal

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

12.2.11 Postservice Claim

Any claim related to Services you have already received.

12.2.12 Preservice Appeal

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

12.2.13 Preservice Claim

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

12.2.14 Urgent Preservice Claim

Any Preservice Claim that, if subject to the normal timeframes for determination, could seriously jeopardize your life, health or ability to regain maximum function or that, in the opinion of your treating Physician, would subject you to severe pain that could not be adequately managed without the requested Services. Whether a claim is an Urgent Preservice Claim will be determined by an individual acting on behalf of 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 File a Claim for Benefits

12.3.1 Urgent Preservice Claims

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

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

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

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

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

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

12.3.2 Other Preservice Claims

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

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

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

12.3.3 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 12-month period from the date of the expense or as soon as reasonably possible. Claims received outside of this timeframe will be denied. Failure to file a claim does not bar recovery under the policy if SelectHealth fails to show it was prejudiced by the failure.

Notice of Adverse Benefit Determinations will be provided in writing within a reasonable period of time, but no later than 30 days after receipt of the claim. However, 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.

12.4 Problem Solving

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

12.5 Formal Appeals

If you are not satisfied with the result of working with Member Services, you may file a written formal Appeal of any Adverse Benefit Determination. Written formal Appeals should be sent to the 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.

12.5.1 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.

12.5.2 Form and Timing

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

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

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

12.5.3 Appeals Process

The Appeals process includes both mandatory and voluntary reviews. You must exhaust all mandatory reviews before you may pursue civil action, including, if applicable, 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 Appeal is pending. Your decision whether or not to seek voluntary review will have no effect on your rights to any other Benefits. SelectHealth will provide you, upon request, sufficient information to enable you to make an informed decision about whether or not to engage in a voluntary review.

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

12.5.4 Preservice Appeals

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

Mandatory Review

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. However, SelectHealth may extend this period 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.

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

Voluntary Review

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

Voluntary External Review

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, or a Rescission of coverage. To request an External Review, you must complete the Independent Review Request Form. For a copy of this form, or for other questions, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City, UT 84114; by phone at 801-538-3077; or electronically at healthappeals.uid@utah.gov. An External Review request must be made within 180 days from the date the Appeals Department notifies you of the Final Internal Adverse Benefit Determination. An authorization to obtain medical records may be required. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. The IRO will provide written notice of its decision within 45 days after receipt of the request.

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

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

Voluntary Internal Review

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

12.5.5 Postservice Appeals

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

Mandatory Review

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

Voluntary Review

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

Voluntary External Review

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, or a Rescission of coverage. To request an External Review you must complete the Independent Review Request Form. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. For a copy of this form, or for other questions, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City, UT 84114; by phone at 801-538-3077; or electronically at healthappeals.uid@utah.gov. An External Review request must be made within 180 days from the date SelectHealth sends the Final Internal Adverse Benefit Determination. An authorization to obtain medical records may be required. The IRO will provide written notice of its decision within 45 days after receipt of the request.

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

Voluntary Internal Review

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

SECTION 13 OTHER PROVISIONS AFFECTING YOUR BENEFITS

13.1 Coordination of Benefits (COB)

When you or your Dependents have healthcare coverage under more than one health benefit plan, SelectHealth will coordinate Benefits with the other healthcare coverage according to the COB rules set forth in Utah Administrative Code R590-131.

13.1.1 Required Cooperation

You are required to cooperate with SelectHealth in administering COB. Cooperation may include providing notice of other health benefit coverage, copies of divorce decrees, bills and payment notices from other payers, and/or signing documents required by SelectHealth to administer COB. 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 the responsibility of SelectHealth. 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, Reimbursement and Recovery

13.2.1 Payment of Claims When a Third Party is Liable

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

13.2.2 SelectHealth's Recovery Rights

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

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

13.2.3 Agreement by Members

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

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

13.2.4 Constructive Trust and First Lien

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

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

13.2.5 Rights to Intervene and Sue

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 SelectHealth's restitution and other interests described in this section 13.2. 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 restitution or other interests under this section 13.2, to enforce the constructive trust required by this section 13.2, and/or take any other action to collect funds from you.

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

The amount that SelectHealth is entitled to recover from you and your Dependents under this section 13.2 is specifically unreduced by any attorney, legal or other fees and costs incurred by you or your Dependents in seeking recovery from a third party (whether the third party is the responsible party or is an insurer), except if SelectHealth specifically agrees in writing to participate in these fees.

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

13.2.6 Special Subrogation Rules for Utah

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

13.3 Excess Payment

SelectHealth will have the right to recover any payment made in excess of the obligations of SelectHealth under the Contract. Such recoveries are limited to a time period of 12 months (or 24 months for a COB error) from the date a payment is made unless the recovery is due to fraud or intentional misrepresentation of material fact by you or your Dependents. This right of recovery will apply to payments made to you, your Dependents, 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:

14.1 Payment

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

14.2 Changes in Eligibility or Contact Information

Notify your employer when there is a change in your situation that may affect your Eligibility, the Eligibility of your 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.

15.3 Contract

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

15.4 Compliance

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

SECTION 16 DEFINITIONS

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

16.1 Activities of Daily Living

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

16.2 Affordable Care Act (ACA)

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

16.3 Allowed Amount

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

16.4 Ambulatory Surgical Facility

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

16.5 Annual Open Enrollment

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

16.6 Anodontia

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

16.7 Application

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

16.8 Approved Clinical Trials

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

a. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

   i. The National Institutes of Health.

   ii. The Centers for Disease Control and Prevention.

   iii. The Agency for Health Care Research and Quality.

   iv. The Centers for Medicare & Medicaid Services.

   v. Cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

   vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

   vii. Any of the following if the appropriate review and approval through a system of peer review has been attained:

      1) The Department of Veterans Affairs.

      2) The Department of Defense.

      3) The Department of Energy.

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

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

16.9 Autism Spectrum Disorder

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

a. Asperger's Syndrome;

b. Autistic Disorder;

c. Childhood Disintegrative Disorder; and

d. Pervasive developmental disorder not otherwise specified.

16.10 Benefit(s)

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

16.11 Certificate of Coverage (Certificate)

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

16.12 COBRA Coverage

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

16.13 Coinsurance

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

16.14 Continuation Coverage

COBRA Coverage and/or Utah mini-COBRA coverage.

16.15 Contraceptive

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

16.16 Contract

The Group Health Insurance Contract between SelectHealth and your employer.

16.17 Copay (Copayment)

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

16.18 Covered Services

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

16.19 Custodial Care

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

16.20 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.

16.21 Dental Services

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

16.22 Dependents

Your Eligible dependents as set forth in Section 2 Eligibility.

16.23 Durable Medical Equipment (DME)

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

16.24 Effective Date

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

16.25 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.

16.26 Emergency Condition(s)

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

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

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

c. Serious impairment to bodily functions; or

d. Serious dysfunction of any bodily organ or part.

16.27 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.

16.28 Employer's Plan

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

16.29 Endorsement

A document that amends the Contract.

16.30 ERISA

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

16.31 Excess Charges

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

16.32 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.

16.33 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.

16.34 Facility

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

16.35 Formulary

The Prescription Drugs covered by your Plan.

16.36 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.

16.37 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. If your employer is not directly sponsoring the Plan, references to employer throughout the Certificate of Coverage can also include the party contracting with SelectHealth for Benefits provided to you (such as an association trust or board of trustees).

16.38 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.

16.39 Healthcare Management Program

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

16.40 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.

16.41 Hospice Care

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

16.42 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.

16.43 Infertility

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

16.44 Injectable Drugs and Specialty Medications

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

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

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

c. Require special training to administer;

d. Have special storage and handling requirements;

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

f. Often have additional monitoring requirements.

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

16.45 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.

16.46 Lifetime Maximum

The maximum accumulated amount that SelectHealth will pay for certain Covered Services (as allowed by the Affordable Care Act) during a 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 amount. If applicable, lifetime maximums are specified in your Member Payment Summary.

16.47 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.

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

b. Gene-based testing and genetic testing;

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

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

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

16.49 Major Surgery

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

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

b. Typically requiring general anesthesia;

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

d. Requires the special training to perform.

16.50 Maximum Annual Out-of-Network Payment

The maximum accumulated amount SelectHealth will pay each Year for Covered Services applied to the Nonparticipating (Out-of-Network) Benefit.

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

16.51 Medical Director

The Physician(s) designated as such by SelectHealth.

16.52 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.

16.53 Member

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

16.54 Member Payment Summary

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

16.55 Minor Diagnostic Tests

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

a. Bone density tests;

b. Certain EKGs;

c. Echocardiograms;

d. Common blood and urine tests;

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

f. Spirometry/pulmonary function testing.

16.56 Miscellaneous Medical Supplies (MMS)

Supplies that are disposable or designed for temporary use.

16.57 Nonparticipating (Out-of-Network) Benefits

A lower level of Benefits available for Covered Services obtained from a Nonparticipating Provider or Facility, even when such Services are not available through Participating Providers or Facilities.

16.58 Nonparticipating (Out-of-Network) Facility

Healthcare Facilities that are not under contract with SelectHealth.

16.59 Nonparticipating (Out-of-Network) Pharmacies

Pharmacies that are not under contract with SelectHealth.

16.60 Nonparticipating (Out-of-Network) Provider

Providers that are not under contract with SelectHealth.

16.61 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.

16.62 Oligodontia

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

16.63 Optional Benefit

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

16.64 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 Maximum amounts. Payments you make for Excess Charges, non-Covered Services, and certain categories of Services specified in your Member Payment Summary are not applied to the Out-of-Pocket Maximum.

16.65 Participating (In-Network) Benefits

The higher level of Benefits available to you when you obtain Covered Services from a Participating Provider or Facility.

16.66 Participating (In-Network) Facility

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

16.67 Participating (In-Network) Pharmacies

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

16.68 Participating (In-Network) Providers

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

16.69 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.

16.70 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.

16.71 Plan Sponsor

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

16.72 Preauthorization (Preauthorize)

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

16.73 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.

16.74 Prescription Drugs

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

16.75 Preventive Services

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

16.76 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.

16.77 Private Duty Nursing

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

16.78 Provider

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

16.79 Qualified Medical Child Support Order (QMCSO)

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

16.80 Rescission (Rescind)

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

16.81 Residential Treatment Center

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

16.82 Respite Care

Care provided primarily for relief or rest from caretaking responsibilities.

16.83 Routine Care

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

16.84 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).

16.85 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.

The Select Med Plus® Service Area is the State of Utah.

16.86 Service(s)

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

16.87 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.

16.88 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.

16.89 Subscriber

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

16.90 TeleHealth

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

16.91 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.

16.92 Utah mini-COBRA

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

16.93 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
optional benefits

selecthealth℠

MENTAL HEALTH/CHEMICAL DEPENDENCY OPTIONAL BENEFIT

1. Your Mental Health Benefits

This Optional Benefit 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 Optional Benefit, please call the Behavioral Health Advocates℠ weekdays, from 8:00 a. m. to 6:00 p. m. at 800-876-1989.

2. Using Participating Mental Health Providers

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

3. Services requiring Preauthorization

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

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 of your Certificate of Coverage for additional information.

4. Exclusions

4.1 The following Services are not covered:

a. Behavior modification;

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

c. Education or training;

d. Long-term care;

e. Marriage counseling and/or therapy;

f. Milieu therapy;

g. Rest cures;

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

i. Surgical procedures to remedy a condition diagnosed as psychological, emotional, or mental.

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

ASH CHIROPRACTIC OPTIONAL BENEFIT

Your Chiropractic Benefits are administered by American Specialty Health Group, 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 Group Incorporated
Attn: ASH Member Services Department
P.O. Box 509002
San Diego, CA 92150-9002

1. Definitions

This Optional Benefit uses the following capitalized defined terms in addition to Section 16Ð"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 Practitioner 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 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 Musculoskeletal and Related 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. Examples of Clinical Appeals may include the following scenarios:

a. Treatment plan was denied or modified due to lack of Medical Necessity.

b. The number of visits requested by the Practitioner did not meet clinical criteria.

1.8 Covered Chiropractic Services

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

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 Musculoskeletal and Related Disorders

Musculoskeletal and Related Disorders are conditions with associated signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related 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 the state in which they provide the Service 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 Medical Necessity Review Form (MNR Form) 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 an MNR 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 an MNR 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 an MNR 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; services that are provided pursuant to a continuity of care plan approved by ASH Networks; or services that are provided upon referral by ASH Networks in situations where such services are not available and accessible to a Member from a Contracted Practitioner within the Service Area;

c. Services for examinations (other than an initial examination to determine the appropriateness of Chiropractic Services) and/or treatments for conditions other than those related to Musculoskeletal and Related Disorders;

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. Services for children 12 and younger;

i. Magnetic resonance imaging (MRI), CAT scans, and any types of diagnostic radiology;

j. Transportation costs including local ambulance charges;

k. Education programs, nonmedical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing;

l. Services or treatments for pre-employment physicals or vocational rehabilitation;

m. Any services or treatments caused by or arising out of the course of employment or covered under any public liability insurance;

n. 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;

o. All chiropractic appliances or Durable Medical Equipment, except as specified herein;

p. Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order;

q. Services provided by a chiropractor practicing outside of the Service Area, except for Emergency Chiropractic Services.

r. Hospitalization, anesthesia, manipulation under anesthesia, or other related services;

s. All auxiliary aids and services, including interpreters, transcription services, written materials, telecommunication devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids;

t. Adjunctive therapy not associated with spinal, muscle, or joint manipulation;

u. Vitamins, minerals, nutritional supplements, injectable supplements and injection services, or other similar products;

v. Any services or treatments that are furnished before the date the Member becomes eligible or after the date the member ceases to be eligible under the Member's plan;

w. Massage Therapy, venipuncture, or Natural childbirth services;

x. Services rendered in excess of visits or benefit maximums;

y. Any service or supply that is not permitted by state law with respect to the provider's scope of practice;

z. Any services provided by a person who is a Family Member. Family Member means a person who is related to the covered person in any of the following ways: spouse, domestic partner, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child). A Family Member also includes individuals who normally live in the covered person's household; or

aa. Any services rendered for elective or maintenance care (e.g., services provided to a Member whose treatment records indicate he or she has reached Maximum Therapeutic Benefit).

7. This Optional Benefit

This Optional Benefit 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 Optional Benefit administered by ASH and that the provisions have been applied consistently with respect to similarly situated Claimants.

8.1 Defined Terms

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

8.1.1 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 ASH Utilization Management Program, and determinations that particular Services are Experimental and/or Investigational or not Medically Necessary or appropriate.

8.1.2 Appeal(s)

Review by ASH of an Adverse Benefit Determination.

8.1.3 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 ASH Appeals Department or ASH 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.

8.1.4 Benefit Determination

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

8.1.5 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.

8.1.6 Concurrent Care Decisions

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

8.1.7 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).

8.1.8 Final Internal Adverse Benefit Determination

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

8.1.9 Independent Review Organization (IRO)

An entity that conducts independent External Reviews.

8.1.10 Postservice Appeal

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

8.1.11 Postservice Claim

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

8.1.12 Preservice Appeal

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

8.1.13 Preservice Claim

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

8.1.14 Urgent Preservice Claim

Any Preservice Claim that if subject to the normal timeframes for determination could seriously jeopardize your life, health, or ability to regain maximum function or that, in the opinion of your treating Physician, would subject you to severe pain that could not 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 Physician determines is an Urgent Preservice Claim will be treated as such.

8.3 How to File a Claim for Benefits

8.3.1 Urgent Preservice Claims

In order to file an Urgent Preservice Claim, you must provide ASH 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, ASH will notify you of the failure and the proper procedures to be followed. ASH will notify you as soon as reasonably possible, but no later than 24 hours after receiving the claim. This notice may be verbal unless you specifically request otherwise in writing.

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

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

8.3.2 Other Preservice Claims

The procedure for filing most Preservice Claims (Preauthorization) is set forth in Section 11 Healthcare Management. If there is any other Benefit that would be subject to a Preservice Claim, you may file a claim for that Benefit by contacting ASH Member Services. Under certain circumstances provided by federal law, if you fail to follow the proper procedures for filing a Preservice Claim, ASH 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, 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 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 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.

8.3.3 Postservice Claims

a. Participating Practitioner(s) and Facilities. Participating Practitioner(s) and Facilities file Postservice Claims with ASH and ASH makes payment to the Providers and Facilities.

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

Notice of Adverse Benefit Determinations will be provided in writing within a reasonable period of time, but no later than 30 days after receipt of the claim. However, ASH may extend this period 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.

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.

8.4 Problem Solving

ASH is committed to making sure that any concerns or problems regarding your claims are investigated and resolved as soon as possible. Many situations can be resolved informally by contacting ASH Member Services at 800-678-9133.

8.5 Formal Appeals

If you are not satisfied with the result of working with ASH Member Services, you may file a written formal Appeal of any Adverse Benefit Determination. Written formal Appeals should be sent to the ASH Appeals Department. As the delegated claims review fiduciary under your Employer's Plan, 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.

8.5.1 General Rules and Procedures

You will 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.

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 ASH in connection with the Adverse Benefit Determination, whether or not the advice was relied upon in making the Adverse Benefit Determination.

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

8.5.2 Form and Timing

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

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

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 ASH Appeals Department at 800-678-9133.

If the request is made verbally, the ASH Appeals Department 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.

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

8.5.3 Appeals Process

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

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

8.5.4 Preservice Appeals

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

Mandatory Review

Your Appeal will be investigated by the ASH Appeals Department. All relevant, available information will be reviewed. The ASH 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. However, ASH may extend this period 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 your Appeal involves an Urgent Preservice Claim, you may request an expedited review. You will be notified of the Appeal decision on an expedited review as soon as possible, taking into account the medical circumstances, but no later than 72 hours after the receipt of your Appeal. A decision communicated verbally will be followed up in writing.

Voluntary Review

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

Voluntary External Review

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, or a Rescission of coverage. To request an External Review, you must complete the Independent Review Request Form. For a copy of this form, or for other questions, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City, UT 84114; by phone at 801-538-3077; or electronically at healthappeals.uid@utah.gov. An External Review request must be made within 180 days from the date the ASH Appeals Department notifies you of the Final Internal Adverse Benefit Determination.

An authorization to obtain medical records may be required. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. The IRO will provide written notice of its decision within 45 days after receipt of the request.

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

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

Voluntary Internal Review

If you choose to pursue the voluntary internal review process, you may first request a review of your Appeal by the ASH Grievance Committee. Such a request must be made in writing to the ASH Appeals Department within 60 days of the date the ASH Appeals Department notifies you the Final Internal Adverse Benefit Determination. ASH will notify you of the result of the review in writing within 30 days of the date you requested the review. However, ASH may extend this period 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 you are not satisfied with the decision made by the ASH Grievance Committee, you may request a review by the ASH Appeals Committee. Such a request must be made in writing to the ASH Appeals Department within 60 days of the date the ASH Grievance Committee notifies you of its decision.

8.5.5 Postservice Appeals

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

Mandatory Review

Your Appeal will be investigated by the ASH Appeals Department. All relevant information will be reviewed and the ASH 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. However, ASH may extend this period 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.

Voluntary Review

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

Voluntary External Review

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, or a Rescission of coverage. To request an External Review you must complete the Independent Review Request Form. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. For a copy of this form, or for other questions, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City, UT 84114; by phone at 801-538-3077; or electronically at healthappeals.uid@utah.gov. An External Review request must be made within 180 days from the date of ASH's Final Internal Adverse Benefit Determination. An authorization to obtain medical records may be required. The IRO will provide written notice of its decision within 45 days after receipt of the request.

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

Voluntary Internal Review

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

Once approved, please forward to Contract Administrator

UTA

CONTRACT ROUTING SHEET

Agenda Item No.:
Board Review Date:

CONTRACT SECTION

1) Contract/P.O. No. **16-2067TP-4** *(Assigned by Purchasing)* Contract Administrator: **Teressa Pickett**
Project Manager: **Jacob Gomez**

2) Contract Type ☐ A. A&E/Design ☐ B. Blanket PO ☐ C. Construction ☐ D. Goods ☐ E. Modification ☑ E. Option ☐ F. Other _____ ☐ G. Renewal ☐ H. Services ☐ I. Task Orders

3) Procurement Method ☐ RFQ (Quote) ☐ IFB (Low Bid) ☐ RFQU (Qualification) ☑ RFP (Best-value) ☐ Sole source ☐ Other: _____

4) Contract Title **Employer Health Insurance Agreement - Bargaining**

5) Description / Purpose *(of contract or project)* **Employer Health Insurance Agreement between UTA/ATU Joint Insurance Trust and SelectHealth for Medical Healthcare Benefits.**

6) Contractor Name **SelectHealth**

7) Effective Dates Beginning: **05/01/19** Ending: **04/30/20**

8) Option to renew? ☑ Yes ☐ No Renewal terms: **One year term (starting 5/1/17) with an option to renew every year up to a total of 5 years, ending 4/30/2022.**

FINANCIAL SECTION

9) Total Board Approval Amount:

9a) Current Contract Value:	$ 25,000,000.00
9b) Amendment Amount:	$ 12,500,000.00
9d) New Contract Value (including all amendments)	$ 37,500,000.00

9e) Is the amount an estimate? ☑ Yes ☐ No
(Estimate if per transaction cost)

9f) *If estimated, how was the estimate calculated?* The total amount is dependent on how many employees choose the Select Health program for their insurance.

10) Is the amount a one-time purchase or annual recurring purchase? ☐ One-time ☑ Recurring

11) Account Code ~~4-10410-IHC~~ JIC Capital Project Code

12) Budgeted? ☑ Yes ☐ No Budget amount: **$ 37,500,000.00**

13) Will this contract require support from another department? ☑ Yes ☐ No

14) If so, is the other department(s) aware of this contract and the required support? ☑ Yes ☐ No

15) If box 2a or 2c is checked, has the Qualified Heath Insurance Certificate been verified? N/A ☐ Yes ☐ No

SIGNATURE SECTION

	Route to?		Initials	
Contract Compliance	☑ Yes			Lisa Bohman
Accounting Review	☑ Yes	☐ No		Trey Billings for Bryan Steele
IT Review (IT software or hardware)	☐ Yes	☑ No		N/A
Up to $10K Manager/Program Manager	☑ Yes	☐ No		Jacob Gomez
Up to $50K Dir, Sr. Mgr, RGM, or Chief/VP	☐ Yes	☑ No		N/A
Up to $100K Chief/VP, or Dir, Sr. Mgr, RGM (Capital, Maint., Ops. only)	☑ Yes	☐ No		Kimberly S. Ulibarri
Over $100K Executive Director	☑ Yes	☐ No		W. Steve Meyer
Over $200K Board Approval	☑ Yes	☐ No		Approval Date

If Yes, route to the Sr. Supply Chain Manager for board meeting agenda and approval

2019

Medical Contract

UTA-ATU / Joint Insurance Trust

selecthealth.

GROUP APPLICATION

Product	Select Med PLUS
Employer	UTA-ATU/Joint Insurance Trust
Employer Contact	Heather Austin
Employer Address	669 W 200 S
	SALT LAKE CITY, UT 84101

Affiliated Businesses/Subsidiaries Covered by this Application

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

1. Monthly Premiums.

On or before the first day of each month, employer shall pay the following Premiums to SelectHealth:

$ 517.14	for each single party enrollment
$ 1292.38	for each Subscriber plus spouse enrollment
$ 1292.38	for each Subscriber plus child enrollment
$ 1809.52	for each Subscriber plus children enrollment
$ 1809.52	for each family enrollment

2. Eligibility, Prepayment and Enrollment Criteria.

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

2.1 Scheduled hours of work per week.

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

2.2 Portion of Premium Subscriber must contribute.

Wellness program	No Wellness	
$92.00	$117.08	for each single party enrollment
$227.55	$290.68	for each two party enrollment
$321.47	$410.79	for each family enrollment

2.3 Limiting Age.

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

2.4 Retirees.

Retirees are not covered.

2.5 Domestic Partners.

Domestic partners are not covered.

2.6 Leave of Absence.

Eligible employees may be granted up to a 60 day leave of absence by employer or up to the time allowed for a qualifying leave under the Family Medical Leave Act. Leave time can only be accrued and used by the employee using the leave time. Leave banks beyond what is required by the FMLA, i.e. where employees share or purchase leave time from other employees, are not allowed.

2.7 Initial Eligibility Period.

The Initial Eligibility Period is 31 days.

2.8 Waiting Period.

The Employer Waiting Period for employees classified as Operator is 60 days and the Effective Date is the first day of the next calendar month following the Employer Waiting Period. The Employer Waiting Period for all other employees is 30 days and the Effective Date is the first day of the next calendar month following the Employer Waiting Period.

2.9 Other employees.

Leased employees and independent contractors are not Eligible for coverage by SelectHealth.

2.10 Termination.

Coverage will terminate on the end of the calendar month in which Subscriber and/or Dependents lose Eligibility. When a loss of Eligibility is not reported in a timely fashion as required by the Contract and federal or state law prevents SelectHealth from retroactively terminating coverage, SelectHealth has the discretion to determine the prospective date of termination. SelectHealth also has the discretion to determine the date of termination for Rescissions.

3. Duration of Contract.

This Contract is effective on May 1, 2019 to April 30, 2020, for a term of 12 months.

4. Additional Terms.

4.1 Additional Eligibility.

Eligible participants shall also include full time officials of the Amalgamated Transit Union, Local 382 ("Union"), who are on leave of absence for the Authority in order to serve as elected officials of the Union.

An eligible employee who waives COBRA continuation coverage or enrolls on COBRA at any time while on a medical leave of absence of up to one year will remain eligible for reinstatement upon return to work on a full-time basis within the one-year period.

In Section 2.3 "Grace Period" of the contract LE-CONTRACT 01/01/19, the grace period has been extended from thirty (30) days to forty five (45) days.

Product: Select Med PLUS

Effective Date: May 1, 2019

Acknowledged and agreed:

Employer: UTA-ATU Joint Insurance Trust

By: _____

Printed Name: Kim S Ulibarri

Title: Chief People Officer

Date: 5-23-19

By: _____

Printed Name: _____

Title: _____

Date: _____

Legally Sufficient, Lee Bell, Assistant Attorney General

SelectHealth:

By: _____

Printed Name: Patricia R. Richards

Title: President / Chief Executive Officer

Date: 3/14/2019

LE-GROUP APP 01/01/15

medical
contract

TABLE OF CONTENTS

SECTION 1 INTRODUCTION

1.1 Contract

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

1.2 SelectHealth

SelectHealth is an HMO licensed by the State of Utah located at 5381 Green Street, Murray, Utah 84123. We are affiliated with Intermountain Healthcare, but are 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 for our obligations or actions.

1.3 Agency

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

1.4 Administration of Contract

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

1.5 ERISA and SelectHealth's Authority

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

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

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

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

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

SECTION 2 PREMIUM

2.1 Employer Responsibility

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

2.2 Premium Rates

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

2.3 Grace Period

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

2.4 Refund of Premium

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

SECTION 3 COVERAGE

3.1 Certificate of Coverage

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

3.2 Administrative Processes

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

3.3 No Vested Rights

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

SECTION 4 ELIGIBILITY AND ENROLLMENT

4.1 Eligibility

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

4.2 Changes in Member Information or Eligibility

You must notify us within 31 days whenever there is a change in a Member's situation that may affect Eligibility or enrollment. This includes the following events:

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

b. Child loses Dependent status;

c. Death;

d. Divorce;

e. Marriage;

f. Involuntary loss of other coverage;

g. Member called to active military duty;

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

i. Reduction in employment hours;

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

k. Termination of employment; and

l. Other events as required by federal law.

If you fail to notify us within 31 days of a Member's termination from employment or other event that results in the loss of a Member's Eligibility, you agree to promptly pay us any amounts paid as Benefits for such Member before we were notified.

4.3 Enrollment

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

4.4 Enrolling a Dependent Because of a Court Order

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

4.5 COBRA or Utah mini-COBRA Coverage (Continuation Coverage)

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

4.5.1 Minimum Extent

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

4.5.2 Documentation

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

4.6 Right to Decline Enrollment

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

SECTION 5 RESPONSIBILITIES OF THE PARTIES

5.1 Compliance

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

5.2 Indemnification

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

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

5.3 Reports

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

5.4 Internal Revenue Code (IRC) Section 6055 Reporting

You agree to request the Social Security Numbers of your Employees and their Dependents, and provide this information to us, in the time and manner required by IRC Section 6055.

5.5 Summary of Benefits and Coverage (SBC)

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

SECTION 6 TERMINATION

6.1 Reasons for Termination

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

6.1.1 Termination by Employer

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

6.1.2 Termination of Employer Group by SelectHealth

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

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

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

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

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

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

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

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

6.1.3 Employer Notice of Termination to Subscribers

It is your responsibility to provide Subscribers a 30-day written notice of the Contract's termination. We will provide you a sample notice upon request.

6.2 Rescission

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

6.3 Liability for Services After Termination

We do not cover Services obtained after the date of termination, regardless of when a condition arose and despite care or treatment anticipated or already in progress.

SECTION 7 GENERAL

7.1 Binding Effect

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

7.2 Partial Invalidity

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

7.3 Non-Assignability

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

7.4 Choice of Law

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

7.5 Right to Audit Employer Records

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

7.6 Term

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

7.7 Circumstances Beyond Control

Neither party will be responsible for a delay in performing its obligations under the Contract due to circumstances reasonably beyond its control, such as natural disaster, epidemic, riot, war, terrorism, or nuclear release.

7.8 Workers' Compensation Insurance

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

7.9 No Waiver

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

7.10 Notices

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

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

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

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

d. We do not provide COBRA notification services.

SECTION 8 DEFINITIONS

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

8.1 Affordable Care Act (ACA)

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

8.2 Benefit(s)

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

8.3 Certificate of Coverage (Certificate)

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

8.4 COBRA Coverage

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

8.5 Continuation Coverage

COBRA Coverage and/or Utah mini-COBRA coverage.

8.6 Contract

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

8.7 Covered Services

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

8.8 Dependents

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

8.9 Effective Date

The date on which coverage for a Member begins.

8.10 Eligible, Eligibility

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

8.11 Employer Waiting Period

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

8.12 Employer Plan

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

8.13 ERISA

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

8.14 Exclusion(s)

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

8.15 Facility

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

8.16 Group Application

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

8.17 Grace Period

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

8.18 Limitation(s)

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

8.19 Member

A Subscriber and any Dependents, when properly enrolled in the Plan and accepted by us.

8.20 Member Payment Summary

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

8.21 Optional Benefit

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

8.22 Plan

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

8.23 Plan Sponsor

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

8.24 Premium(s)

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

8.25 Provider

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

8.26 Qualified Medical Child Support Order

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

8.27 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.

8.28 Service Area

As defined in the Certificate(s) of Coverage.

8.29 Service(s)

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

8.30 Subscriber

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

8.31 Utah mini-COBRA

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

selecthealth

MED NETWORK

MEMBER PAYMENT SUMMARY	PARTICIPATING *(In-Network)* When using participating providers, you are responsible to pay the amounts in this column.	NONPARTICIPATING *(Out-of-Network)* When using nonparticipating providers, you are responsible to pay the amounts in this column.
CONDITIONS AND LIMITATIONS		
Lifetime Maximum Plan Payment - *Per Person*	None	
Pre-Existing Conditions (PEC)	None	
Benefit Accumulator Period	plan year	
Maximum Annual Out-of-Network Payment - (per plan year)	None	None
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5]	**PARTICIPATING**	**NONPARTICIPATING**
Self Only Coverage, 1 person enrolled - per plan year		
Deductible	$1,000	$2,000
Out-of-Pocket Maximum	$3,000	$6,000
Family Coverage, 2 or more enrolled - per plan year		
Deductible - per person/family	$1000/$3000	$2000/$6000
Out-of-Pocket Maximum - per person/family	$3000/$6000	$6000/$12000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)		
INPATIENT SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Medical, Surgical and Hospice[4]	20% after deductible	40% after deductible
Skilled Nursing Facility[4] - Up to 60 days per plan year	20% after deductible	40% after deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	20% after deductible	40% after deductible
Up to 40 days per plan year for all therapy types combined		
PROFESSIONAL SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP)[1]	$25	40% after deductible
Secondary Care Provider (SCP)[1]	$35	40% after deductible
Allergy Tests	See Office Visits Above	Not Covered
Allergy Treatment and Serum	20%	Not Covered
Major Surgery	20%	40% after deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after deductible	40% after deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**PARTICIPATING**	**NONPARTICIPATING**
Primary Care Provider (PCP)[1]	Covered 100%	Not Covered
Secondary Care Provider (SCP)[1]	Covered 100%	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Not Covered
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	Not Covered
Diagnostic Tests: Minor	Covered 100%	Not Covered
Other Preventive Services	Covered 100%	Not Covered
VISION SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Preventive Eye Exams	Covered 100%	Not Covered
All Other Eye Exams	$35	40% after deductible
OUTPATIENT SERVICES[4]	**PARTICIPATING**	**NONPARTICIPATING**
Outpatient Facility and Ambulatory Surgical	20% after deductible	40% after deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after deductible	See Participating Benefit
Emergency Room - *(Participating facility)*	$300 after deductible	See Participating Benefit
Emergency Room - *(Nonparticipating facility)*	$300 after deductible	See Participating Benefit
Intermountain InstaCare® Facilities, Urgent Care Facilities	$40	40% after deductible
Intermountain KidsCare® Facilities	$25	Not Available
Intermountain Connect Care®	$10	Not Available
Chemotherapy, Radiation and Dialysis	20% after deductible	40% after deductible
Diagnostic Tests: Minor[3]	Covered 100%	40% after deductible
Diagnostic Tests: Major[3]	20% after deductible	40% after deductible
Home Health, Hospice, Outpatient Private Nurse	20% after deductible	40% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational	$35 after deductible	40% after deductible

See other side for additional benefits

selecthealth

MED NETWORK

	MEMBER PAYMENT SUMMARY	
	PARTICIPATING *(In-Network)*	**NONPARTICIPATING** *(Out-of-Network)*
MISCELLANEOUS SERVICES	**PARTICIPATING**	**NONPARTICIPATING**
Durable Medical Equipment (DME)[4]	20% after deductible	40% after deductible
Miscellaneous Medical Supplies (MMS)[3]	20% after deductible	40% after deductible
Maternity and Adoption[4,6]	See Professional, Inpatient or Outpatient	40% after deductible
Cochlear Implants[4]	See Professional, Inpatient or Outpatient	Not Covered
Infertility - *Select Services* *(Max Plan Payment $1,500/ plan year; $5,000 lifetime)*	*50% after deductible	Not Covered
Donor Fees for Covered Organ Transplants[4]	20% after deductible	Not Covered
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient	Not Covered
OPTIONAL BENEFITS	**PARTICIPATING**	**NONPARTICIPATING**
Mental Health and Chemical Dependency[4]		
Office Visits	$25	40% after deductible
Inpatient	20% after deductible	40% after deductible
Outpatient	20%	40% after deductible
Residential Treatment[2]	20% after deductible	40% after deductible
Chiropractic - 800-678-9133	$20 (up to 15 visits per plan year)	Not Covered
Injectable Drugs and Specialty Medications[4]	20% after deductible	40% after deductible
PRESCRIPTION DRUGS		
Pharmacy Deductible - Per Person per plan year	$100	
Prescription Drug List (formulary)	RxSelect®	
Prescription Drugs - *Up to 30 Day Supply of Covered Medications* [4]		
Tier 1	$10	
Tier 2	25% after pharmacy deductible (minimum $25 maximum $75)	
Tier 3	50% after pharmacy deductible (minimum $50 maximum $150)	
Tier 4	20% after pharmacy deductible	
Maintenance Drugs - *90 Day Supply (Mail-Order, Retail90 ®)-selected drugs* [4]		
Tier 1	$10	
Tier 2	25% after pharmacy deductible (minimum $50 maximum $150)	
Tier 3	50% after pharmacy deductible (minimum $100 maximum $300)	
Generic Substitution Required	Generic required or must pay copay plus cost difference between name brand and generic	

To remain compliant with state and federal regulations including the Affordable Care Act (ACA), these benefits are subject to change.

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

2 Refer to your Certificate of Coverage for more information.

3 Frequency and/or quantity limitations apply to some preventive care and MMS services.

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

5 All deductible/copay/coinsurance amounts are based on the allowed amounts and not on the providers billed charges. Nonparticipating Providers or Facilities have not agreed to accept the Allowed Amount for Covered Services. When this occurs, you are responsible to pay for any charges that exceed the amount that SelectHealth pays for Covered Services. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

6 SelectHealth provides a $4000 adoption indemnity as outlined by the state of Utah. Medical deductible, copay, or coinsurance listed under the benefit applies and may exhaust the benefits prior to any plan payments.

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

All covered services obtained outside the United States, except for routine, urgent, or emergency conditions require preauthorization.

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

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

medical
certificate of coverage

selecthealth

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Non-Discrimination Notice

SelectHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide free aid and services to people with disabilities to help them communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). We also provide free language services to people whose primary language is not English, such as qualified interpreters and member materials written in other languages.

If you need these services, please call SelectHealth Member Services at **1-800-538-5038**. Any member or other person who believes he/she may have been subject to discrimination may file a complaint or grievance by calling the SelectHealth 504/Civil Rights Coordinator at **1-844-208-9012** or the Compliance Hotline at **1-800-442-4845** (TTY Users: 711). You may also call the Office for Civil Rights at **1-800-368-1019** (TTY Users: **1-800-537-7697**).

selecthealth.

Language Access Services

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a SelectHealth: **1-800-538-5038**.

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 SelectHealth: **1-800-538-5038**. 。

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số SelectHealth: **1-800-538-5038**.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. SelectHealth: **1-800-538-5038**.

번으로 전화해 주십시오.

Navajo

Díí baa akó nínízin: Díí saad bee yáníltí̀go Diné Bizaad, saad bee áká̀ánída̓áwo̓dę́ę́'', t̓áá jiik̀eh, éí ná hóló', koj̨į̀ hódíílnih SelectHealth: **1-800-538-5038**.

Nepali

ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नमि्ति भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । SelectHealth: **1-800-538-5038** मा फोन गर्नुहोस्।

Tongan

FAKATOKANGA̓I: Kapau ʻoku ke lea fakatonga, ko e kau fakatonu lea te nau tokoni atu ta̓etotongi, pea te ke lava ʻo ma̓u ia. Telefoni ki he SelectHealth: **1-800-538-5038**.

Serb-Croatian

ОБАВЕШТЕЊЕ: Ако говорите српски језик, услуге језичке помоћи доступне су вам бесплатно. Позовите SelectHealth: **1-800-538-5038**.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa SelectHealth: **1-800-538-5038**.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: SelectHealth: **1-800-538-5038**.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните SelectHealth: **1-800-538-5038**

Arabic

ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم SelectHealth: **1-800-538-5038**.

Mon-khmer, Cambodian

សម្គាល់៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ សូវៅជំនួយផ្នែកភាសា ជាយមិនគិតថ្លៃ គឺអាចមានសវាប អ្នក។ សូមទូរស័ព្ទមក SelectHealth: **1-800-538-5038** ។

French

ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez SelectHealth: **1-800-538-5038**.

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。SelectHealth: **1-800-538-5038**. まで、お電話にてご連絡ください。

SECTION 1 INTRODUCTION

1.1 This Certificate

This Certificate of Coverage describes the terms and conditions of the health insurance Benefits provided under the Group Health Insurance Contract. 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, Inc.

SelectHealth is an HMO licensed by and **domiciled in the State of Utah and is located at 5381 Green Street, Murray, Utah 84123**. 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 the obligations or actions of SelectHealth.

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) agree 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 the principal office of SelectHealth. 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 the SelectHealth complaint resolution system.

1.10 Questions

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

1.11 Benefit Changes

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

a. In the event of a discrepancy between information given by a SelectHealth employee and the written terms of the Contract, the terms of the Contract will control.

b. Any changes or modifications that would increase your Benefits must be provided in writing and signed by the president, vice president, or medical director of 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. Eligibility may not be established retroactively.

2.3.2 Children

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

2.3.3 Disabled Children

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

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

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

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

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 26th birthday.

2.3.4 Incarcerated Dependents

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

2.4 Court-Ordered Dependent Coverage

When you or your lawful spouse are required by a court or administrative order to provide health insurance coverage for a child, the child will be enrolled in your family coverage according to SelectHealth guidelines and only to the minimum extent required pursuant to Utah Code Annotated 31A-22-610 through 611, and 718. If you are not enrolled for coverage at the time the court or administrative order becomes effective, only you and the affected Dependent will be allowed to enroll for coverage. 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:

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

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

c. The period to which the order applies.

2.4.2 National Medical Support Notice (NMSN)

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

2.4.3 Eligibility and Enrollment

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

2.4.4 Duration of Coverage

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

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 an Application accepted 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 an 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 an Annual Open Enrollment will take effect on the day the Contract is effective.

3.3.2 Newly Eligible Employees

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

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

3.3.3 Court or Administrative Order

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

a. The start date indicated in the order;

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

c. The date SelectHealth receives the order.

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 an Annual Open Enrollment if each of the following conditions are 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). One exception to this rule exists: if a Dependent is enrolled on another group health plan and the Annual Open Enrollment periods of the two plans do not coincide, the Dependent may voluntarily drop coverage under their health plan's open enrollment and a special enrollment period will be permitted under the Plan in order to avoid a gap in coverage; and

c. You and/or your Dependents who lost the other coverage must enroll in the Plan within 31 days after the date the other coverage is lost.

Proof of loss of the other 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:

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 guardianship court order or testamentary appointment 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 60 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.

3.4.5 As Required by State or Federal Law

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

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

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

a. If enrolling the child requires additional Premium, you must enroll the child within 31 days of the child's birth, adoption, or placement for adoption or under legal guardianship.

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 an Annual Open Enrollment or if you experience an event that creates a Special Enrollment Right.

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 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.

4.1.2 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 the minimum group participation and/or employer contribution requirements of SelectHealth;

e. No employees 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 Termination Date

If you and/or your enrolled Dependents lose Eligibility, then coverage will terminate either on the date Eligibility is lost or the end of the month in which Eligibility is lost, as specified in the Group Application. However, when a Dependent child ceases to be a Dependent, coverage will terminate at the end of the month in which Dependent status is lost. When a loss of Eligibility is not reported in a timely fashion as required by the Contract, and federal or state law prevents SelectHealth from retroactively terminating coverage, SelectHealth has the discretion to determine the prospective date of termination. SelectHealth also has the discretion to determine the date of termination for Rescissions.

4.2.2 Fraud or Misrepresentation

a. Made During Enrollment:

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

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

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

b. Made After Enrollment: Coverage for you and/or your Dependents may be terminated or Rescinded if you or they commit fraud or make an intentional misrepresentation of material fact in connection with Benefits or Eligibility. At the discretion of SelectHealth, the Rescission may be effective retroactively to the date of the fraud or misrepresentation.

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

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 an 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.

4.2.6 Court or Administrative Order

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

4.3 Member Receiving Treatment at Termination

All Benefits under the Plan terminate when the Contract terminates, including coverage for Members hospitalized or otherwise within a course of care or treatment. 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 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 or Utah mini-COBRA (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.

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:

a. Notify persons entitled to Continuation Coverage;

b. Notify SelectHealth of such individuals; and

c. 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 Minimum Extent

Continuation Coverage will only be provided for the minimum time and only to the minimum extent required by applicable federal law or pursuant to Utah Code Annotated 31A-22-722. 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.

6.1.1 Participating Providers and Facilities

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

6.1.2 Nonparticipating Providers and Facilities

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

6.1.3 Other Networks

For Dependent children residing and receiving care outside of the Service Area, Participating Benefits apply for Services received from Providers on the Select Med network in Utah, SelectHealth network in Idaho, and MultiPlan/PHCS Providers outside of Utah or Idaho. Contact Member Services for additional information.

6.2 Access to Healthcare Providers

You may be entitled to coverage for healthcare Services from the following Nonparticipating Providers if you live or reside within 30 paved road miles of the listed Providers, or if you live or reside in closer proximity to the listed Providers than to your Participating Providers:

Independent Hospital(s)
Brigham City Community Hospital, Brigham City, Box Elder County, Utah

Federally Qualified Health Centers
Beaver Medical Clinic, Beaver, Beaver County, Utah
Blanding Family Practice/Blanding Medical Center, Blanding, Utah
Bryce Valley Clinic, Cannonville, Utah
Carbon Medical Services, Carbon, Carbon County, Utah
Circleview Clinic, Circleview, Piute County, Utah
Duchesne Valley Medical Clinic, Duchesne, Duchesne County, Utah
Emery Medical Center, Castledale, Emery County, Utah
Enterprise Valley Medical Clinic, Enterprise, Washington County, Utah
Garfield Memorial Clinic, Panguitch, Garfield County, Utah
Green Valley/River Clinic, Green River, Emery/Grand Counties, Utah
Halchita Clinic, San Juan County, Utah
Hurricane Family Practice Clinic, Hurricane, Washington County, Utah
Kamas Health Center, Kamas, Summit County, Utah
Kazan Memorial Clinic, Escalante, Garfield County, Utah
Long Valley Medical, Kane County, Utah
Milford Valley Clinic, Milford, Beaver County, Utah
Montezuma Creek Health Center, Montezuma Creek, San Juan County, Utah
Monument Valley Health Center, Monument Valley, Utah
Navajo Mountain Health Center, San Juan County, Utah
Wayne County Medical Clinic, Bicknell, Wayne County, Utah

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

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

6.3 Providers and Facilities not Agents/Employees of 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.

6.4 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.

6.4.1 Incentives

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

6.4.2 Payments to Members

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

6.5 Provider/Patient Relationship

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

6.6 Continuity of Care

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

If you or your Dependent is under the care of a Provider when 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 the Allowed Amount as payment in full;

b. Follow SelectHealth's Healthcare Management Program 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

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, Limitations on the use of Nonparticipating Providers and Facilities, and expenses that do not count against your Out-of-Pocket Maximum.

7.3 Identification (ID) Cards

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

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

7.4 Medical Necessity

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

7.5 Benefit Changes

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

7.6 Calendar-Year or Plan-Year Basis

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

7.7 Lifetime Maximums

Your Member Payment Summary will specify any applicable Lifetime Maximums.

7.8 Two Benefit Levels

7.8.1 Participating Benefits

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

7.8.2 Nonparticipating Benefits

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

7.9 Emergency Conditions

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

If you or your Dependent is hospitalized for an emergency:

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

b. If you are in a Nonparticipating Facility, once the 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 Out-of-Area Benefits and Services

Other than for Emergency Conditions and Urgent Conditions, as described above, Nonparticipating Benefits apply for Covered Services rendered by Nonparticipating Providers or Facilities outside of SelectHealth's Service Area.

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

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

b. Visit selecthealth.org;

c. Refer to your Provider & Facility Directory; or

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

8.1 Facility Services

8.1.1 Educational Training

Only when rendered by a Participating Provider for a covered diagnosis.

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

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

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

8.1.5 Outpatient Facility and Ambulatory Surgical Facility

Outpatient surgical and medical Services.

8.1.6 Skilled Nursing Facility

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

8.1.7 Urgent Care Facility

8.2 Provider Services

8.2.1 After-Hours Visits

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

8.2.2 Anesthesia

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

8.2.3 Dental Services

Only:

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

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

   i. Maxillary and/or mandibular procedures;

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

   iii. Orthognathic Services; or

   iv. Services for Congenital Oligodontia/Anodontia.

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

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

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

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

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

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

8.2.4 Dietary Products

Only in the following limited circumstances:

a. For hereditary metabolic disorders when:

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

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

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

b. Certain enteral formulas according to SelectHealth policy.

8.2.5 Genetic Counseling

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

8.2.6 Genetic Testing

Only in the following circumstances and according to SelectHealth criteria or as required by state or federal law:

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

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

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

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

8.2.7 Home Visits

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

8.2.8 Infertility

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

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

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

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

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

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

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

8.2.11 Medical/Surgical

In an inpatient, outpatient, or Ambulatory Surgical Facility.

8.2.12 Maternity Services

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

8.2.13 Office Visits

For consultation, diagnosis, and treatment.

8.2.14 Preventive Services

8.2.15 Sleep Studies

Only when provided by:

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

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

8.2.16 Sterilization Procedures

8.3 Miscellaneous Services

8.3.1 Adoption Indemnity Benefit

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

If you adopt more than one child from the same birth (e.g., twins), only one adoption indemnity Benefit applies. If you and/or your spouse are covered by multiple plans, 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 Ambulance/Transportation Services

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

8.3.3 Approved Clinical Trials

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

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

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

c. Either:

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

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

8.3.4 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.

8.3.6 Durable Medical Equipment (DME)

Only:

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

   i. Prescribed by a Provider;

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

   iii. Required for Activities of Daily Living;

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

   v. Not attached to a home or vehicle.

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

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

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. Injectable drugs and specialty medications must be provided by a Participating Provider unless otherwise approved in writing in advance by SelectHealth. You may be required to receive the drug or medication in your Provider's office. Some Injectable Drugs and Specialty Medications may only be obtained from certain drug distributors. Call Member Services to determine if this is the case and to obtain information on participating drug vendors.

8.3.10 Miscellaneous Medical Supplies (MMS)

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

8.3.11 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. Patients with Parkinson's Disease;

d. Stroke patients undergoing formal rehabilitation; and

e. Post-traumatic-brain-injury patients.

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

8.3.12 Organ Transplants

a. Only if:

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

b. And only the following:

i. Bone marrow as outlined in SelectHealth criteria;

ii. Combined heart/lung;

iii. Combined pancreas/kidney;

iv. Cornea;

v. Heart;

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

vii. Liver;

viii. Pancreas after kidney; and

ix. Single or double lung.

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

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

8.3.13 Orthotics and Other Corrective Appliances for the Foot

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

8.3.14 Osteoporosis Screening

Only central bone density testing (DEXA scan)

8.3.15 Private Duty Nursing

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

8.3.16 Rehabilitation Therapy

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

8.3.17 Temporomandibular Joint (TMJ)

8.3.18 TeleHealth

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

8.3.19 Vision Aids

Only:

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

b. Monofocal intraocular lenses after cataract surgery.

8.4 Prescription Drug Services

Refer to Section 9 Prescription Drug Benefits for details.

SECTION 9 PRESCRIPTION DRUG BENEFITS

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

9.1 Prescription Drug Benefit Resources

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

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

b. Visit selecthealth.org/pharmacy;

c. Refer to your Provider & Facility Directory; or

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

9.2 Use Participating Pharmacies

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

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

9.3 Tiered Benefits

There are tiers (or levels) of covered prescriptions listed on your ID card and 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.

9.4 Filling Your Prescription

9.4.1 Copay/Coinsurance

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

9.4.2 Quantity and Day Supply

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

9.4.3 Refills

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

9.5 Generic Drug Substitution Required

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

9.6 Maintenance Drugs

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

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

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

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

Maintenance drugs are identified by the letter (M) on the Prescription Drug List. You have two options when filling prescriptions under the maintenance drug Benefit: (1) Retail90SM, 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.

9.7 Preauthorization of Prescription Drugs

There are certain drugs that require Preauthorization by your Provider 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 drug is prescribed in excess of the Plan limits (quantity, duration of use, maximum dose, etc.). The most current information can be found at the SelectHealth website.

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

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

9.8 Step Therapy

Certain drugs require your Provider to first prescribe an alternative drug preferred by 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. The letters (ST) appear next to each drug that requires step therapy.

9.9 Coordination of Benefits (COB)

If you have other health insurance that is your primary coverage, claims must be submitted first to your primary insurance carrier before being submitted to 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 drugs.

a. These drugs include:
   i. Narcotic analgesics;
   ii. Other addictive or potentially addictive drugs; and
   iii. Drugs prescribed in quantities, dosages, or usages that are outside the usual standard of care for the medication in question.

b. These drugs are not covered when they are prescribed:
   i. Outside the usual standard of care for the practitioner prescribing the drug;
   ii. In a manner inconsistent with accepted medical practice; or
   iii. For indications that are Experimental and/or Investigational.

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

9.11 Prescription Drug Benefit Abuse

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

a. Obtain prescriptions in limited dosages and supplies;

b. Obtain prescriptions only from a specified Provider;

c. Fill your prescriptions at a specified pharmacy;

d. Participate in specified treatment for any underlying medical problem (such as a pain management program);

e. Complete a drug treatment program; or

f. Adhere to any other specified limitation or program designed to reduce or eliminate drug abuse or dependence.

If you seek to obtain drugs in amounts in excess of what is Medically Necessary, such as making repeated emergency room/urgent care visits to obtain drugs, 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, such as by intentionally misrepresenting your condition, other medications, healthcare encounters, or other medically relevant information. At the discretion of SelectHealth, you may be permitted to retain your coverage if you comply with specified conditions.

9.12 Pharmacy Injectable Drugs and Specialty Medications

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

9.13 Prescription Drug List (PDL)

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

9.14 Exceptions Process

If your Provider believes that you require a certain drug that is not on your Formulary, normally requires step therapy, or exceeds a Quantity Limit, he or she may request an exception through the Preauthorization process.

9.15 Prescriptions Dispensed in a Provider's Office

Prescriptions dispensed in a Provider's office are not covered unless expressly approved by SelectHealth.

9.16 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 A Optional Benefits, the following Limitations and Exclusions apply.

10.1 Abortions/Termination of Pregnancy

Abortions are not covered except:

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

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

Medical complications resulting from an abortion 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 Administrative 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. Rebuck Skin Window Test;

   viii. Rinkel Test;

   ix. Subcutaneous Provocative Food and Chemical Test; and

   x. Sublingual Provocative Food and Chemical Test.

b. The following allergy treatments are not covered:

   i. Allergoids;

   ii. Autogenous urine immunization;

   iii. LEAP therapy;

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

   v. Neutralization therapy;

   vi. Photo-inactivated extracts; and

   vii. Polymerized extracts.

10.5 Anesthesia

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

10.6 Bariatric Surgery

Surgery, including any revision or reversal of such surgery, to facilitate weight loss is not covered. This Exclusion does not apply if your Member Payment Summary indicates that your Plan includes the Bariatric Surgery Optional Benefit.

10.7 Biofeedback/Neurofeedback

Biofeedback/neurofeedback is not covered.

10.8 Birthing Centers and Home Childbirth

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

10.9 Certain Cancer Therapies

Neutron beam therapy is not covered.

Proton beam therapy is not covered except in the following limited circumstances:

a. Chordomas or chondrosarcomas arising at the base of the skull or along the axial skeleton without distant metastases;

b. Other central nervous system tumors located near vital structures;

c. Pituitary neoplasms;

d. Uveal melanomas confined to the globe (not distant metastases); or

e. In accordance with SelectHealth medical policy.

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

10.10 Certain Illegal Activities

Subject to the nondiscrimination provisions of the Health Insurance Portability and Accountability Act (HIPAA), Services for an illness, condition, accident, or injury related directly to voluntary participation in an illegal activity are not covered. This exclusion does not apply for any injuries sustained from an act of domestic violence or a medical condition.

10.11 Chiropractic Services

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

10.12 Claims After One Year

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

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

10.13 Complementary and Alternative Medicine (CAM)

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

10.14 Custodial Care

Custodial Care is not covered.

10.15 Debarred Providers

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

10.16 Dental Anesthesia

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

a. You or your Dependent is developmentally delayed, regardless of his or her chronological age;

b. You or your Dependent, regardless of age, has a congenital cardiac or neurological condition and documentation is provided that the dental anesthesia is needed to closely monitor the condition; or

c. You or your Dependent is younger than five years of age and:

   i. The proposed dental work involves three or more teeth;

   ii. The diagnosis is nursing bottle-mouth syndrome or extreme enamel hypoplasia; and

   iii. The proposed procedures are restoration or extraction for rampant decay.

10.17 Dry Needling

Dry needling procedures are not covered.

10.18 Duplication of Coverage

The following are not covered:

a. Services that are covered by, or would have been covered, if you or your Dependents had enrolled and maintained coverage in automobile insurance, including no-fault type coverage up to the minimum amount required by law. In the event of a claim, you should provide a copy of the Personal Injury Protection (PIP) documentation from the automobile insurance carrier.

b. Services that are covered by, or would have been covered, if your employer had enrolled and maintained coverage in, Workers' Compensation insurance.

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

d. Services received by you or one of your Dependents while incarcerated in a prison, jail, or other correctional facility at the time Services are provided, including care provided outside of a correctional facility to a person who has been arrested or is under a court order of incarceration.

10.19 Exercise Equipment or Fitness Training

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

10.20 Experimental and/or Investigational Services

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

10.21 Eye Surgery, Refractive

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

10.22 Food Supplements

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

10.23 Hearing Aids

Except for cochlear implants, as described in Section 8 Covered Services, and unless otherwise noted in your Member Payment Summary, 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.

10.24 Home Health Aides

Services provided by a home health aide are not covered.

10.25 Immunizations

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

10.26 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 Optional Benefit.

10.27 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.

10.28 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.

10.29 Prescription Drugs/Injectable Drugs and Specialty Medications

The following are not covered:

a. Appetite suppressants and weight loss drugs;

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

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

d. Compound drugs when alternative products are available commercially;

e. Cosmetic health and beauty aids;

f. Drugs not on your Formulary;

g. Drugs purchased from Nonparticipating Providers over the Internet;

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

i. Flu symptom drugs, except when approved by an expert panel of Physicians and SelectHealth;

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

k. Infertility drugs;

l. Medical foods;

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

   i. Food and Drug Administration (FDA) approval;

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

   iii. Nationally recognized compendium sources currently utilized by SelectHealth;

   iv. National Comprehensive Cancer Network (NCCN); or

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

n. Drugs used for infertility purposes;

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

p. New drugs approved by the FDA after the previous May 1st, unless approved for coverage by SelectHealth;

q. Non-Sedating Antihistamines;

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

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

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

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

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

t. Prescription Drugs used for cosmetic purposes;

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

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

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

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

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

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

10.30 Reconstructive, Corrective, and Cosmetic Services

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

i. To improve form or appearance;

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

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

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

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

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

i. Congenital cleft lip except for treatment rendered within 12 months of birth, or a planned, staged series of Services (as specifically documented in you or your Dependent's medical record) is initiated, or when congenital cleft lip surgery is performed as part of a cleft palate repair; or

ii. Treatment for venous telangiectasias (spider veins).

10.31 Related Provider Services

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

10.32 Respite Care

Respite Care is not covered.

10.32 Robot-Assisted Surgery

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

10.33 Sexual Dysfunction

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

10.34 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.

10.35 Specific Services

The following Services are not covered:

a. Anodyne infrared device for any indication;

b. Auditory brain implantation;

c. Automated home blood pressure monitoring equipment;

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

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

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

g. Computer-assisted navigation for orthopedic procedures;

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

i. Extracorporeal shock wave therapy for musculoskeletal indications;

j. Freestanding/home cervical traction;

k. Home anticoagulation or hemoglobin A1C testing;

l. Infrared light coagulation for the treatment of hemorrhoids;

m. Interferential/neuromuscular stimulators;

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

o. Magnetic Source Imaging (MSI);

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

q. Mole mapping;

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

s. Nucleoplasty or other forms of percutaneous disc decompression;

t. Oncofertility;

u. Pediatric/infant scales;

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

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

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

y. Prolotherapy;

z. Radiofrequency ablation for lateral epicondylitis;

aa. Radiofrequency ablation of the dorsal root ganglion;

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

cc. Whole body scanning.

10.36 Telephone/E-mail Consultations

Except for TeleHealth Services, as described in Section 8 Covered Services, charges for Provider telephone, e-mail, or other electronic consultations are not covered.

10.37 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.

10.38 Travel-related Expenses

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

10.39 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. Preauthorization requirements for Prescription Drugs are also found in Section 9 – Prescription Drug Benefits.

11.1.1 Services Requiring Preauthorization

Preauthorization is required for the following Services:

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

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

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

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

e. Joint replacement;

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

g. Pain management/pain clinic Services;

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

i. Certain genetic testing;

j. Certain ultrasounds;

k. Certain radiation therapies;

l. Certain sleep studies;

m. Certain medical oncology drugs;

n. Continuous glucose monitors;

o. Hysterectomy;

p. Tonsillectomy;

q. Adenoidectomy;

r. Vision rehabilitation therapy;

s. Outpatient Rehabilitative, Habilitative, and Chiropractic-therapy Services after 10 visits;

t. The following Durable Medical Equipment:

   i. Insulin pumps;

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

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

iv. Motorized or customized wheelchairs; and

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

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

In addition to these Services, Participating Providers must Preauthorize other Services as specified in SelectHealth medical policy.

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.

11.1.3 How to request Preauthorization

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

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

11.1.4 Penalties

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

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

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

11.2 Case Management

If you have certain serious or chronic conditions (such as spinal cord injuries, diabetes, asthma, or premature births), 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 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 do not supersede the express provisions of this Certificate. Coverage decisions are subject to all terms and conditions of the applicable Plan, including specific Exclusions and Limitations. Because medical policies are based on constantly changing science, they are periodically reviewed and updated by SelectHealth. For questions about SelectHealth's medical policies, call Member Services at 800-538-5038.

SECTION 12 CLAIMS AND APPEALS

12.1 Administrative Consistency

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

12.2 Claims and Appeals Definitions

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

12.2.1 Adverse Benefit Determination

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

12.2.2 Appeal(s)

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 Appeals process.

12.2.9 Independent Review Organization (IRO)

An entity that conducts independent External Reviews.

12.2.10 Postservice Appeal

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

12.2.11 Postservice Claim

Any claim related to Services you have already received.

12.2.12 Preservice Appeal

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

12.2.13 Preservice Claim

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

12.2.14 Urgent Preservice Claim

Any Preservice Claim that, if subject to the normal timeframes for determination, could seriously jeopardize your life, health or ability to regain maximum function or that, in the opinion of your treating Physician, would subject you to severe pain that could not be adequately managed without the requested Services. Whether a claim is an Urgent Preservice Claim will be determined by an individual acting on behalf of 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 File a Claim for Benefits

12.3.1 Urgent Preservice Claims

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

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

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

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

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

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

12.3.2 Other Preservice Claims

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

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

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

12.3.3 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 12-month period from the date of the expense or as soon as reasonably possible. Claims received outside of this timeframe will be denied. Failure to file a claim does not bar recovery under the policy if SelectHealth fails to show it was prejudiced by the failure.

Notice of Adverse Benefit Determinations will be provided in writing within a reasonable period of time, but no later than 30 days after receipt of the claim. However, 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.

12.4 Problem Solving

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

12.5 Formal Appeals

If you are not satisfied with the result of working with Member Services, you may file a written formal Appeal of any Adverse Benefit Determination. Written formal Appeals should be sent to the 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.

12.5.1 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.

12.5.2 Form and Timing

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

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

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

12.5.3 Appeals Process

The Appeals process includes both mandatory and voluntary reviews. You must exhaust all mandatory reviews before you may pursue civil action, including, if applicable, 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 Appeal is pending. Your decision whether or not to seek voluntary review will have no effect on your rights to any other Benefits. SelectHealth will provide you, upon request, sufficient information to enable you to make an informed decision about whether or not to engage in a voluntary review.

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

12.5.4 Preservice Appeals

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

Mandatory Review

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. However, SelectHealth may extend this period 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.

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

Voluntary Review

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

Voluntary External Review

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, or a Rescission of coverage. To request an External Review, you must complete the Independent Review Request Form. For a copy of this form, or for other questions, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City, UT 84114; by phone at 801-538-3077; or electronically at healthappeals.uid@utah.gov. An External Review request must be made within 180 days from the date the Appeals Department notifies you of the Final Internal Adverse Benefit Determination. An authorization to obtain medical records may be required. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. The IRO will provide written notice of its decision within 45 days after receipt of the request.

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

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

Voluntary Internal Review

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

12.5.5 Postservice Appeals

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

Mandatory Review

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

Voluntary Review

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

Voluntary External Review

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, or a Rescission of coverage. To request an External Review you must complete the Independent Review Request Form. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. For a copy of this form, or for other questions, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City, UT 84114; by phone at 801-538-3077; or electronically at healthappeals.uid@utah.gov. An External Review request must be made within 180 days from the date SelectHealth sends the Final Internal Adverse Benefit Determination. An authorization to obtain medical records may be required. The IRO will provide written notice of its decision within 45 days after receipt of the request.

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

Voluntary Internal Review

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

SECTION 13 OTHER PROVISIONS AFFECTING YOUR BENEFITS

13.1 Coordination of Benefits (COB)

When you or your Dependents have healthcare coverage under more than one health benefit plan, SelectHealth will coordinate Benefits with the other healthcare coverage according to the COB rules set forth in Utah Administrative Code R590-131.

13.1.1 Required Cooperation

You are required to cooperate with SelectHealth in administering COB. Cooperation may include providing notice of other health benefit coverage, copies of divorce decrees, bills and payment notices from other payers, and/or signing documents required by SelectHealth to administer COB. 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 the responsibility of SelectHealth. 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, Reimbursement and Recovery

13.2.1 Payment of Claims When a Third Party is Liable

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

13.2.2 SelectHealth's Recovery Rights

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

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

13.2.3 Agreement by Members

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

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

13.2.4 Constructive Trust and First Lien

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

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

13.2.5 Rights to Intervene and Sue

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 SelectHealth's restitution and other interests described in this section 13.2. 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 restitution or other interests under this section 13.2, to enforce the constructive trust required by this section 13.2, and/or take any other action to collect funds from you.

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

The amount that SelectHealth is entitled to recover from you and your Dependents under this section 13.2 is specifically unreduced by any attorney, legal or other fees and costs incurred by you or your Dependents in seeking recovery from a third party (whether the third party is the responsible party or is an insurer), except if SelectHealth specifically agrees in writing to participate in these fees.

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

13.2.6 Special Subrogation Rules for Utah

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

13.3 Excess Payment

SelectHealth will have the right to recover any payment made in excess of the obligations of SelectHealth under the Contract. Such recoveries are limited to a time period of 12 months (or 24 months for a COB error) from the date a payment is made unless the recovery is due to fraud or intentional misrepresentation of material fact by you or your Dependents. This right of recovery will apply to payments made to you, your Dependents, 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:

14.1 Payment

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

14.2 Changes in Eligibility or Contact Information

Notify your employer when there is a change in your situation that may affect your Eligibility, the Eligibility of your 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.

15.3 Contract

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

15.4 Compliance

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

SECTION 16 DEFINITIONS

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

16.1 Activities of Daily Living

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

16.2 Affordable Care Act (ACA)

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

16.3 Allowed Amount

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

16.4 Ambulatory Surgical Facility

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

16.5 Annual Open Enrollment

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

16.6 Anodontia

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

16.7 Application

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

16.8 Approved Clinical Trials

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

a. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

   i. The National Institutes of Health.

   ii. The Centers for Disease Control and Prevention.

   iii. The Agency for Health Care Research and Quality.

   iv. The Centers for Medicare & Medicaid Services.

   v. Cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

   vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

   vii. Any of the following if the appropriate review and approval through a system of peer review has been attained:

      1) The Department of Veterans Affairs.

      2) The Department of Defense.

      3) The Department of Energy.

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

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

16.9 Autism Spectrum Disorder

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

a. Asperger's Syndrome;

b. Autistic Disorder;

c. Childhood Disintegrative Disorder; and

d. Pervasive developmental disorder not otherwise specified.

16.10 Benefit(s)

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

16.11 Certificate of Coverage (Certificate)

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

16.12 COBRA Coverage

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

16.13 Coinsurance

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

16.14 Continuation Coverage

COBRA Coverage and/or Utah mini-COBRA coverage.

16.15 Contraceptive

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

16.16 Contract

The Group Health Insurance Contract between SelectHealth and your employer.

16.17 Copay (Copayment)

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

16.18 Covered Services

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

16.19 Custodial Care

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

16.20 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.

16.21 Dental Services

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

16.22 Dependents

Your Eligible dependents as set forth in Section 2 Eligibility.

16.23 Durable Medical Equipment (DME)

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

16.24 Effective Date

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

16.25 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.

16.26 Emergency Condition(s)

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

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

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

c. Serious impairment to bodily functions; or

d. Serious dysfunction of any bodily organ or part.

16.27 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.

16.28 Employer's Plan

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

16.29 Endorsement

A document that amends the Contract.

16.30 ERISA

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

16.31 Excess Charges

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

16.32 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.

16.33 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.

16.34 Facility

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

16.35 Formulary

The Prescription Drugs covered by your Plan.

16.36 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.

16.37 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. If your employer is not directly sponsoring the Plan, references to employer throughout the Certificate of Coverage can also include the party contracting with SelectHealth for Benefits provided to you (such as an association trust or board of trustees).

16.38 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.

16.39 Healthcare Management Program

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

16.40 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.

16.41 Hospice Care

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

16.42 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.

16.43 Infertility

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

16.44 Injectable Drugs and Specialty Medications

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

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

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

c. Require special training to administer;

d. Have special storage and handling requirements;

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

f. Often have additional monitoring requirements.

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

16.45 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.

16.46 Lifetime Maximum

The maximum accumulated amount that SelectHealth will pay for certain Covered Services (as allowed by the Affordable Care Act) during a 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 amount. If applicable, lifetime maximums are specified in your Member Payment Summary.

16.47 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.

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

b. Gene-based testing and genetic testing;

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

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

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

16.49 Major Surgery

A surgical procedure having one or more of the following characteristics:

a. Performed within or upon the contents of the abdominal, pelvic, cranial or thoracic cavities;

b. Typically requiring general anesthesia;

c. Has a level of difficulty or length of time to perform which constitutes a hazard to life or function of an organ or tissue; or

d. Requires the special training to perform.

16.50 Maximum Annual Out-of-Network Payment

The maximum accumulated amount SelectHealth will pay each Year for Covered Services applied to the Nonparticipating (Out-of-Network) Benefit.

The limit includes all amounts paid on behalf of the Member under any prior Plans provided by SelectHealth or any of its affiliated or subsidiary companies for any one Year. The Maximum Annual Out-of-Network Payment amount is specified in your Member Payment Summary.

16.51 Medical Director

The Physician(s) designated as such by SelectHealth.

16.52 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.

16.53 Member

You and your Dependents, when properly enrolled in the Plan and accepted by SelectHealth.

16.54 Member Payment Summary

A summary of your Benefits by category of service, attached to and considered part of this Certificate.

16.55 Minor Diagnostic Tests

Tests not categorized as Major Diagnostic Tests. Examples of common minor diagnostic tests are:

a. Bone density tests;

b. Certain EKGs;

c. Echocardiograms;

d. Common blood and urine tests;

e. Simple X-rays such as chest and long bone X-rays; and

f. Spirometry/pulmonary function testing.

16.56 Miscellaneous Medical Supplies (MMS)

Supplies that are disposable or designed for temporary use.

16.57 Nonparticipating (Out-of-Network) Benefits

A lower level of Benefits available for Covered Services obtained from a Nonparticipating Provider or Facility, even when such Services are not available through Participating Providers or Facilities.

16.58 Nonparticipating (Out-of-Network) Facility

Healthcare Facilities that are not under contract with SelectHealth.

16.59 Nonparticipating (Out-of-Network) Pharmacies

Pharmacies that are not under contract with SelectHealth.

16.60 Nonparticipating (Out-of-Network) Provider

Providers that are not under contract with SelectHealth.

16.61 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.

16.62 Oligodontia

The condition of congenitally missing more than six teeth, not including third molars or wisdom teeth.

16.63 Optional Benefit

Additional coverage purchased by your employer as noted in your Member Payment Summary that modifies Limitations and/or Exclusions.

16.64 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 Maximum amounts. Payments you make for Excess Charges, non-Covered Services, and certain categories of Services specified in your Member Payment Summary are not applied to the Out-of-Pocket Maximum.

16.65 Participating (In-Network) Benefits

The higher level of Benefits available to you when you obtain Covered Services from a Participating Provider or Facility.

16.66 Participating (In-Network) Facility

Facilities under contract with SelectHealth to accept Allowed Amounts as payment in full for Covered Services.

16.67 Participating (In-Network) Pharmacies

Pharmacies under contract with SelectHealth to accept Allowed Amounts as payment in full for Covered Services.

16.68 Participating (In-Network) Providers

Providers under contract with SelectHealth to accept Allowed Amounts as payment in full for Covered Services.

16.69 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.

16.70 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.

16.71 Plan Sponsor

As defined in ERISA. The Plan Sponsor is typically your employer.

16.72 Preauthorization (Preauthorize)

Prior approval from SelectHealth for certain Services. Refer to Section 11 Healthcare Management and your Member Payment Summary.

16.73 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.

16.74 Prescription Drugs

Drugs and medications, including insulin, that by law must be dispensed by a licensed pharmacist and that require a Provider's written prescription.

16.75 Preventive Services

Periodic healthcare that includes screenings, checkups, and patient counseling to prevent illness, disease, or other health problems not previously known to exist in the individual, and as defined by the Affordable Care Act and/or SelectHealth. Some examples of these services are well-child exams, immunizations, pediatric vision screenings, and Contraceptives as required by the ACA. Preventive services also include a Contraceptive that is medically necessary for you as determined by your Provider and evidenced through written documentation submitted to SelectHealth.

16.76 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.

16.77 Private Duty Nursing

Services rendered by a Nurse to prepare and educate family members and other caregivers on proper procedures for care during the transition from an acute Hospital setting to the home setting.

16.78 Provider

A vendor of healthcare Services licensed by the state where Services are provided and that provides Services within the scope of its license.

16.79 Qualified Medical Child Support Order (QMCSO)

A court order for the medical support of a child as defined in ERISA.

16.80 Rescission (Rescind)

A cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required Premiums or contributions towards the cost of coverage.

16.81 Residential Treatment Center

A licensed psychiatric facility which provides 24-hour continuous, individually-planned programs of therapeutic treatment and supervision.

16.82 Respite Care

Care provided primarily for relief or rest from caretaking responsibilities.

16.83 Routine Care

Care that is intended to monitor identified health conditions or assess new symptoms or signs of possible health conditions in a non-urgent or non-emergency setting.

16.84 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).

16.85 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.

The Select Med Plus® Service Area is the State of Utah.

16.86 Service(s)

Services, care, tests, treatments, drugs, medications, supplies, or equipment.

16.87 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.

16.88 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.

16.89 Subscriber

You, the individual with an employment or another defined relationship to the Plan Sponsor, through whom Dependents may be enrolled with SelectHealth.

16.90 TeleHealth

Services provided via interactive (synchronous) video and audio telecommunications systems.

16.91 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.

16.92 Utah mini-COBRA

Continuation coverage required by Utah law for employers with fewer than 20 employees.

16.93 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
optional benefits

selecthealth℠

MENTAL HEALTH/CHEMICAL DEPENDENCY OPTIONAL BENEFIT

1. Your Mental Health Benefits

This Optional Benefit 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 Optional Benefit, please call the Behavioral Health Advocates℠ weekdays, from 8:00 a. m. to 6:00 p. m. at 800-876-1989.

2. Using Participating Mental Health Providers

Mental health Services will be covered only when rendered by a Participating Provider unless otherwise noted on your Member Payment Summary.

3. Services requiring Preauthorization

Preauthorization is required for the following mental health services that are not for Emergency Conditions:

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 of your Certificate of Coverage for additional information.

4. Exclusions

4.1 The following Services are not covered:

a. Behavior modification;

b. Counseling with a patient's family, friend(s), employer, school authorities, or others, except for approved Medically Necessary collateral visits, with or without the patient present, in connection with otherwise covered treatment of the patient's mental illness;

c. Education or training;

d. Long-term care;

e. Marriage counseling and/or therapy;

f. Milieu therapy;

g. Rest cures;

h. Self-care or self-help training (nonmedical); and

i. Surgical procedures to remedy a condition diagnosed as psychological, emotional, or mental.

4.2 In addition, Services for conduct disorder are not covered.

ASH CHIROPRACTIC OPTIONAL BENEFIT

Your Chiropractic Benefits are administered by American Specialty Health Group, 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 Group Incorporated
Attn: ASH Member Services Department
P.O. Box 509002
San Diego, CA 92150-9002

1. Definitions

This Optional Benefit uses the following capitalized defined terms in addition to Section 16Ð"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 Practitioner 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 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 Musculoskeletal and Related 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. Examples of Clinical Appeals may include the following scenarios:

a. Treatment plan was denied or modified due to lack of Medical Necessity.

b. The number of visits requested by the Practitioner did not meet clinical criteria.

1.8 Covered Chiropractic Services

The Chiropractic Services that ASH determines to be Medically Necessary, as limited by this Optional Benefit.

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 Musculoskeletal and Related Disorders

Musculoskeletal and Related Disorders are conditions with associated signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related 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 the state in which they provide the Service 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 Medical Necessity Review Form (MNR Form) 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 an MNR 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 an MNR 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 an MNR 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; services that are provided pursuant to a continuity of care plan approved by ASH Networks; or services that are provided upon referral by ASH Networks in situations where such services are not available and accessible to a Member from a Contracted Practitioner within the Service Area;

c. Services for examinations (other than an initial examination to determine the appropriateness of Chiropractic Services) and/or treatments for conditions other than those related to Musculoskeletal and Related Disorders;

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. Services for children 12 and younger;

i. Magnetic resonance imaging (MRI), CAT scans, and any types of diagnostic radiology;

j. Transportation costs including local ambulance charges;

k. Education programs, nonmedical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing;

l. Services or treatments for pre-employment physicals or vocational rehabilitation;

m. Any services or treatments caused by or arising out of the course of employment or covered under any public liability insurance;

n. 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;

o. All chiropractic appliances or Durable Medical Equipment, except as specified herein;

p. Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order;

q. Services provided by a chiropractor practicing outside of the Service Area, except for Emergency Chiropractic Services.

r. Hospitalization, anesthesia, manipulation under anesthesia, or other related services;

s. All auxiliary aids and services, including interpreters, transcription services, written materials, telecommunication devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids;

t. Adjunctive therapy not associated with spinal, muscle, or joint manipulation;

u. Vitamins, minerals, nutritional supplements, injectable supplements and injection services, or other similar products;

v. Any services or treatments that are furnished before the date the Member becomes eligible or after the date the member ceases to be eligible under the Member's plan;

w. Massage Therapy, venipuncture, or Natural childbirth services;

x. Services rendered in excess of visits or benefit maximums;

y. Any service or supply that is not permitted by state law with respect to the provider's scope of practice;

z. Any services provided by a person who is a Family Member. Family Member means a person who is related to the covered person in any of the following ways: spouse, domestic partner, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child). A Family Member also includes individuals who normally live in the covered person's household; or

aa. Any services rendered for elective or maintenance care (e.g., services provided to a Member whose treatment records indicate he or she has reached Maximum Therapeutic Benefit).

7. This Optional Benefit

This Optional Benefit 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 Optional Benefit administered by ASH and that the provisions have been applied consistently with respect to similarly situated Claimants.

8.1 Defined Terms

This section uses the following additional (capitalized) defined terms:

8.1.1 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 ASH Utilization Management Program, and determinations that particular Services are Experimental and/or Investigational or not Medically Necessary or appropriate.

8.1.2 Appeal(s)

Review by ASH of an Adverse Benefit Determination.

8.1.3 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 ASH Appeals Department or ASH 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.

8.1.4 Benefit Determination

The decision by ASH regarding the acceptance or denial of a claim for Benefits.

8.1.5 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.

8.1.6 Concurrent Care Decisions

Decisions by ASH regarding coverage of an ongoing course of treatment that has been approved in advance.

8.1.7 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).

8.1.8 Final Internal Adverse Benefit Determination

An Adverse Benefit Determination that has been upheld by ASH at the completion of the mandatory Appeals process.

8.1.9 Independent Review Organization (IRO)

An entity that conducts independent External Reviews.

8.1.10 Postservice Appeal

A request to change an Adverse Benefit Determination for Services you have already received.

8.1.11 Postservice Claim

Any claim related to care or treatment that has already been received by the Member.

8.1.12 Preservice Appeal

A request to change an Adverse Benefit Determination on a Preservice Claim.

8.1.13 Preservice Claim

Any claim related to care or treatment that has not been received by the Member.

8.1.14 Urgent Preservice Claim

Any Preservice Claim that if subject to the normal timeframes for determination could seriously jeopardize your life, health, or ability to regain maximum function or that, in the opinion of your treating Physician, would subject you to severe pain that could not 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 Physician determines is an Urgent Preservice Claim will be treated as such.

8.3 How to File a Claim for Benefits

8.3.1 Urgent Preservice Claims

In order to file an Urgent Preservice Claim, you must provide ASH 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, ASH will notify you of the failure and the proper procedures to be followed. ASH will notify you as soon as reasonably possible, but no later than 24 hours after receiving the claim. This notice may be verbal unless you specifically request otherwise in writing.

Notice of a Benefit Determination will be provided as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receipt of the claim. However, if ASH gives you notice of an incomplete claim, the notice will give you at least 48 hours to provide the requested information. ASH will then provide a notice of Benefit Determination within 48 hours after receiving the specified information or the end of the period of time given you to provide the information, whichever occurs first. If the Benefit Determination is provided verbally, it will be followed in writing no later than three days after the verbal notice.

If the Urgent Preservice Claim involves a Concurrent Care Decision, notice of the Benefit Determination will be provided as soon as possible but no later than 24 hours after receipt of your claim for extension of treatment or care, as long as the claim is made at least 24 hours before the prescribed period of time expires or the prescribed number of treatments ends.

8.3.2 Other Preservice Claims

The procedure for filing most Preservice Claims (Preauthorization) is set forth in Section 11 Healthcare Management. If there is any other Benefit that would be subject to a Preservice Claim, you may file a claim for that Benefit by contacting ASH Member Services. Under certain circumstances provided by federal law, if you fail to follow the proper procedures for filing a Preservice Claim, ASH 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, 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 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 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.

8.3.3 Postservice Claims

a. Participating Practitioner(s) and Facilities. Participating Practitioner(s) and Facilities file Postservice Claims with ASH and ASH makes payment to the Providers and Facilities.

b. Nonparticipating Practitioner(s) and Facilities. Nonparticipating Practitioner and Facilities are not required to file claims with ASH. If a Nonparticipating Practitioner or Facility does not submit a Postservice Claim to ASH or you pay the Nonparticipating Practitioner or Facility, you must submit the claim in writing in a form approved by ASH. Call ASH Member Services or your employer to find out what information is needed to submit a Postservice Claim. All claims must be received by ASH within a 12-month period from the date of the expense or as soon as reasonably possible. Claims received outside of this timeframe will be denied.

Notice of Adverse Benefit Determinations will be provided in writing within a reasonable period of time, but no later than 30 days after receipt of the claim. However, ASH may extend this period 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.

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.

8.4 Problem Solving

ASH is committed to making sure that any concerns or problems regarding your claims are investigated and resolved as soon as possible. Many situations can be resolved informally by contacting ASH Member Services at 800-678-9133.

8.5 Formal Appeals

If you are not satisfied with the result of working with ASH Member Services, you may file a written formal Appeal of any Adverse Benefit Determination. Written formal Appeals should be sent to the ASH Appeals Department. As the delegated claims review fiduciary under your Employer's Plan, 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.

8.5.1 General Rules and Procedures

You will 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.

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 ASH in connection with the Adverse Benefit Determination, whether or not the advice was relied upon in making the Adverse Benefit Determination.

Before ASH can issue a Final Internal Adverse Benefit Determination, you will be provided with any new or additional evidence or rationale considered, relied upon, or generated by us in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of a Final Internal Benefit Determination is required to be provided to give you a reasonable opportunity to respond prior to the date.

8.5.2 Form and Timing

All requests for an Appeal of an Adverse Benefit Determination (other than those involving an Urgent Preservice Claim) must be in writing and should include a copy of the Adverse Benefit Determination and any other pertinent information that you want ASH to review in conjunction with your Appeal. Send all information to the ASH Appeals Department at the following address:

ASH Appeals Coordinator
P.O. Box 509001
San Diego, CA 92150-9002

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 ASH Appeals Department at 800-678-9133.

If the request is made verbally, the ASH Appeals Department 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.

Appeals that do not comply with the above requirements are not subject to review by ASH or legal challenge.

8.5.3 Appeals Process

The Appeals process includes both mandatory and voluntary reviews. You must exhaust all mandatory reviews before you may pursue civil action under ERISA Section 502(a). It is your choice, however, whether or not to seek voluntary review, and you are not required to do so before pursuing civil action. ASH agrees that any statute of limitations or other legal defense based on timeliness is suspended during the time that any voluntary Appeal is pending. Your decision whether or not to seek voluntary review will have no effect on your rights to any other Benefits. ASH will provide you, upon request, sufficient information to enable you to make an informed decision about whether or not to engage in a voluntary review.

After a mandatory review process, you may choose to pursue civil action under ERISA Section 502(a). Failure to properly pursue the mandatory Appeals process may result in a waiver of the right to challenge ASH's original decision.

8.5.4 Preservice Appeals

The process for appealing a Preservice Claim provides one mandatory review, possible voluntary reviews, and the right to pursue civil action under ERISA Section 502(a).

Mandatory Review

Your Appeal will be investigated by the ASH Appeals Department. All relevant, available information will be reviewed. The ASH 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. However, ASH may extend this period 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 your Appeal involves an Urgent Preservice Claim, you may request an expedited review. You will be notified of the Appeal decision on an expedited review as soon as possible, taking into account the medical circumstances, but no later than 72 hours after the receipt of your Appeal. A decision communicated verbally will be followed up in writing.

Voluntary Review

After completing the mandatory review process described above, you may pursue a voluntary External Review or a voluntary internal review. However, External Review is only available in the circumstances described below. If you choose to pursue a voluntary External Review, you may not pursue the voluntary internal review process.

Voluntary External Review

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, or a Rescission of coverage. To request an External Review, you must complete the Independent Review Request Form. For a copy of this form, or for other questions, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City, UT 84114; by phone at 801-538-3077; or electronically at healthappeals.uid@utah.gov. An External Review request must be made within 180 days from the date the ASH Appeals Department notifies you of the Final Internal Adverse Benefit Determination.

An authorization to obtain medical records may be required. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. The IRO will provide written notice of its decision within 45 days after receipt of the request.

If your Appeal involves an Urgent Preservice Claim, you may request an expedited review. You will be notified by the IRO of the Appeal decision on an expedited review as soon as possible, taking into account the medical circumstances, but no later than 72 hours after the receipt of your Appeal. A decision communicated verbally will be followed up in writing.

If you pursue a voluntary External Review, it will be your last level of Appeal.

Voluntary Internal Review

If you choose to pursue the voluntary internal review process, you may first request a review of your Appeal by the ASH Grievance Committee. Such a request must be made in writing to the ASH Appeals Department within 60 days of the date the ASH Appeals Department notifies you the Final Internal Adverse Benefit Determination. ASH will notify you of the result of the review in writing within 30 days of the date you requested the review. However, ASH may extend this period 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 you are not satisfied with the decision made by the ASH Grievance Committee, you may request a review by the ASH Appeals Committee. Such a request must be made in writing to the ASH Appeals Department within 60 days of the date the ASH Grievance Committee notifies you of its decision.

8.5.5 Postservice Appeals

The process for appealing a Postservice Claim provides two mandatory reviews, possible voluntary reviews, and the right to pursue civil action under ERISA Section 502(a).

Mandatory Review

Your Appeal will be investigated by the ASH Appeals Department. All relevant information will be reviewed and the ASH 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. However, ASH may extend this period 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.

Voluntary Review

After completing the mandatory review process described above, you may pursue either a voluntary External Review or a voluntary internal review. However, External Review is only available in the circumstances described below. If you choose to pursue the voluntary External Review process, you may not pursue the voluntary internal review process.

Voluntary External Review

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, or a Rescission of coverage. To request an External Review you must complete the Independent Review Request Form. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. For a copy of this form, or for other questions, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City, UT 84114; by phone at 801-538-3077; or electronically at healthappeals.uid@utah.gov. An External Review request must be made within 180 days from the date of ASH's Final Internal Adverse Benefit Determination. An authorization to obtain medical records may be required. The IRO will provide written notice of its decision within 45 days after receipt of the request.

If you pursue a voluntary External Review, it will be your last level of Appeal.

Voluntary Internal Review

If you choose to pursue the voluntary internal review process, you may request a review of your Appeal. Such a request must be made in writing to the ASH Appeals Department within 60 days of the date the ASH Appeals Department notifies you of the Final Internal Adverse Benefit Determination. ASH will notify you of the result of the review in writing within 30 days of the date you requested the review. If you are not satisfied with the decision made by the reviewing committee, you may request a review by the Appeals Committee. Such a request must be made in writing to the ASH Appeals Department within 60 days of the date the reviewing committee notifies you of its decision.

Detailed Contract Description & Purpose

Board Review Date:	5/29/2019	**Document Type:**	Change Order
Action Requested:	Motion to approve the contract or change order		
Criteria:	New total contract value is > $1,000,000 and Change-order is > 15% or $200,000		

Contract Title:	TIGER Phase 2 Amendment 8 - Midvale Crosswalk Improvement Project	**Contract #**	18-2398TP
Project Manager:	Heather Bening	**Contract Administrator:**	Teressa Pickett
Impacted Areas:	Midvale City	**Included in budget?**	Yes
Procurement method:	Best value (RFP)	**Contractor:**	Granite Construction
Sole-Source Reason:	N/A	**Qty & Unit price**	
		Change Order Value	$411,380
		Total Contract Value	$7,504,111
Contract term (Months)	6 months	**Contract Start Date**	5/29/2019
Contract options (Months)	N/A	**Contract End Date:**	11/27/2019
Number of responding firms:	6	**$ Value of Next Lowest Bidder**	N/A

General Description & Purpose:

UTA is engaged in a Project to design and construct projects in cities and counties throughout the region, funded in part with a Transportation Investment Generating Economic Recovery (TIGER) Grant. The TIGER Grant First/Last Mile Connections Project consists of 94 separate projects. Of the 94 projects, 33 of the projects received local matching funds from the cities and counties in which the projects will be constructed and the remaining 61 projects will be funded by UTA.

On April 11, 2018, UTA executed a Construction Manager/General Contractor (CM/GC) Agreement for Phase 1 Pre-Construction Services for the TIGER Grant First/Last Mile Connections Project with Granite Construction (Contract # 18-1398TP). The CM/GC Contract states that "For those projects on which UTA and Contractor agree on a scope of construction services and a lump sum construction price, UTA and Contractor may execute an amendment to this Agreement (a "Phase 2 Construction Services Amendment")". The CM/GC Agreement (Contract # 18-1398TP) will expire on December 31, 2021. To date, 7 Phase 2 Construction Services Amendments have been executed. the current Contract value is $7,092,731.

This TIGER Phase 2 Amendment 8 is for construction of a new signalized crosswalk in Midvale City in the amount of $411,380, which brings the total Contract value to $7,504,111.

Attachments:	Contract routing sheet attached? Yes
Other attachments:	Amendment 8 Contract, Phase 1 Contract available at address below: https://www.rideuta.com/-/media/Files/Board-of-Trustees/Board-Agenda-PDFs/2019/April/2019_0424_TigerGrantPhase1_Board_Meeting.ashx?la=en

Once approved, please forward to Contract Administrator

UTA

CONTRACT ROUTING SHEET

CONTRACT SECTION

1) Contract/P.O. No. **18-2398TP** *(Assigned by Purchasing)* Contract Administrator: **Teressa Pickett**
Project Manager: **Heather Bening**

2) Contract Type ☐ A. A&E/Design ☐ B. Blanket PO ☐ C. Construction ☐ D. Goods ☑ E. Modification
☐ E. Option ☐ F. Other _____ ☐ G. Renewal ☐ H. Services ☐ I. Task Orders

3) Procurement Method ☐ RFQ (Quote) ☐ IFB (Low Bid) ☐ RFQU (Qualification)
☑ RFP (Best-value) ☐ Sole source ☐ Other: _____

4) Contract Title **TIGER Phase 2 Construction Services Amendment 8**

5) Description / Purpose *(of contract or project)* **Amendment 8 - Midvale Crosswalk Improvement Project**

6) Contractor Name **Granite Construction**

7) Effective Dates Beginning: **06/05/19** Ending: **11/27/19**

8) Option to renew? ☐ Yes ☑ No Renewal terms

FINANCIAL SECTION

9a) Current Contract Value: $ 7,092,731.00
9b) Amendment Amount: $ 411,380.00
9c) New Contract Value (including all amendments) $ 7,504,111.00
9d) Is the amount an estimate? ☐ Yes ☑ No
(Estimate if per transaction cost)

9e) *If estimated, how was the estimate calculated?* N/A

10) Is the amount a one-time purchase or annual recurring purchase? ☑ One-time ☐ Recurring

11) Account Code **20-1802MID.58912.06132502** Capital Project Code **MSP205**

12) Budgeted? ☑ Yes ☐ No Budget amount: **$ 411,380.00**

13) Will this contract require support from another department? ☑ Yes ☐ No

14) If so, is the other department(s) aware of this contract and the required support? ☑ Yes ☐ No

15) If box 2a or 2c is checked, has the Qualified Heath Insurance Certificate been verified? ☑ Yes ☐ No

SIGNATURE SECTION

	Route to?		Initials	
Contract Compliance	☐ Yes	☑ No		N/A
AAG Legal Review	☑ Yes	☐ No	MB	Michael Bell
Accounting Review	☑ Yes	☐ No		Tracy Bingham Bryan Steele
IT Review (IT software or hardware)	☐ Yes	☑ No		N/A
Up to $10K Manager/Program Manager	☑ Yes	☐ No	✓	Heather Bening
Up to $50K Dir, Sr. Mgr, RGM, or Chief/VP	☐ Yes	☑ No		N/A
Up to $100K Chief, or Dir, Sr. Mgr, RGM (Capital, Maint., Ops. only)	☑ Yes	☐ No		D. Eddy Cumins
Over $100K Executive Director	☑ Yes	☐ No		W. Steve Meyer
Over $200K Board Approval	☑ Yes	☐ No		Approval Date

If Yes, route to the Sr. Supply Chain Manager for board meeting agenda and approval

CONSTRUCTION MANAGER / GENERAL CONTRACTOR AGREEMENT -
Phase 2 Construction Services Amendment No. 8
(Midvale Crosswalk Improvement Project)

This Construction Manager / General Contractor Agreement – Phase 2 Construction Services Amendment ("**Amendment**") is between the Utah Transit Authority, a public transit district organized under the laws of the State of Utah ("**UTA**"), and Granite Construction Company, a Utah corporation ("**Contractor**").

RECITALS

A. UTA is engaged in a Program to construct first and last mile improvements. (collectively, the "**Program**").

B. Pursuant to Request for Proposals No. 18-2398TP, UTA and Contractor entered into the Construction Manager/General Contractor Agreement – Phase 1 Pre-Construction Services, dated April 11, 2018 (UTA Contract No. 18-2398TP and hereinafter the "**Phase 1 Agreement**").

C. Pursuant to the process and pricing methodologies outlined in the Phase 1 Agreement, UTA and Contractor have negotiated and agreed on the lump sum construction price, schedule, and scope of work for the construction services for the following Project in the City of Midvale: Midvale Crosswalk Improvement Project (MID_CWI_1) (the "Project").

D. UTA and Contractor desire to amend the Phase 1 Agreement to include that scope, schedule, and price for the Project specified herein. Hereafter, the term "**Agreement**" refers collectively to the Phase 1 Agreement and this Amendment for the Projects.

E. UTA and Contractor intend to enter into additional, separate and distinct Phase 2 construction services amendments for other projects that are part of the Program.

AGREEMENT

Therefore, the Parties agree as follows:

1. Scope of Work. Contractor shall perform the Work. In the Contract Documents, "**Work**" means all construction and other services required by the Contract Documents, including procuring and furnishing all material, equipment, services and labor reasonably inferable from the Contract Documents as necessary to complete construction of the Projects. The term "Work" does not include the Phase 1 Work, which was defined and performed pursuant to the Phase 1 Agreement.

2. Schedule. (a) Contractor is authorized to commence all Work upon the execution of this Amendment. The Contractor's initial baseline project schedule is attached as Exhibit A.

(b) The Contractor shall achieve Substantial Completion of the entire Work under this Amendment no later than October 21, 2019 (the "**Substantial Completion Date**"). In the Contract Documents, "**Substantial Completion**" means that the Work is sufficiently complete in

accordance with the Contract Documents so that UTA and/or a Local Partner, as applicable, can occupy and use the Project for its intended purpose.

(c) The Contractor shall achieve Final Completion of the Work under this Amendment as expeditiously as reasonably practicable, but in no event later than November 27, 2019 (the **"Final Completion Date"**). In this Agreement, **"Final Completion"** means that the Work is complete in accordance with the Contract Documents, including but not limited to, final completion of all punch list items and delivery of all documents in accordance with this Agreement and the General Conditions.

(d) Time is of the essence with respect to the dates set forth in this section.

(e) Contractor acknowledges that if Substantial Completion is not attained by the Substantial Completion Date, UTA will incur significant losses, including loss of reputation, loss of potential government funding, and losses arising out of other contracts held by UTA related to the Project. Contractor acknowledges that those potential losses, while actual, are difficult to measure and determine with precision. If Substantial Completion is not attained by the Substantial Completion Date, Contractor shall pay UTA nine hundred and thirty dollars ($930.00) as liquidated damages for each calendar day that Substantial Completion extends beyond the Substantial Completion Date.

3. Price and Payment. (a) As full compensation for completing the Work in accordance with the Contract Documents, UTA shall pay to the Contractor the lump sum amount of FOUR HUNDRED ELEVEN THOUSAND, AND THREE HUNDRED AND SEVENTY NINE DOLLARS AND NINETY EIGHT CENTS ($411,379.98) and hereinafter the **"Contract Price"**), as more particularly set forth on the Price Form, attached as Exhibit B. The Contract Price does not include the Phase 1 Contract Pricing, which is defined by, and paid under, the Phase 1 Agreement. The procedures for invoicing and payment are set forth in Article 4 of the General Conditions.

4. Contract Documents. (a) The Contract Documents consist of the following:

(1) All written amendments and Change Orders to this Amendment executed in accordance with Article 7 of the General Conditions;

(2) This Amendment, including its exhibits, and specifically including the General Conditions;

(3) The "Released for Construction" delivery package (the "RFC Drawings") for the Project, attached as Exhibit C, dated February 2019, which is also included in the ProjectWise Site and in IPCS.

(4) All written amendments and Change Orders to the Phase 1 Agreement, executed in accordance with the Phase 1 Agreement;

(5) The Phase 1 Agreement, including its exhibits, and specifically including the Federal Clauses and General Conditions;

(6) The Contractor's Proposal in response to the RFP;

(7) The RFP.

(b) The Parties intend that the Contract Documents include and provide for all aspects of the Work that are necessary for the proper initiation, performance, and Final Completion of the Work by the Contractor, by the Final Completion Date, and for the Contract Price. The Parties intend that the Contract Documents be interpreted in harmony so as to avoid conflict, with words and phrases interpreted in a manner consistent with construction industry standards.

(c) If any terms of the Contract Documents contradict any other terms, the terms contained in the more recent Contract Document will govern.

(d) Contractor acknowledges that, prior to the execution of this Agreement, it has carefully reviewed the Contract Documents for errors, omissions, conflicts or ambiguities (each, a "**Discrepancy**"), and is not aware of any Discrepancies as of the execution of this Agreement. If the Contractor becomes aware of a Discrepancy, the Contractor shall immediately notify UTA's Project Manager of that Discrepancy in writing. UTA's Project Manager shall promptly resolve the Discrepancy in writing. Contractor's failure to promptly notify UTA of an apparent discrepancy will be deemed a waiver of Contractor's right to seek an adjustment of the Contract Price or Contract Times due to the discrepancy.

(e) The Contract Documents form the entire contract between UTA and the Contractor and by incorporation in this Agreement are as fully binding on the Parties as if repeated in this Agreement. No oral representations or other agreements have been made by the Parties except as specifically stated in the Contract Documents.

5. Representatives of the Parties. (a) UTA designates Heather Bening as its Project Manager, and Grey Turner as its Senior Representative. UTA's Contract Administrator for this Agreement is Teressa Pickett. Questions or correspondence regarding the contractual aspects of this Agreement should be directed to Ms. Pickett, at the address set forth in Section 9.

(b) Contractor designates Casey Green as its Project Manager, and Eric Wells as its Senior Representative.

6. Key Personnel. (a) Contractor shall ensure that the following Key Personnel remain assigned to the Project until Final Completion:

(1) Project Manager: Casey Green

(2) Construction Manager: Randy Cox

(b) Contractor must obtain permission, in writing, from UTA's Senior Representative or his/her designee, prior to removal of the Key Personnel identified above. In connection with a request to replace Key Personnel, the Contractor must identify a proposed replacement, who must meet the requirements of the position stated in the RFP.

7. Bonds and Insurance. (a) Contractor shall obtain and maintain the insurance coverages set forth in Exhibit C of the Phase 1 Agreement, and comply with the obligations set forth therein.

(b) The Contractor shall provide to UTA a performance bond and a payment bond (the "Bonds") issued by a surety doing business in Salt Lake County, Utah, and listed in the then current US Department of the Treasury's Circular 570. The Bonds must each be in an amount sufficient to cover 100% of the Contract Price, and in a form acceptable to UTA. The Bonds may, as necessary, be consolidated with those for Work to be performed under other Phase 2 Amendments, subject to UTA's approval, provided that the combined amount of the Bonds is equal to the combined Contract Prices of all of the Phase 2 Amendments consolidated for this purpose. Contractor shall provide the Bonds to UTA prior to commencing any Work.

8. Prevailing Wages. Contractor shall pay or cause to be paid to all applicable workers employed by it or its Subcontractors to perform the Work not less than the prevailing rates of wages, as provided in the statutes and regulations applicable to public work contracts, including the Davis-Bacon Act. The applicable prevailing wages mandated by the Davis-Bacon Act as of the date of execution of this Phase 2 Amendment and for the county in which the Work will occur are attached as Exhibit D. Contractor shall comply with and cause its subcontractors to comply with all laws pertaining to prevailing wages.

9. Notices. (a) To be deemed valid, all notices, requests, claims, demands and other communications between the Parties ("**Notices**") must be in writing and addressed as follows:

If to the Utah Transit Authority:

Utah Transit Authority
ATTN: Teressa Pickett
669 West 200 South
Salt Lake City, UT 84101

With a required copy to:

Utah Transit Authority
ATTN: Compliance Officer
669 West 200 South
Salt Lake City, UT 84101

If to the Contractor:

Granite Construction Company
ATTN: Eric Wells
1000 N. Warm Springs Road
Salt Lake City, UT 84116

(b) To be deemed valid, Notices must be given by one of the following methods: (i) by delivery in person (ii) by a nationally recognized next day courier service, (iii) by first class, registered or certified mail, postage prepaid. Notice shall be deemed received when received in hand by the Party, as set forth above.

(c) Either Party may change the address at which that Party desires to receive written notice by delivery of Notice of such change to the Party as set forth above. Notices will be deemed effective on delivery to the notice address then applicable for the Party to which the Notice is directed, provided, however, that refusal to accept delivery of a Notice or the inability to deliver a Notice because of an address change that was not properly communicated shall not defeat or delay the effectiveness of a Notice.

10. Counterparts. The Parties may execute this Amendment in any number of counterparts, each of which when executed and delivered will constitute a duplicate original, but all counterparts together will constitute a single agreement.

11. Effectiveness; Date. The Amendment will become effective when all Parties have fully signed it. The date of this Amendment will be the date it is signed by the last individual to sign it (as indicated by the date associated with that individual's signature).

Each individual is signing this Amendment on the date stated opposite that individual's signature.

UTAH TRANSIT AUTHORITY

By: _____ Date: _____
W. Steve Meyer
Interim Executive Director

By: _____ Date: 5/23/2019
D. Eddy Cumins
Chief Operating Officer

By: _____ Date: 5/20/19
Heather Bening
Project Manager

Approved as to Legal Form:

By: _____ Date: 5/23/19
Utah Transit Authority
Legal Counsel

GRANITE CONSTRUCTION COMPANY

By: _____ Date: 5/15/2019
Dave Richards,
Senior Vice President Granite
Construction Northwest Group

Contractor's Federal ID Number: _____

EXHIBIT A

Baseline Project Schedule

EXHIBIT B

Pricing Form

EXHIBIT C

RFC Drawings

EXHIBIT D

Wage Determination

General Decision Number: UT180029 04/06/2018 UT29

Superseded General Decision Number: UT20170029

State: Utah

Construction Type: Heavy

County: Salt Lake County in Utah.

Including Water and Sewer line and Natural Gas Pipeline Construction

Note: Under Executive Order (EO) 13658, an hourly minimum wage of $10.35 for calendar year 2018 applies to all contracts subject to the Davis-Bacon Act for which the contract is awarded (and any solicitation was issued) on or after January 1, 2015. If this contract is covered by the EO, the contractor must pay all workers in any classification listed on this wage determination at least $10.35 per hour (or the applicable wage rate listed on this wage determination, if it is higher) for all hours spent performing on the contract in calendar year 2018. The EO minimum wage rate will be adjusted annually. Please note that this EO applies to the above-mentioned types of contracts entered into by the federal government that are subject to the Davis-Bacon Act itself, but it does not apply to contracts subject only to the Davis-Bacon Related Acts, including those set forth at 29 CFR 5.1(a)(2)-(60). Additional information on contractor requirements and worker protections under the EO is available at www.dol.gov/whd/govcontracts.

Modification Number	Publication Date
0	01/05/2018
1	04/06/2018

ELEC0057-002 03/01/2015

	Rates	Fringes
LINE CONSTRUCTION		
Lineman	$ 42.94	13.32

ENGI0003-005 07/01/2013

	Rates	Fringes
OPERATOR: Power Equipment		
(1)Mechanic-Excluding Natural Gas Pipeline Construction	$ 27.55	15.65
(2A)Blade/Grader	$ 25.89	15.65

(3) Backhoe/Excavator, Front End Loader(Over 5 cu.yds.)	$ 25.37	15.65
(4) Asphalt Paver, Bulldozer, Front End Loader(2 to 5 cu. yds.), Grade Setter, Oil Distributor, Scraper	$ 24.37	15.65
(5) Asphalt Roller, Bobcat/Skid loader, Front End Loader(Under 2 cu. yds.), Oiler	$ 23.37	15.65
(6) Screed	$ 22.41	15.65
(7) Roller(Dirt and Grade Compaction)	$ 21.50	15.65

ENGI0003-056 07/01/2013

Natural Gas Pipeline Construction Only

	Rates	Fringes
OPERATOR: Power Equipment Backhoe/Excavator/Trackhoe, Blade/Grader, Boom, Bulldozer, Mechanic	$ 35.68	17.57
Oiler	$ 22.03	11.88

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* IRON0027-002 07/01/2017

	Rates	Fringes
IRONWORKER (Ornamental,Structural)	$ 27.18	20.55

IRON0847-001 08/01/2013

	Rates	Fringes
IRONWORKER, REINFORCING	$ 26.61	11.60

LABO0295-006 07/01/2014

Natural Gas Pipeline Construction Only

	Rates	Fringes
LABORER Common or General, Pipelayer	$ 20.59	8.65
Pot Tender and Sand blaster	$ 20.85	8.65

LABO0295-015 07/01/2014

	Rates	Fringes
LABORER		

(1)Flagger	$ 20.59	8.65
(3)Mason Tender (Cement/Concrete), Hand Held Saw, Jackhammer, Power Saw	$ 20.85	8.65
(5)Hand Held Drill	$ 21.65	8.65

LABO0295-038 07/01/2014

Excluding Natural Gas Pipeline & Water/Sewer Line Construction

	Rates	Fringes
LABORER (1)Common or General)	$ 20.59	8.65

TEAM0222-001 06/05/2017

NATURAL GAS PIPELINE CONSTRUCTION ONLY

	Rates	Fringes
TRUCK DRIVER		
Group 1: Articulated End Dump, Low Boy, Rollagon or Similar type Equipment, Truck Mechanic	$ 35.75	11.57
Group 2: A-Frame, Challenger(For transportation purposes), Forklift, Fuel Truck, Gin Pole, Rubber-Tired Tractor, Tandem Float (4 & 5 Axle), Track Truck/All-Track Dumper Equipment, Vacuum Truck, Winch Truck	$ 35.19	11.57
Group 3: Ambulance , Bus, Dump Truck (2 and 3 axle), Flatbed Truck (2 and 3 axle), Grease Truck, Hot Pass Truck (3 axle), Jeep, Pick-up, Single Axle Float (3 axle), Skid Truck (2 and 3 axle), Station Wagon, Stringer Bead & Hot Pass (2 axle), Swamp Buggy/ Marsh Buggy, or similar type equipment, Team Driver, Water Truck (2 and 3 axle).	$ 34.85	11.57

Premium Pay:

Add $2.25 to the above Rate for the following classifications

Group 1: Low Boy and Truck Mechanic
Group 2: Stringer Truck

SUUT2008-039 08/19/2008

	Rates	Fringes
CARPENTER, Includes Form Work	$ 14.63	0.97
CEMENT MASON/CONCRETE FINISHER	$ 17.06	3.16
ELECTRICIAN	$ 23.74	7.64
LABORER: Landscape	$ 7.25	0.00
LABORER: Pipelayer (Excluding Natural Gas Pipeline Construction)	$ 14.00	0.00
OPERATOR: Crane	$ 28.97	9.40
OPERATOR: Trackhoe (Excluding Natural Gas Pipeline and Water/Sewer Line Construction)	$ 19.98	0.00
TRUCK DRIVER (Excluding Natural Gas Pipeline Construction)	$ 14.44	3.99
WATER & SEWER LINES: Laborer, Common or General	$ 12.81	0.00
WATER & SEWER LINES: Operator - Backhoe/Trackhoe	$ 16.50	0.00

WELDERS - Receive rate prescribed for craft performing operation to which welding is incidental.

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Note: Executive Order (EO) 13706, Establishing Paid Sick Leave for Federal Contractors applies to all contracts subject to the Davis-Bacon Act for which the contract is awarded (and any solicitation was issued) on or after January 1, 2017. If this contract is covered by the EO, the contractor must provide employees with 1 hour of paid sick leave for every 30 hours they work, up to 56 hours of paid sick leave each year. Employees must be permitted to use paid sick leave for their own illness, injury or other health-related needs, including preventive care; to assist a family member (or person who is like family to the employee) who is ill, injured, or has other health-related needs, including preventive care; or for reasons resulting from, or to assist a family member (or person who is like family to the employee) who is a victim of, domestic

violence, sexual assault, or stalking. Additional information on contractor requirements and worker protections under the EO is available at www.dol.gov/whd/govcontracts.

Unlisted classifications needed for work not included within the scope of the classifications listed may be added after award only as provided in the labor standards contract clauses (29CFR 5.5 (a) (1) (ii)).

The body of each wage determination lists the classification and wage rates that have been found to be prevailing for the cited type(s) of construction in the area covered by the wage determination. The classifications are listed in alphabetical order of "identifiers" that indicate whether the particular rate is a union rate (current union negotiated rate for local), a survey rate (weighted average rate) or a union average rate (weighted union average rate).

Union Rate Identifiers

A four letter classification abbreviation identifier enclosed in dotted lines beginning with characters other than "SU" or "UAVG" denotes that the union classification and rate were prevailing for that classification in the survey. Example: PLUM0198-005 07/01/2014. PLUM is an abbreviation identifier of the union which prevailed in the survey for this classification, which in this example would be Plumbers. 0198 indicates the local union number or district council number where applicable, i.e., Plumbers Local 0198. The next number, 005 in the example, is an internal number used in processing the wage determination. 07/01/2014 is the effective date of the most current negotiated rate, which in this example is July 1, 2014.

Union prevailing wage rates are updated to reflect all rate changes in the collective bargaining agreement (CBA) governing this classification and rate.

Survey Rate Identifiers

Classifications listed under the "SU" identifier indicate that no one rate prevailed for this classification in the survey and the published rate is derived by computing a weighted average rate based on all the rates reported in the survey for that classification. As this weighted average rate includes all rates reported in the survey, it may include both union and non-union rates. Example: SULA2012-007 5/13/2014. SU indicates the rates are survey rates based on a weighted average calculation of rates and are not majority rates. LA indicates the State of Louisiana. 2012 is the year of survey on which these classifications and rates are based. The next number, 007 in the example, is an internal number used in producing the wage determination. 5/13/2014 indicates the survey completion

date for the classifications and rates under that identifier.

Survey wage rates are not updated and remain in effect until a new survey is conducted.

Union Average Rate Identifiers

Classification(s) listed under the UAVG identifier indicate that no single majority rate prevailed for those classifications; however, 100% of the data reported for the classifications was union data. EXAMPLE: UAVG-OH-0010 08/29/2014. UAVG indicates that the rate is a weighted union average rate. OH indicates the state. The next number, 0010 in the example, is an internal number used in producing the wage determination. 08/29/2014 indicates the survey completion date for the classifications and rates under that identifier.

A UAVG rate will be updated once a year, usually in January of each year, to reflect a weighted average of the current negotiated/CBA rate of the union locals from which the rate is based.

WAGE DETERMINATION APPEALS PROCESS

1.) Has there been an initial decision in the matter? This can be:

* an existing published wage determination
* a survey underlying a wage determination
* a Wage and Hour Division letter setting forth a position on a wage determination matter
* a conformance (additional classification and rate) ruling

On survey related matters, initial contact, including requests for summaries of surveys, should be with the Wage and Hour Regional Office for the area in which the survey was conducted because those Regional Offices have responsibility for the Davis-Bacon survey program. If the response from this initial contact is not satisfactory, then the process described in 2.) and 3.) should be followed.

With regard to any other matter not yet ripe for the formal process described here, initial contact should be with the Branch of Construction Wage Determinations. Write to:

Branch of Construction Wage Determinations
Wage and Hour Division
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

2.) If the answer to the question in 1.) is yes, then an interested party (those affected by the action) can request

review and reconsideration from the Wage and Hour Administrator (See 29 CFR Part 1.8 and 29 CFR Part 7). Write to:

Wage and Hour Administrator
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

The request should be accompanied by a full statement of the interested party's position and by any information (wage payment data, project description, area practice material, etc.) that the requestor considers relevant to the issue.

3.) If the decision of the Administrator is not favorable, an interested party may appeal directly to the Administrative Review Board (formerly the Wage Appeals Board). Write to:

Administrative Review Board
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

4.) All decisions by the Administrative Review Board are final.

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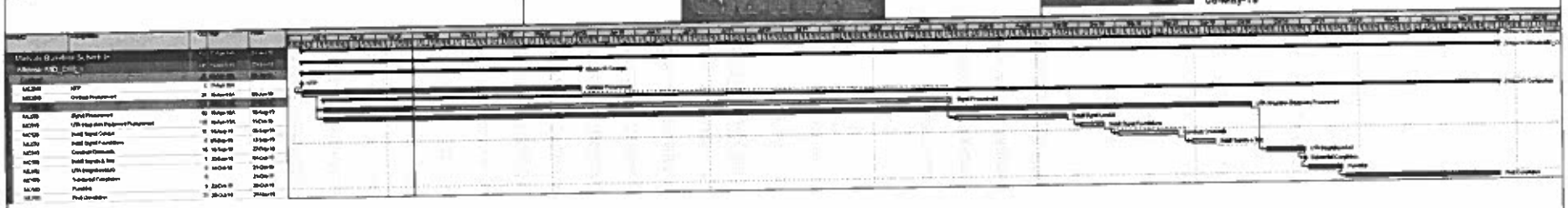
END OF GENERAL DECISION

GRANITE CONSTRUCTION 05/07/2019 MIDVALE - MID_CWI_1
COST ESTIMATE Revision 2

Item #	Item	Quantity	Units	GRANITE Unit Cost	GRANITE Total Cost	Standard Reference - Notes
A-1	Mobilization	1	Lump	$ 7,387.35	$ 7,387.35	
A-2	UTA Flagger	0	Day	$ 1,058.00	$ -	
A-3	Traffic Control	1	Lump	$ 4,950.00	$ 4,950.00	
A-4	Survey	1	Lump	$ 5,352.03	$ 5,352.03	
A-5	Public Involvement	1	Lump	$ 3,187.40	$ 3,187.40	
A-6	Quality Control	1	Lump	$ 7,525.00	$ 7,525.00	
A-7	Pedestrian Ramps	3	Each	$ 3,605.92	$ 10,817.75	
A-8	Pedestrian Traffic Signal System	1	Lump	$ 103,303.55	$ 103,303.55	Includes mast arm-mounted signs
A-9	Signal Materials	1	Lump	$ 56,964.75	$ 56,964.75	
A-10	ATMS	1	Lump	$ 7,265.78	$ 7,265.78	
A-11	Sign Type A-1, 24"x30"	4	Each	$ 200.00	$ 800.00	
A-12	Sign Post P3	2	Each	$ 215.39	$ 430.77	
A-13	Slipbase Sign Base (B3)	2	Each	$ 410.26	$ 820.51	
A-14	Pavement Marking Paint	1	Lump	$ 1,917.95	$ 1,917.95	
A-15	Pavement Marking Paint (Stop Bar, 12-inch Crosswalk)	156	Feet	$ 2.48	$ 386.88	
A-16	Remove Stop Bar Pavement Message	28	Feet	$ 3.08	$ 86.16	
A-17	Removals	1	Lump	$ 7,742.90	$ 7,742.90	Existing median, curb & gutter, sidewalk, fence
	Subtotal				**$ 218,938.78**	
B-1	UTA Signal Integration Package	1	LS	$ 110,424.61	$ 110,424.61	
				TOTAL PROJECT COSTS	**$ 329,363.39**	
				INDIRECTS	**$51,544.00**	
				MARKUP (8%)	**$30,472.59**	
				GRAND TOTAL	**$ 411,379.98**	

Midvale Baseline Schedule FIRST MILE LAST MILE

08-May-19



Remaining Level of Effort
Actual Work
Remaining Work
Critical Remaining Work
Milestone
Summary

TASK filter: All Activities

MSP205 TIGER Grant First/Last Mile

Contract #	CO No.	Amend No.	Contractor/Consultant	Service Type	Scope (Project ID)	Contract Budget
18-2398TP	0	N/A	Granite Construction	CM/GC-Phase 1	Pre-Construction Services	$297,390.00
					Construction Total (Phase 1)	**$297,390.00**
18-2398TP	1	1	Granite Construction	CM/GC-Phase 2 Construction	Ogden Grant Ave (OG_BKL_4)	$3,752,910.56
18-2398TP	2	2	Granite Construction	CM/GC-Phase 2 Construction	Farmington Swk & ADA Ramps (FAR_ADA_1; FAR_SWK 4, FAR_SWK 7)	$971,141.00
18-2398TP	3	3	Granite Construction	CM/GC-Phase 2 Construction	Bountiful ADA Ramps (BOU_ADA_1)	$369,916.00
18-2398TP	4	4	Granite Construction	CM/GC-Phase 2 Construction	Parley's Trail (SSL_MUP_2)	$417,707.00
18-2398TP	5	5	Granite Construction	CM/GC-Phase 2 Construction	SOJ_HER_DRA Bike Lanes (SOJ_BKL_2; SOJ_BKL_4; SOJ_BKL_5; SOJ_BKL_6; SOJ_BKL_7; HER_BKL_8; DRA_BKL_5)	$126,750.00
18-2398TP	6	N/A	Granite Construction	CM/GC-Phase 2 Construction	Farmington Sidewalk Changes	$7,534.00
18-2398TP	7	N/A	Granite Construction	CM/GC-Phase 2 Construction	Parley's Trail Bollards	$77,618.00
18-2398TP	8	N/A	Granite Construction	CM/GC-Phase 2 Construction	Parley's Trail Widening	$24,115.00
18-2398TP	9	N/A	Granite Construction	CM/GC-Phase 2 Construction	Bountiful Contract Extension	$0.00
18-2398TP	10	6	Granite Construction	CM/GC-Phase 2 Construction	Summit County Bike Shares (SUCo_BKS_1)	$682,904.00
18-2398TP	11	7	Granite Construction	CM/GC-Phase 2 Construction	Tooele Bike Lanes (TOCo_BKL_1; TOCo_BKL_2)	$360,023.19
18-2398TP	12	4	Granite Construction	CM/GC-Phase 2 Construction	Parley's Trail (SSL_MUP_2)-No Cost Time Extension; Ogden Grant Ave (OG_BKL_4)-No Cost Time Extension;Additional Pre-Construction Services for Summit County Bike Share (SUCo_BKS_1)	$4,722.00
18-2398TP	TBD	8	Granite Construction	CM/GC-Phase 2 Construction	Midvale Crosswalk Improvement (MID_CWI_1)	$411,379.98
					Construction Total (Phase 2)	**$7,206,720.73**

TOTAL CO's (Contract Ph 1 & Ph 2 Amendments)	**$7,390,121.73**
TOTAL CO's (Other)	**$113,989.00**
TOTAL Contract Value (to Date)	**$7,504,110.73**
TOTAL Contract Value (anticipated)	**$25,191,478.71**

Detailed Contract Description & Purpose

Board Review and/or Approval Date:	6/5/2019	**Agenda Item #**	
Action Requested:	Motion to approve disbursement		
Criteria:	Disbursement over $200,000 not on an approved contract		

Check #:	TBD	**Contract Title:**	
Project Manager:	Troy Bingham	**Contract Administrator:**	

Impacted Areas:	Light Rail Parts Inventory	**Included in budget?**	N/A
Procurement method:	Lowest Bidder	**Contractor:**	Siemens Mobility Inc.
Sole-Source Reason:	N/A	**Total Disbursement Qty & Unit price**	$ 246,346.12
Contract term (Months)		**Contract options (Months)**	
Contract start date:		**Contract end date:**	
Number of responding firms:		**$ Value of Next Lowest Bidder**	

Detailed Description & Purpose:

Supply Chain has implemented a forecasted inventory strategy for light rail parts that generates orders daily based on what maintenance staff has forecasted for the light rail fleet. These orders generate purchase orders daily from $1 to $150,000 dollars based on lowest bidder responses to fulfill those orders. As those orders arrive at UTA, they are submitted for payment to Accounts Payable and occasionally multiple payments to a single vender are combined and result in a payment over $200,000.

This disbursement is compromised of 43 invoices on 34 purchase orders that were generated by Siemens Mobility Inc. from August 8, 2018 to April 30, 2019. The individual invoice charges range from $9.60 to $116,504. More detailed invoice information is on the attached check detail list.

Attachments: Contract routing sheet attached? N/A

Attachment - Check Detail List

Seimens Check #345674

Invoice #	Purch Order	Due Date	Address #	Part Description	Payment Amount
5610166651	1108959	4/26/2019	1478795	2 Bridge plates	$ 116,504.00
5610167273	1108444	4/30/2019	1478795	308 Sliding Shoes, 126 Anti-slip Coatings	28,792.40
5610166653	1105468	4/26/2019	1478795	52 Ground Assemblies	22,880.00
5610166656	1106899	4/26/2019	1478795	21 Ground Assemblies	10,190.00
5610141344	1110879	2/22/2019	1478795	200 Equalizers	7,100.00
5610140684	1108036	10/30/2018	1478795	8 Junction Boxes	6,936.00
5610158938	1108388	3/12/2019	1478795	104 Anti-slip Coatings	6,240.00
5610157112	1110819	2/22/2019	1478795	6 PCB Assemblies	5,700.00
5610167265	1111205	4/30/2019	1478795	34 Torsion Springs	5,202.00
5610166657	1111359	4/26/2019	1478795	30 Torsion Springs	5,100.00
5610129407	1104986	8/8/2018	1478795	8 Passenger Windows	4,680.00
5610162805	1111659	3/29/2019	1478795	2 Slides, 1 J-Box, and 2 Bracket Straps	2,490.00
5610140683	1109840	10/30/2018	1478795	4 Holders	2,472.00
5610140922	1109978	10/26/2018	1478795	2 Isolators	2,400.00
5610160447	1109453	3/18/2019	1478795	Separation Wall	1,864.00
5610167269	1112360	4/30/2019	1478795	112 Keylock Fastener	1,814.40
5610157114	1105222	2/22/2019		3 Press Switch Assemblies	1,638.00
5610166654	1108420	4/26/2019	1478795	20 Clamping Plates	1,482.00
5610157116	1107427	2/22/2019	1478795	10 Grounding Cables	1,330.00
5610131576	1107427	8/30/2018	1478795	6 Switch Assemblies	1,268.00
5610144753	1109978	11/20/2018	1478795	3 Fuses	1,215.00
5610165861	1112169	4/23/2019	1478795	3 Bushings, 2 J-Box Covers	1,130.90
5610157115	1111659	2/22/2019	1478795	2 Plates	1,006.00
5610167271	1108444	4/30/2019	1478795	3 Bridge plate Heated Mats	930.00
5610157111	1110976	2/22/2019	1478795	2 Motor Disconnects	876.00
5610158159	1106035	3/29/2019	1478795	12 Cables	792.00
5610167266	1111584	4/30/2019	1478795	4 Coupler Brackets	772.00
5610133214	1107791	12/14/2018	1478795	1 Right Nozzle	614.40
5610160465	1110008	3/18/2019		2 Sand Filter Lids	472.00
5610167268	1110392	4/30/2019		25 Brush Caqb Blower	465.00
5610157113	1111361	2/22/2019	1478795	10 Relay Controls	437.00
5610140682	1108798	10/30/2018	1478795	24 Crinkles Collar Form	373.92
5610166655	1111359	4/26/2019		2 Cab Heater Plugs	210.00
5610161957	1111359	3/26/2019	1478795	2 Hydraulic Pipes	204.00
5610167267	1110126	4/30/2019		4 Mounting Plates	190.00
5610166658	1112701	4/26/2019	1478795	15 Protective Covers	184.50
5610157110	1111184	2/22/2019	1478795	5 Connectors	156.00
5610166652	1112480	4/26/2019	1478795	3 Conduit Fittings	84.00
5610167270	1112480	4/30/2019	1478795	3 Conduit Fittings	65.40
5610140681	1109936	10/30/2018	1478795	1 Cable Assembly	43.40
5610167272	1112753	4/30/2019	1478795	2 Cab Bulbs	41.80
5610133214A	1107791	12/14/2018	1478795	1 Right Nozzle	9.60
5620021318	1107791	1/10/2019	1478795	1 Right Nozzle	(9.60)
					$ 246,346.12

Detailed Contract Description & Purpose

Board Review Date:	6/5/2019	**Document Type:**	Pre-Procurement
Action Requested:	Pre-Procurement (information only)		
Criteria:	Contract is $200,000 - $999,999		

Contract Title:	Meadowbrook Building 8 Paint Booth Furnish and Install	**Contract #**	19-03045TP
Project Manager:	Greg Thorpe	**Contract Administrator:**	Teressa Pickett
Impacted Areas:	Meadowbrook Building 8	**Included in budget?**	Yes
Procurement method:	Best value (RFP)	**Contractor:**	TBD
Sole-Source Reason:	N/A	**Qty & Unit price**	
		Change Order Value	
		Total Contract Value	$385,491
Contract term (Months)	TBD	**Contract Start Date**	TBD
Contract options (Months)		**Contract End Date:**	TBD
Number of responding firms:	TBD	**$ Value of Next Lowest Bidder**	TBD

General Description & Purpose:

UTA proposes a project to replace the existing paint booth (16'-8" x 56'-0") at Meadowbrook Building 8 with a longer and wider paint booth (80' by 16'). The project will require two separate contracts, one for a paint booth supplier (estimated at $220,000), and one for a general contractor to perform building modifications to accommodate the new paint booth (estimated at $130,000). The contracts will be procured through two separate RFPs, but only the paint booth supplier contract will require board approval.

Replacement of the paint booth is necessary to allow for painting the longer 60’ articulated buses in service on the UVX route while maintaining the ability to paint traditional buses and paratransit buses. The existing paint booth, constructed in 1980, will be replaced with a new booth incorporating new technologies with better environmental controls and protection. Plans and specifications for the paint booth were prepared by Epic Engineering. The supplier of the paint booth will be required to coordinate their work with other work being performed by the general contractor.

Total budget for the paint booth replacement project is estimated at $385,491, which includes $220,000 for the paint booth supplier (the subject of this RFP), $130,000 for building modifications by the general contractor, and $35,491 for UTA admin, permitting, inspection and contingency costs.

Attachments: Contract routing sheet attached? N/A (Pre-Procurement)
Other attachments? Requisition

REQUISITION FOR PURCHASE-RSS

Requisition Number 6776 OU **Department** 3700 ASSET MANAGEMENT - SGR **Requested By** 2668 Stockley, Kyle **Date** 5/16/2019
Request Date

Title Building 8 paint booth replace **Justification**

Line	Description	Qty	UoM	Unit Price	Extended	Line Status	Account Number	Subledger-Type	Percent
1.000	Paint booth	1	EA	**********	255,491.00	Canceled	40-7375.68912	SGR375 C	100.0000
2.000	Building Modification	1	EA	**********	130,000.00	Canceled	40-6224.68912	REV224 C	100.0000
3.000	Booth and building mod	1	EA	**********	385,491.00	Approved	40-7375.68912	SGR375 C	100.0000

Approval History

Process ID	Line No.	Approver Number and Name	Approver Action Taken	Date and Time Updated
611	Order Level	1366097 Hofer, Daniel Charles	Approved	5/20/2019 140640
611	Order Level	1456823 Hancock, David W	Approved	5/20/2019 140640
611	Order Level	1440978 Cumins, Donald E	Approved	5/24/2019 151913
611	Order Level	4835 Meyer, William Steven	Approved	5/28/2019 131443