2025

Certificate of Coverage

Large Employer

Nevada - HMO

Select Health

Fair Treatment Notice

Select Health obeys Federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

We provide free:

- Aid to those with disabilities to help them talk with us. This may be sign language interpreters or info in other formats (large print, audio, electronic).
- Help for those whose first language is not English, such as interpreters or member materials in other languages.

Need help? Call Select Health Member Services at **800-538-5038**.

If you feel you've been treated unfairly, call Select Health 504/Civil Rights Coordinator at **1-844-208-9012** (TTY Users: 711) or the Compliance Hotline at **1-800-442-4845** (TTY Users: 711). You may also call the Office for Civil Rights at **1-800-368-1019** (TTY Users: **1-800-537-7697**).

Language Access Services

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Select Health.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 Select Health

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Select Health.

통지: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. Select Health. 번호로 전화해 주십시오.

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। Select Health मा फोन गर्नुहोस्।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Select Health.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: Select Health.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните Select Health.

ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez Select Health.

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

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎቶች ያለክፍያ ለእርስዎ ይገኛሉ። Select Health ን ያናግሩ።

ПАЖЊА: Ако говорите Српски, бесплатне услуге пмоћи за језик, биће вам доступне. Контактирајте Select Health.

تنبيه: إذا كنت تتحدث عربى، فستتوفر لك خدمات المساعدة اللغوية مجانا. اتصل بـ Select Health.

توجه: اگر به زبان اردو صحبت می‌کنی، خدمات کمک زبانی، بصورت رایگان در اختیار شما ست. با Select Health تماس بگیری.

หมายเหตุ: หากคุณพูด ใส่ภาษา, การบริการภาษา โดยไม่มีค่าใช้จ่าย มีพร้อมบริการให้กับคุณ ติดต่อ Select Health

Select Health: 1-800-538-5038

SECTION 1 - INTRODUCTION

1.1 This Certificate

This Certificate of Coverage describes the terms and conditions of the health insurance Benefits provided under 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 Select Health

Select Health is an HMO licensed by and **domiciled in the State of Nevada** and is located at 5381 Green Street, Murray, Utah 84123. Select Health is affiliated with Intermountain Health, but is a separate company. The Contract does not involve Intermountain Health or any other affiliated Intermountain Health companies, or their officers or employees. Such companies are not responsible to you or any other Members for the obligations or actions of Select Health.

1.3 Managed Care

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

1.4 Your Agreement

As a condition to enrollment and to receiving Benefits from Select Health, you (the Subscriber) and every other Member enrolled through your coverage (your Dependents) agree to the managed care features that are a part of the Plan in which you are enrolled and 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 Select Health as Members. You do not have any permanent or vested interest in any Benefits under the Plan. Benefits may change as the Contract is renewed or modified from year to year. Unless otherwise expressly stated in this Certificate, all Benefits end when the Contract ends.

1.6 Administration

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

1.7 Non-Assignment

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

1.8 Notices

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

1.9 Nondiscrimination

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

1.10 Questions

If you have questions about your Benefits, call Member Services at 800-538-5038, or visit selecthealth.org. Member Services can also provide you with a provider directory and information about In-Network Providers, such as name, address, phone number, professional qualifications, specialty, medical school attended, residency completed, and board certification status. Select Health offers foreign language assistance. The provider directory also includes information about receiving care after business hours.

1.11 Benefit Changes

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

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

b. Any changes or modifications that would increase your Benefits must be provided in writing and signed by the president, vice president, or medical director of Select Health.

c. Administrative errors will not invalidate Benefits otherwise in force or give rise to rights or Benefits not otherwise provided for by the Plan.

SECTION 2 - ELIGIBILITY

2.1 General

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

2.2 Subscriber Eligibility

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

2.3 Dependent Eligibility

Unless stated otherwise in the Group Application, your 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.

Select Health 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.

2.4 Court-Ordered Dependent Coverage

When you or your lawful spouse are required by a court or administrative order to provide health insurance coverage for a child, the child will be enrolled in your family coverage according to Select Health guidelines and only to the minimum extent required pursuant to Nevada Code. 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 Select Health 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. Select Health 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 the 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 Select Health; and

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

3.2 Enrollment Process

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

3.3 Effective Date of Coverage

Coverage for you and your 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 Select Health 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 Select Health receives the order.

3.4 Special Enrollment Rights

Select Health provides Special Enrollment Rights in the following circumstances:

3.4.1 Loss of Other Coverage

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

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

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 group health plan's open enrollment and a special enrollment period will be permitted under the Plan in order to avoid a gap in coverage; and

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

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

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

3.4.2 New 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 60 days of the marriage, birth, adoption, placement for adoption or placement under legal guardianship (there is an exception for enrolling a newborn, adopted child, 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, 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 Select Health.

3.4.3 Loss of Medicaid or CHIP Coverage

If you and/or your 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.

3.4.4 As Required by State and Federal Law

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

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

If you gain a Dependent through birth, adoption, placement for adoption or legal guardianship, the Dependent will be covered from the date of birth for 31 days, upon notification. To remain enrolled beyond 31 days, you must enroll the Dependent within 60 days of gaining the Dependent.

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, or 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 Select Health for up to the length of time specified in the Group Application, as long as the monthly Premiums for your coverage are paid to Select Health by your employer. Military personnel called into active duty will continue to be covered to the extent required by law. A leave of absence may not be treated retroactively as a termination of employment.

3.7 Family Medical Leave Act

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

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

b. If Premiums are not paid, your coverage will be terminated. Upon your return to work, you and any previously enrolled Dependents who are still Eligible will be prospectively reinstated if the applicable Premium for you is paid to Select Health by your employer within 30 days. Select Health will not be responsible for any claims incurred by you or your 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 Select Health 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 Select Health with written notice of termination not less than 30 days before the proposed termination date.

4.1.2 Termination of Employer Group by Select Health

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

a. Nonpayment of applicable Premiums;

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

c. Your employer's coverage under the Contract is through an association and your employer terminates membership in the association;

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

e. No employees live, reside, or work in the Service Area;

f. Select Health elects to discontinue offering a particular health benefit plan. If that happens, you will be given at least 90 days' advance notice; or

g. Select Health 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 year in which Dependent status is lost. When a loss of Eligibility is not reported in a timely fashion as required by the Contract, and federal or state law prevents Select Health from retroactively terminating coverage, Select Health has the discretion to determine the prospective date of termination. Select Health also has the discretion to determine the date of termination for Rescissions.

4.2.2 Fraud or Misrepresentation

Coverage for you and/or your Dependents may be terminated upon 30 days notice if you or they make an intentional misrepresentation of material fact or a fraudulent misrepresentation in connection with insurability.

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 Nonpayment of Premium or Contributions

Select Health 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 Select Health may recover from you and/or your Dependent(s) the amount of any Benefits you or they received during the period of lost coverage.

4.2.5 Annual Open Enrollment

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

4.2.6 Court or Administrative Order

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

4.3 Member Receiving Treatment at Termination

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

4.4 Reinstatement

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

SECTION 5 - 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 Employer's Obligation

Continuation Coverage is an employer obligation. Select Health is not the administrator of Continuation Coverage procedures and requirements. Select Health 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 Select Health of such individuals; and

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

If the Contract is terminated, your Continuation Coverage with Select Health 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. Select Health 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 unless required by applicable law.

SECTION 6 - PROVIDERS/NETWORKS

6.1 Providers and Facilities

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

If you need access to primary care, specialty care, Mental Health/Substance Use Disorder (if a Covered Service), or Hospital services, call Select Health Member Advocates at 800-515-2220.

You can also find the most current list of Providers online. Visit selecthealth.org/findadoctor, or call Member Services at 800-538-5038 to request a copy of the provider directory.

6.1.1 Other Networks

For Dependents residing and receiving care outside of the Service Area, In-Network Benefits apply for Services received from Providers in the following networks:

a. Select Health Med in Utah and Nevada;

b. Select Health in Idaho; and

c. Other networks as listed on selecthealth.org.

Contact Member Services for additional information.

6.2 Providers and Facilities Not Agents/Employees of Select Health

Providers contract independently with Select Health and are not agents or employees of Select Health. They are entitled and required to exercise independent professional medical judgment in providing Covered Services. Select Health makes a reasonable effort to credential In-Network 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 Select Health, are solely responsible for their actions, or failures to act, in providing Services to you.

Providers and Facilities are not authorized to speak on behalf of Select Health or to cause Select Health to be legally bound by what they say. A recommendation, order, or referral from a Provider or Facility, including In-Network Providers and Facilities, does not guarantee coverage by Select Health.

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

6.3 Payment

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

6.3.1 Incentives

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

6.3.2 Payments to Members

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

6.4 Provider/Patient Relationship

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

6.5 Continuity of Care

Select Health will provide you with 30 days' notice of an In-Network Provider or Facility termination if you or your Dependent is receiving ongoing care from that Provider or Facility. However, if Select Health does not receive adequate notice of a Provider or Facility termination, Select Health will notify you within 30 days of receiving notice that the Provider or Facility is no longer participating with Select Health.

If you or your Dependent is under the care of a Provider or Facility when participation changes, Select Health will continue to treat the Provider or Facility as an In-Network Provider/Facility until the completion of the care (not to exceed 120 days). This does not apply when a Provider is terminated from the network for failure to meet applicable quality standards or for fraud. Continuity of care treatment is eligible for coverage if you or your Dependent are:

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

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

c. scheduled to undergo non-elective surgery from the Provider or Facility, including receipt of postoperative care from such Provider or Facility with respect to such surgery;

d. pregnant and undergoing a course of treatment for pregnancy from the Provider or Facility (until the 90th day after the date of delivery, or if the pregnancy does not end in delivery, the date of the end of the pregnancy); or

e. determined to have a life expectancy of six months or less and are receiving treatment for such illness from the Provider or Facility until the Member's death.

To continue care, the In-Network Provider or Facility must not have been terminated by Select Health for quality reasons, remain in the Service Area, and agree to do all of the following:

a. Accept the Allowed Amount as payment in full;

b. Follow Select Health's Healthcare Management Program policies and procedures;

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

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

6.6 Referrals

Except for general ophthalmology, gynecological and obstetrical, general podiatry, Mental Health, and substance use disorder, Services received from a Secondary Care Provider or ancillary Provider require a referral from your Primary Care Provider.

6.7 Finding an In-Network Provider

For help finding an In-Network Provider, do any of the following:

a. Visit selecthealth.org;

b. Refer to your Provider & Facility Directory; or

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

SECTION 7 - ABOUT YOUR BENEFITS

7.1 General

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

7.2 Member Payment Summary

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

7.3 Identification (ID) Cards

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

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

7.4 Medical Necessity

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

7.5 Benefit Changes

Your Benefits may change if the Contract changes. Your employer is responsible for providing at least 60 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 In-Network Benefits

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

7.9 Emergency Conditions

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

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

If you or your Dependent is hospitalized for an emergency:

a. You or your representative must contact Select Health once the condition has been stabilized, or as soon as reasonably possible; and

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

7.10 Surprise Billing Protections

When certain Services are received from Out-of-Network Providers, you or your Dependents will only be responsible for cost sharing at an In-Network Benefit level. To the extent required by the No Surprises Act (NSA), this is applicable for air ambulance and emergency Services from Out-of-Network Providers, including post-stabilization care, and Services received from Out-of-Network Providers at an In-Network Facility. In these circumstances, cost sharing amounts will be based on the qualifying payment amount (as defined by the NSA). If you or your Dependents consent to waive balance billing protections for Services obtained by an Out-of-Network Provider at in In-Network Facility by signing a waiver as allowed by the NSA, the protections of the NSA will not apply. Out-of-Network Providers may initiate a dispute resolution process if they do not agree with the Allowed Amount. The outcome of that process may

change the Allowed Amount.

7.11 Urgent Conditions

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

7.12 Third Party Payments

Select Health will accept third-party Premium payments from the following entities as required by state and federal law:

a. Ryan White HIV/AIDS Program:

b. Indian tribes, tribal organizations, or urban Indian organizations: and

c. Local, state, or federal government programs, including grantees directed by a government program to make payments on its behalf.

d. Your family and friends.

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

   i. Provides assistance based on your financial need;

   ii. Is not a healthcare provider; and

   iii. Is not financially interested.

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

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

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

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

7.13 Deductible Waiver

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

a. Retinopathy screening for diabetes;

b. Hemoglobin A1c testing for diabetes;

c. Peak flow meter for asthma;

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

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

7.14 Travel Outside the U.S.

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

SECTION 8 - COVERED SERVICES

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

Benefits are limited. Services must satisfy all of the

requirements of the Contract to be covered by Select Health. For additional information affecting Covered Services, refer to your Member Payment Summary and Section 10 - Limitations and Exclusions. In addition to this Certificate, you can find further information about your Benefits by doing any of the following:

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

b. Visit selecthealth.org;

c. Refer to your Provider & Facility Directory; or

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

8.1 Facility Services

8.1.1 Educational Training

Only for diabetes, asthma, or chronic kidney disease.

8.1.2 Emergency Room (ER)

If you are admitted directly to the Hospital 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. Private Duty Nursing.

d. Intensive care unit.

e. Preadmission testing.

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

g. Maternity/obstetrical Services.

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

8.1.4 Nutritional Therapy

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

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

Only:

a. General anesthesia, deep anesthesia, and Monitored Anesthesia Care (MAC) pursuant to Select Health policy when administered in connection with otherwise Covered Services and by a Physician certified as an anesthesiologist or by a Certified Registered Nurse Anesthetist (CRNA); and

b. Dental anesthesia when rendered by an In-Network Provider according to Select Health policy.

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 Select Health determines the following to be Medically Necessary:

   i. Maxillary and/or mandibular procedures;

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

   iii. Orthognathic Services; or

c. Services for Congenital Oligodontia/Anodontia.

d. 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 Select Health policy.

8.2.5 Genetic Counseling

Only when rendered by an In-Network Provider.

8.2.6 Genetic Testing

Only when ordered or recommended by a medical geneticist, a genetic counselor, or a provider with recognized expertise in the area being assessed and only when all of the following criteria are met:

a. Diagnostic results from physical examination, pedigree analysis, and conventional testing are inconclusive and a definitive diagnosis is uncertain;

b. The clinical utility of all requested genes and gene mutations must be established; and

c. The clinical record indicates how test results will guide decisions regarding disease treatment, prevention, or management.

8.2.7 Home Visits

8.2.8 Infertility

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

8.2.9 Major Surgery

8.2.10 Mastectomy/Reconstructive Services

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

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

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

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

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

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

8.2.11 Maternity Services

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

8.2.12 Medical/Surgical

In an inpatient, outpatient, or Ambulatory Surgical Facility.

8.2.13 Office Visits

For consultation, diagnosis, and treatment.

8.2.14 Preventive Services

8.2.15 Sleep Studies

8.2.16 Sterilization Procedures

8.3 Miscellaneous Services

8.3.1 Ambulance/Transportation Services

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

8.3.2 Approved Clinical Trials

Only when received as part of an approved clinical trial or study if the following applies:

a. The clinical trial or study is conducted in the state of Nevada and the medical treatment is provided:

   i. In a Phase I, Phase II, Phase III or Phase IV clinical trial or study for the treatment of cancer or other life-threatening disease or condition;

   ii. In a Phase II, Phase III or Phase IV clinical trial or study for the treatment of chronic fatigue syndrome;

   iii. For cardiovascular disease (cardiac/stroke), surgical musculoskeletal disorders of the spine, hip, and knee, and other diseases or disorders which are not life-threatening, when the clinical trial meets the qualifying criteria;

Only when rendered by an In-Network Provider. In the event an In-Network Provider does not offer a clinical trial with the same protocol as the one the Member's Provider recommended, the Member may select an Out-of-Network Provider performing a clinical trial with that protocol within the State of Nevada. If there is no Provider offering the clinical trial with the same protocol as the one the Member's Provider recommended in Nevada, the Member may select a clinical trial outside the State of Nevada but within the United States of America.

Select Health may require a copy of the clinical trial or study certification approval, the Member's signed statement of consent, and any other materials related to the scope of the clinical trial or study.

b. Services received during a clinical trial or study are limited to the following:

   i. The initial consultation to determine whether the Member is eligible to participate in the clinical trial or study;

   ii. Any drug or device that is approved for sale by the FDA without regard to whether the approved drug or device has been approved for use in the medical treatment of the Member, if the drug or device is not paid for by the manufacturer, distributor, or Provider;

   iii. Services normally covered under this Plan that are required as a result of the medical treatment or related complications provided in the clinical trial or study when not provided by the sponsor of the clinical trial or study;

   iv. Services required for the clinically appropriate monitoring of the Member during the clinical trial or study when not provided by the sponsor of the clinical trial or study;

Benefits for Covered Services in connection with a clinical trial or study are covered to the same extent as any other Illness or Injury.

8.3.3 Bariatric Surgery

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

8.3.4 Biomarker Testing

Biomarker testing for the diagnosis, treatment, appropriate management, and ongoing monitoring of cancer when conducted by an In-Network Provider where biomarker testing falls within the scope of their practice, training, and experience.

8.3.5 Breast Cancer Imaging and Diagnostic Imaging Tests

Breast cancer imaging tests are covered with no cost sharing at the age and interval deemed most appropriate by the Member's provider based on personal or family medical history. Diagnostic imaging tests are covered with no cost sharing to evaluate an abnormality which is seen or suspected from a mammogram or imaging test or detected by other means of examination. Except for Preventive Services, if you are on a high deductible health plan, cost sharing will still apply for these Services.

8.3.6 Chemotherapy, Radiation Therapy, and Dialysis

8.3.7 Chiropractic Benefits

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

a. Chiropractic appliances;

b. Services for treatment of non-neuromusculoskeletal disorders;

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

d. Services for children ages eight and under.

8.3.8 Cochlear Implants and Osseointegrated Auditory Devices

Only in limited circumstances that satisfy Select Health criteria.

8.3.9 Diabetes Management and Treatment

Management and treatment of diabetes, including prescription drugs, equipment, supplies, appliances, and education.

8.3.10 Durable Medical Equipment (DME)

Only:

a. When used in conjunction with an otherwise covered condition and when:
   i. Prescribed by a Provider;
   ii. Primarily used for medical purposes and not for convenience, personal comfort, or other nontherapeutic purposes;
   iii. Required for Activities of Daily Living;
   iv. Not for duplication or replacement of lost, damaged, or stolen items; and
   v. Not attached to a home or vehicle.
b. Batteries only when used to power a wheelchair, an insulin pump for treatment of diabetes, or for a covered Cochlear Implant.
c. Continuous passive motion therapy for any indication for up to 21 days of continuous coverage from the first day applied.

Certain DME items can only be rented. Others may be subject to a rental period prior to purchasing. Select Health will not provide payment for rental costs exceeding the purchase price. For covered rental DME that is subsequently purchased, cumulative rental costs are deducted from the purchase price.

8.3.11 Gender Dysphoria and Gender Incongruence

Psychosocial, surgical interventions, and other Services for gender dysphoria and gender incongruence, and any other medically necessary treatment for such disorders provided by:

a. Endocrinologists;
b. Pediatric endocrinologists;
c. Social workers;
d. Psychiatrists;
e. Psychologists;
f. Gynecologists;
g. Speech-language pathologists;
h. Primary care physicians;
i. Advanced practice registered nurses;
j. Physician assistants; and
k. Any other providers of medically necessary services for the treatment of gender dysphoria or gender incongruence.

8.3.12 Habilitation Therapy Services

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

8.3.13 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.

8.3.14 Hospice Care

8.3.15 Injectable Drugs and Specialty Medications

Up to a 30-day supply of injectable drugs or specialty medications may be covered. Infused drugs must be administered by an In-Network Provider. Most specialty oral and self-injectable medications must be obtained from an In-Network specialty pharmacy. Call Member Services to obtain information on participating drug vendors.

8.3.16 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.

8.3.17 Organ Transplants

a. Only if:
    i. Provided by In-Network Providers in an In-Network Facility unless otherwise approved in writing in advance by Select Health.
b. And only the following:
    i. Bone marrow as outlined in Select Health 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;
    ix. Single or double lung; and
    x. Small bowel.

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

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

8.3.18 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.

8.3.19 Osteoporosis Screening

Only central bone density testing (DEXA scan).

8.3.20 Private Duty Nursing

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

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

8.3.22 Sickle Cell Disease Management and Treatment

Management and treatment of sickle cell disease and its variants, including, prescriptions drugs.

8.3.23 TeleHealth

Services are covered in accordance with Select Health's medical policy when rendered by an In-Network Provider. Interprofessional assessment or consultation between Providers as part of your treatment are payable under your office visit Benefit.

8.3.24 Temporomandibular Joint (TMJ)

8.3.25 Tobacco Cessation

Screening for tobacco use and up to two quit attempts per year, including:

a. Four tobacco cessation counseling sessions; and

b. All Food and Drug (FDA) approved tobacco cessation medications, both prescription and over-the-counter medications for a 90-day treatment regimen when prescribed by an In-Network Provider

8.3.26 Vein Procedures

Only when performed at an accredited vein clinic or facility.

8.3.27 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 your member account at selecthealth.org and use Pharmacy Tools;

b. Visit selecthealth.org/pharmacy;

c. Refer to your Provider & Facility Directory; or

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

9.2 Use In-Network Pharmacies

To get the most from your Prescription Drug Benefits, use an In-Network Pharmacy and present your ID card when filling a prescription. Select Health contracts with pharmacy chains on a national basis and with independent pharmacies in Nevada.

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

9.3 Tiered Benefits

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

9.4 Filling Your Prescription

9.4.1 Copay/Coinsurance

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

9.4.2 Quantity and Day Supply

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

9.4.3 Prescription Drug Synchronization

You may request synchronization of your drugs, which aligns your fill dates so that your prescriptions may be refilled on the same day. Call Member Services to request prescription drug synchronization.

9.4.4 Refills

Except for schedule II controlled substances and topical ophthalmic products, refills are allowed after 75 percent of the last refill has been used for a 30-day supply, and 50 percent for a 10-day supply. Topical ophthalmic products can be refilled after 21 days for a 30-day supply of the product, 42 days for a 60-day supply of the product, or 63 days for a 90-day supply of the product. Some exceptions may apply, and the timing of the refill limits may be adjusted as market dynamics change. Call Pharmacy Services for more information.

9.5 Generic Drug Substitution Required

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

9.6 Maintenance Drugs

Select Health offers a maintenance drug Benefit, allowing you to obtain a 90-day supply of certain 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 Select Health. Prescription drugs that require Preauthorization are identified on the Prescription Drug List. The letters (PA) appear next to each drug that requires Preauthorization. Preauthorization is also required if the drug is prescribed in excess of the Plan limits (quantity, duration of use, maximum dose, etc.). The most current information can be found at the Select Health website.

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

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

9.8 Step Therapy

Certain drugs require your Provider to first prescribe an alternative drug preferred by Select Health. This process is called step therapy. The alternative drug is generally a more cost-effective therapy that does not compromise clinical quality. If your Provider feels that the alternative drug does not meet your needs, Select Health may cover the drug without step therapy if Select Health determines it is Medically Necessary. Drugs approved by the U.S. Food and Drug Administration (FDA) to treat a psychiatric condition are not subject to step therapy.

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. A request for an exception to a step therapy protocol will be reviewed, and an appeal can be requested if the request is denied.

9.9 Coordination of Benefits (COB)

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

9.10 Inappropriate Prescription Practices

In the interest of safety for our Members, Select Health reserves the right to not cover certain prescription drugs.

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

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

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

9.11 Prescription Drug Benefit Abuse

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

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

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

Select Health may terminate you from coverage if you make an intentional misrepresentation of material fact in connection with obtaining or attempting to obtain drugs, such as by intentionally misrepresenting your condition, other medications, healthcare encounters, or other medically relevant information. At the discretion of Select Health, 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 an In-Network Provider unless otherwise approved in writing in advance by Select Health. 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.

9.14 Exceptions Process

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

9.15 Prescriptions Dispensed in a Provider's Office

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

9.16 Contraceptives

Up to a 12-month supply per prescription. Self-administered hormonal Contraceptives. When required by Nevada state law, are covered when dispensed by a pharmacist without a prescription from a Provider.

9.17 Human Immunodeficiency Virus (HIV) Laboratory Tests and Drugs

When required by Nevada state law, laboratory tests and drugs for HIV are covered when ordered or dispensed by a pharmacist.

9.18 Disclaimer

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

SECTION 10 - LIMITATIONS AND EXCLUSIONS

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

10.1 Abortions/Termination of Pregnancy

Abortions are not covered except:

a. When determined by Select Health 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, employment, continuing or obtaining insurance coverage, governmental licensure, home health recertification, travel, military service, school, or institutional requirements.

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

10.4 Allergy Tests/Treatments

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

10.5 Biofeedback/Neurofeedback

Biofeedback/neurofeedback is not covered.

10.6 Birthing Centers and Home Childbirth

Childbirth in any place other than a Hospital or an In-Network birthing center connected to a Hospital either through a bridge, ramp, or adjacent to the labor and delivery unit is not covered. This includes all Provider and/or Facility charges related to the delivery.

10.7 Certain Cancer Therapies

Neutron beam therapy is not covered.

Proton beam therapy is not covered except in the following limited circumstances:

a. Chordomas or chondrosarcomas arising at the base of the skull or along the axial skeleton without distant metastases;
b. Other central nervous system tumors located near vital structures;
c. Pituitary neoplasms;
d. Uveal melanomas confined to the globe (not distant metastases); or
e. In accordance with Select Health medical policy.

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

10.8 Claims After One Year

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

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

10. 9 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.

10.10 Custodial Care

Custodial Care is not covered.

10.11 Debarred Providers

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

10.12 Dry Needling

Dry needling procedures are not covered.

10.13 Duplication of Coverage

The following are not covered:

a. If payments Select Health would make for a Covered Service, together with payments for the Covered Service that would be made under other valid coverage (hospital, surgical, medical or major medical benefits provided by individual or family-type coverage, government programs, or workers' compensation) exceed the Allowed Amount, Select Health will be liable only for its proportionate share of the Allowed Amount.

b. Services for which you have obtained a payment, settlement, judgment, or other recovery for future payment intended as compensation.

c. Services received by you or your Dependent 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.

10.14 Exercise Equipment or Fitness Training

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

10.15 Experimental and/or Investigational Services

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

10.16 Eye Surgery, Refractive

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

10.17 Food Supplements

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

10.18 Hearing Aids

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

10.19 Home Health Aides

Services provided by a home health aide are not covered.

10.20 Immunizations

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

10.21 Mental Health/Substance Use Disorder

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

10.22 Non-Covered Service in Conjunction with a Covered Service

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

10.23 Pain Management Services

The following Services are not covered:

a. Prolotherapy;

b. Radiofrequency ablation of dorsal root ganglion; and

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

10.24 Prescription Drugs/Injectable Drugs and Specialty Medications

The following are not covered:

a. Appetite suppressants and weight loss drugs;

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

c. Certain off-label drug usage, unless the use has been approved by a Select Health Medical Director or clinical pharmacist;

d. Compound drugs when alternative products are available commercially;

e. Cosmetic health and beauty aids;

f. Drugs not on your Formulary;

g. Drugs purchased from Out-of-Network 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 Select Health;

j. Human growth hormone for the treatment of idiopathic short stature;

k. Medical foods;

l. Infertility drugs;

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

i. Food and Drug Administration (FDA) approval;

ii. The drug has no active ingredient and/or clinically relevant studies as determined by the Select Health Pharmacy & Therapeutics Committee;

iii. Supported by nationally recognized compendium sources currently utilized by Select Health;

1) Cancer drugs must be specified in the most recent edition of:

a) The United States Pharmacopoeia Drug Information; or

b) The American Hospital Formulary Service Drug Information; or

c) National Comprehensive Cancer Network (NCCN); or

d) Supported by at least two articles reporting the results of scientific studies that are published in scientific or medical journals.

iv. As defined within Select Health's Preauthorization criteria or medical policy.

n. Drugs used for infertility purposes;

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

p. Non-Sedating Antihistamines;

q. Over-the-counter (OTC) drugs, except 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 Select Health Formulary as a covered drug;

ii. The Select Health 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 an In-Network Pharmacy;

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

s. Prescription Drugs used for cosmetic purposes;

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

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

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

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

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

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

10.25 Reconstructive, Corrective, and Cosmetic Services

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

   i. To improve form or appearance;

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

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

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

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

   vi. Treatment for venous telangiectasia (spider veins).

10.26 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.

10.27 Respite Care

Respite Care is not covered.

10.28 Robot-Assisted Surgery

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

10.29 Sexual Dysfunction

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

10.30 Specialty Services

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

10.31 Specific Services

The following Services are not covered:

a. Anodyne infrared device for any indication;

b. Auditory brain implantation;

c. Automated home blood pressure monitoring equipment;

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

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

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

g. Computer-assisted navigation for orthopedic procedures;

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

i. Extracorporeal shock wave therapy for musculoskeletal indications;

j. Freestanding/home cervical traction;

k. Incontinence supplies;

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.

10.32 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.

10.33 Travel-related Expenses

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

10.34 War

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

10.35 Wilderness Therapy

Wilderness Therapy is not covered**.**

SECTION 11 - HEALTHCARE MANAGEMENT

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

11.1 Preauthorization

Preauthorization is prior approval for certain Services and is considered a Preservice Claim (refer to Section 12 - Claims and Appeals). Preauthorization is not required when Select Health is your secondary plan. Obtaining Preauthorization does not guarantee coverage. 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. Adenoidectomy;

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 48 hours for a normal delivery or longer than 96 hours for a cesarean section, and deliveries outside of the Service Area;

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

e. Automated home blood pressure monitoring equipment (when ordered by an Out-of-Network Provider);

f. Bariatric surgery;

g. Biomarker testing for the diagnosis, treatment, appropriate management, and ongoing monitoring of cancer;

h. Certain advanced imaging including Magnetic Resonance Imaging (MRI), Computerized Tomography (CT) scans, Positron Emission Tomography (PET) scans, and cardiac imaging and radiology services/ peripherally inserted central catheter (PICC) line insertion, cath-flow and alteplase (catheter clot treatment) to open line, in home or custodial facility for home bound members;

i. Certain arthroscopic procedures;

j. Certain genetic testing;

k. Certain Home Healthcare;

l. Certain medical oncology drugs;

m. Certain radiation therapies;

n. Certain sleep studies;

o. Certain vein procedures;

p. Cochlear Implants and Osseointegrated Auditory Devices;

q. Continuous glucose monitors;

r. Dental anesthesia;

s. Gender dysphoria and gender incongruence Services;

t. Hospice Care and Private Duty Nursing;

u. Hysterectomy;

v. Insulin pumps;

w. Joint replacement;

x. Organ transplants;

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

z. Pain management/pain clinic Services;

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

bb. Tonsillectomy;

cc. The following Durable Medical Equipment:

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

  ii. Prosthetics (except eye prosthetics);

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

  iv. Motorized or customized wheelchairs; and

  v. DME with a purchase price over $1,500.

dd. The following Mental Health/Substance Use Disorder Services that are not for Emergency Conditions:

  i. Inpatient psychiatric/detoxification admissions;

  ii. Residential treatment; and

  iii. Partial hospitalization.

ee. 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, In-Network Providers must Preauthorize other Services as specified in Select Health medical policy.

11.1.2 Who is responsible for obtaining Preauthorization

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

You are responsible for obtaining Preauthorization when using an Out-of-Network Provider or Facility.

11.1.3 How to request Preauthorization

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

You also should call Select Health Member Services as soon as you know you will be using an Out-of-Network Provider or Facility for any of the Services listed.

11.1.4 Penalties

If you fail to obtain Preauthorization when required, Benefits will be denied. You will be responsible for this penalty, your Copay, Coinsurance, Deductible, and for any amount that exceeds the Allowed Amount.

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

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

11.2 Case Management

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

11.3 Benefit Exceptions

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

When making such exceptions, Select Health reserves the right to specify the Providers, Facilities, and circumstances in which the additional care will be provided and to limit payment for additional Services to the amount Select Health would have paid had the Service been provided in accordance with the other provisions of the Plan. Benefits paid under this section are subject to all other Member payment obligations of the Plan such as Copays, Coinsurance, and Deductibles.

11.4 Second Opinions/Physical Examinations

After enrollment, Select Health 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. Select Health will be responsible for paying for any such physical examination.

11.5 Medical Policies

Select Health has developed medical policies to serve as guidelines for coverage decisions. These guidelines detail when certain Services are considered Medically Necessary or Experimental and/or Investigational by Select Health. Medical policies do not supersede the express provisions of 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 Select Health. For questions about Select Health’s medical policies, call Member Services at 800-538-5038.

SECTION 12 - CLAIMS AND APPEALS

12.1 Administrative Consistency

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

12.2 Claims and Appeals Definitions

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

12.2.1 Adverse Benefit Determination

A determination by Select Health that an admission, availability of care, continued stay or other health-care Service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the Select Health's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

12.2.2 Appeal(s)

Review by Select Health of an Adverse Benefit Determination.

12.2.3 Authorized Representative

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

12.2.4 Benefit Determination

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

12.2.5 Claimant

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

12.2.6 Concurrent Care Decisions

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

12.2.7 External Review

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

12.2.8 Final Internal Adverse Benefit Determination

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

12.2.9 Grievance

A complaint expressing dissatisfaction about any matter other than an Adverse Benefit Determination.

12.2.10 Independent Review Organization (IRO)

Conducts an independent External Review of an Adverse Benefit Determination and is certified by the Commissioner.

12.2.11 Postservice Appeal

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

12.2.12 Postservice Claim

Any claim related to Services you have already received.

12.2.13 Preservice Appeal

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

12.2.14 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.

12.2.15 Urgent Preservice Claim

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

12.4 How to File a Claim for Benefits

12.4.1 Urgent Preservice Claims

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

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

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

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

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

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

12.4.2 Other Preservice Claims

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

Notice of a Benefit Determination will be provided in writing within a reasonable period appropriate to the medical circumstances, but no later than 10 days after receipt of the claim. However, Select Health may extend this period for up to an additional 15 days if Select Health: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 10-day period, of the circumstances requiring the extension and the date by which Select Health expects to render a decision. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information, and you will be given 60 days from your receipt of the notice to provide the requested information.

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

12.4.3 Postservice Claims

a. In-Network Providers and Facilities. In-Network Providers and Facilities file Postservice Claims with Select Health and Select Health makes payment to the Providers and Facilities.

b. Out-of-Network Providers and Facilities. Out-of-Network Providers and Facilities are not required to file claims with Select Health. If an Out-of-Network Provider or Facility does not submit a Postservice Claim to Select Health or you pay the Out-of-Network Provider or Facility, you must submit the claim in writing in a form approved by Select Health. Call Member Services or your employer to find out what information is needed to submit a Postservice Claim. All claims must be received by Select Health within a 12-month period from the date of the expense or as soon as reasonably possible. Claims received outside of this timeframe will be denied. Failure to file a claim does not bar recovery under the policy if Select Health 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, Select Health may extend this period for up to an additional 15 days if Select Health: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which Select Health expects to render a decision.

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

12.5 Problem Solving – Informal Review

Select Health is committed to making sure that any concerns or problems regarding your claims are investigated and resolved as soon as possible. Many situations can be resolved informally by a Member Services representative. Call Member Services at 800-538-5038 or send a secure email via your member account. Select Health offers foreign language assistance.

12.6 Formal Appeals

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

12.6.1 General Rules and Procedures

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

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

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

12.6.2 Form and Timing

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

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

Email: appeals@selecthealth.org

Fax: 801-442-0762

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

You may Appeal an Adverse Benefit Determination of an Urgent Preservice Claim on an expedited basis either verbally or in writing. You may Appeal verbally by calling the Select Health Appeals and Grievances Department at 844-208-9012 by fax at 801-442-0762, or by emailing appeals@selecthealth.org.

You must file a formal Appeal within 180 days from the date you received notification of the Adverse Benefit Determination.

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

12.6.3 Appeals Process

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

After a mandatory review process, you may choose to pursue civil action, 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 Select Health.

12.6.4 Preservice Appeals

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

Mandatory Review

Your Appeal will be investigated by the Appeals and Grievances Department. All relevant, available information will be reviewed. The Appeals and Grievances Department will notify you in writing of the Appeal decision within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after the receipt of your Appeal. However, Select Health may extend this period if Select Health: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which Select Health expects to render a decision.

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

Voluntary Review

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

Voluntary External Review

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. A request must be made in writing to the office for Consumer Health Assistance. For a copy of the External Review request, or for other questions, contact the Office of Consumer Health Assistance; by phone 1-888-333-1597 (toll-free); or by fax at 1-702-486-3586. An External Review request must be made within 4 months 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 15 days after receipt of the request. There is no additional cost to you to request an External Review.

If your Appeal involves an Urgent Preservice Claim, you may request an expedited review. The Office of Consumer Health Assistance shall assign the review to an IRO no later than 1 business day after approving the request. Within 24 hours after receiving notice of the Office for Consumer Health Assistance assigning the request, the Appeals Department shall provide the IRO all documents and materials relating to the Adverse Benefit Determination. 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 48 hours after the receipt of your Appeal. A decision communicated verbally will be followed up in writing.

If the determination of an IRO is in your favor, the determination is final and binding on Select Health.

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

Voluntary Internal Review

If you choose to pursue the voluntary internal review process, you may request a review of your Appeal. Depending on the nature of the Appeal, it will be considered by the Administrative and Clinical Appeal Review Committee. Such a request must be made in writing to the Appeals and Grievances Department within 60 days of the date the Appeals and Grievances Department notifies you of the Final Internal Adverse Benefit Determination. Select Health will notify you of the result of the review in writing within 30 days of the date you requested the review. However, Select Health may extend this period if Select Health: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which Select Health expects to render a decision.

12.6.5 Postservice Appeals

The process for appealing a Postservice Claim provides one mandatory reviews, 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 and Grievances Department. All relevant information will be reviewed The Appeals and Grievances Department will notify you in writing of the Appeal decision within a reasonable period of time appropriate to the medical circumstances, but no later than 60 days after the receipt of your Appeal. However, Select Health may extend this period if Select Health: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 60-day period, of the circumstances requiring the extension and the date by which Select Health expects to render a decision.

Voluntary Review

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

Voluntary External Review

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, a Rescission of coverage, or any Adverse Benefit Determination relating to a surprise medical bill or surprise air ambulance bill subject to the No Surprises Act. 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 Office of Consumer Health Assistance, 888-333-1597 (toll free) or by fax, 702-486-3586. An External Review request must be made within 180 days from the date of Select Health 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. There is no additional cost for requesting an External Review.

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. Select Health will notify you of the result of the review in writing within 30 days of the date you requested the review. However, Select Health may extend this period if Select Health: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which Select Health expects to render a decision.

12.7 Grievances

The Appeals department fully investigates the substance of each Grievance and documents the findings.

When a Grievance is regarding quality of care or quality of Services, the Appeals Department will contact the Provider and/or review the medical records.

The Appeals Department will notify you in writing of the Grievance decision within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after the receipt of your Grievance.

SECTION 13 - OTHER PROVISIONS AFFECTING YOUR BENEFITS

13.1 Coordination of Benefits (COB)

When you or your Dependents have healthcare coverage under more than one health benefit plan, Select Health will coordinate Benefits with the other healthcare coverage according to state law.

13.1.1 Required Cooperation

You are required to cooperate with Select Health 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 Select Health to administer COB. Failure to cooperate may result in the denial of claims.

13.1.2 Direct Payments

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

13.2 Subrogation/Restitution

13.2.1 Payment of Claims When Another Person or Entity is Liable

When you or your Dependents have an illness or injury caused by another person or entity, regardless of whether the person or entity is also an insured under the Plan or any other insurance policy (hereinafter a Recovery Party), the Recovery Party or an insurer for the Recovery Party may be liable for damages or may be willing to pay money in settlement of a claim. This Plan does not cover Benefits for Services you or your Dependents receive for illnesses and injuries when the medical expenses are the responsibility of, or are paid by, a Recovery Party who has caused the illness or injury or a Recovery Party insurer. In situations where Select Health determines that a Recovery Party may be liable for your or your Dependent's medical expenses, Select Health may nonetheless agree to conditionally pay the claims relating to such expenses in advance pending a final determination of a) whether a Recovery Party or you are responsible for such expenses instead of Select Health; and/or b) the claims are excluded from coverage under this Plan. Each Member agrees to reimburse Select Health for such conditional payments when a final determination is made by Select Health that it is not responsible for the payment of such claims as evidenced by a settlement or judgment.

13.2.2 Select Health's Recovery Rights

If Select Health pays benefits under this Plan for an illness or injury and Select Health determines that a Recovery Party is or may be responsible or liable for damages to you or your Dependents, Select Health has the right to recover Benefits paid under this Plan and is subrogated to all and any of your or your Dependent's rights to recover from the Recovery Party and to any money paid in settlement of a claim, but only up to the amount of the Benefits provided by the Plan. Select Health is entitled to reimbursement and/or recovery under this section 13.2 from any judgment, award, and other types of recovery or settlement received by you, your Dependents and/or your or your Dependent's representatives, regardless of whether the recovery is characterized as relating to medical expenses. Select Health is entitled to reimbursement even if you or your covered Dependent is not made whole or fully compensated by the recovery. You and your Dependents are required by this Plan, and agree, to promptly notify Select Health when the terms of this Section 13.2 might apply.

If the person for whom Plan Benefits are paid is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this section 13.2 regardless of whether the minor's representative has access to or control of the recovered funds. The provisions of this section 13.2 are binding upon you and your Dependents and binding upon your and your Dependent's guardians, heirs, executors, assigns and other representatives.

13.2.3 Agreement by Members

As a condition to receiving Benefits under the Plan, you and your Dependent(s) agree (a) that Select Health is automatically subrogated to, and has a right to receive restitution from, any right of recovery you may have against a Recovery Party, as the result of an accident, illness, injury, or other condition involving the Recovery Party (hereinafter a Recovery Event) that causes you or your Dependents to obtain Covered Services that are paid for by Select Health; (b) that Select Health is entitled to receive as restitution the proceeds of any judgment, settlement, or other payment paid or payable in satisfaction of any claim or potential claim that you or your Dependents have or could assert against a Recovery Party to the extent of all Benefits paid by Select Health or payable in the future because of the Recovery Event; (c) not to bring or assert a make whole, common fund, collateral source or other apportionment action or claim in contravention of Select Health's rights described in this section 13.2; (d) not to spend or otherwise disburse funds received under a settlement agreement or from an insurance company or Recovery Party until such time as Select Health has been paid or reimbursed for the amounts due to Select Health under this section 13.2; (e) to cooperate with Select Health to effectuate the terms of this section 13.2 and to do whatever may be necessary to secure the recovery by Select Health of the amount of the Benefits paid, including execution of all appropriate papers, furnishing of information and assistance; and (f) not to interfere with Select Health's rights under this Section 13.2 and not to take any action that prejudices Select Health's rights under this Section 13.2, including settling a dispute with a Recovery Party without protecting Select Health's rights under this Section 13.2.

If requested to do so by Select Health, you and your Dependents must execute a written recovery agreement as a condition of payment on claims arising from injuries or illnesses caused by third parties. If your Dependent is so injured or has such an illness, both you and your Dependent are required to execute the written recovery agreement. If the injured or ill person is a minor or legally incompetent, the written recovery agreement must be executed by the person's parent(s), managing conservator and/or guardian. If you or your Dependent has died, your or your Dependent's legal representative must execute the agreement. Any

Plan benefits paid must be returned to Select Health immediately in the event that Select Health requests that a written recovery agreement be signed and there is a failure or refusal to execute the recovery agreement. Select Health's rights, however, are not waived if Select Health does not request a written recovery agreement under this section 13.2.

13.2.4 Constructive Trust and First Lien

Any funds you and/or your Dependents (or your or your Dependent's agent or attorney) recover by way of settlement, judgment, or other award from a Recovery Party or from your or your Dependent's own insurance due to a Recovery Event shall be held by you and/or your Dependents (or your or your Dependent's agent or attorney) in a constructive trust for the benefit of Select Health until Select Health's rights under this section 13.2 have been satisfied.

Select Health will have, and you and your Dependents grant, a first lien upon any recovery, whether by settlement, judgment, arbitration or mediation, that you or your covered Dependents receive or are entitled to receive from any source, regardless of whether you or your covered Dependents receive a full or partial recovery. Any settlement or recovery received shall first be deemed to be reimbursement of medical expenses paid under this Plan. These first priority rights will not be reduced due to you or your covered Dependent's own negligence. You and/or your Dependents (or your or your Dependent's agent or attorney) will be personally liable for the restitution amount required under this section 13.2 to the extent that Select Health does not recover that amount due to a failure by you and/or your Dependents (or your or your Dependent's agent or attorney) to follow the required process.

13.2.5 Rights to Intervene and Sue

Select Health shall have the right to intervene in any lawsuit, threatened lawsuit, or settlement negotiation involving a Recovery Party for purposes of asserting and collecting Select Health's restitution and other interests described in this section 13.2. Select Health shall have the right to bring a lawsuit against, or assert a counterclaim or cross-claim against, you (or your agent or attorney) for purposes of collecting restitution or other interests under this section 13.2, to enforce the constructive trust required by this section 13.2, and/or take any other action to collect funds from you.

Select Health is entitled to institute these actions in its own name or in your or your Dependent's name or to join any action brought by you, your Dependents or your representatives, with or without specific consent, and to participate in any judgment, award or settlement to the extent of Select Health's interest. You and your Dependents must notify Select Health before filing any suit or settling any claim so as to enable Select Health to participate in the suit or settlement to protect and enforce Select Health's rights under this subrogation provision. You and your Dependents agree to keep Select Health fully informed and advised of all developments in any such suit or settlement negotiations.

The amount that Select Health is entitled to recover from you and your Dependents under this section 13.2 is specifically unreduced by any attorney, legal or other fees and costs incurred by you or your Dependents in seeking recovery from a Recovery Party or Recovery Party insurer, except if Select Health specifically agrees in writing to participate in these fees.

If you or your Dependents fail to fully cooperate with Select Health or its designated agents in asserting its rights under this section 13.2, Select Health may reduce or deny coverage under the Plan and offset against any future claims. Further, Select Health may compromise with you or your Dependents on any issue involving subrogation/restitution in a way that includes you or your Dependents surrendering the right to receive further Services under the Plan.

13.3 Excess Payment

Select Health will have the right to recover any payment made in excess of the obligations of Select Health under the Contract. Such recoveries are limited to a time period of 12 months (or 24 months for a COB error) from the date a payment is made unless the recovery is due to fraud or intentional misrepresentation of material fact by you or your 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 Select Health to you, you agree to promptly refund the amount of the excess. Select Health may, at its sole discretion, offset any future Benefits against any overpayment. Select Health may recover excess payment made to a provider by withholding other amounts payable to the provider from any plan under which Select Health makes payment.

SECTION 14 - SUBSCRIBER RESPONSIBILITIES

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

14.1 Payment

Pay applicable 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 Select Health of these changes.

14.3 Other Coverage

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

14.4 Information/Records

Provide Select Health 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 Select Health. Select Health reserves the right to verify that the Eligibility requirements of the Contract are satisfied. Your employer is obligated to promptly notify Select Health 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 Select Health.

15.3 Contract

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

15.4 Compliance

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

SECTION 16 - DEFINITIONS

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

16.1 Activities of Daily Living

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

16.2 Affordable Care Act (ACA)

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

16.3 Allowed Amount

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

16.4 Ambulatory Surgical Facility

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

16.5 Annual Open Enrollment

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

d. The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial.

e. The Services are provided by a duly licensed Provider of healthcare and the Facility and personnel have the experience and training to provide the Services; and

f. The Member has signed a statement of consent before participation in the clinical trial or study indicating that they have been informed of:

i. The procedure to be undertaken;

ii. Alternative methods of treatment; and

iii. The risks associated with participation in the clinical trial or study.

16.9 Autism Spectrum Disorder

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

16.10 Benefit(s)

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

16.11 Benefit Rider

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

16.12 Certificate of Coverage (Certificate)

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

16.13 COBRA Coverage

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

16.14 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.

16.15 Continuation Coverage

COBRA Coverage.

16.16 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.

16.17 Contract

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

16.18 Copay (Copayment)

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

16.19 Covered Services

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

16.20 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.

16.21 Deductible(s)

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

16.22 Dental Services

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

16.23 Dependents

Your Eligible dependents as set forth in Section 2 - Eligibility.

16.24 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.

16.25 Effective Date

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

16.26 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.

16.27 Emergency Condition(s)

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

a. Placing 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.

16.28 Employer's Plan

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

16.29 Employer Waiting Period

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

16.30 Endorsement

A document that amends the Contract.

16.31 ERISA

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

16.32 Excess Charges

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

16.33 Exclusion(s)

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

16.34 Experimental and/or Investigational

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

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

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

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

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

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

16.35 Facility

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

16.36 Formulary

The Prescription Drugs covered by your Plan.

16.37 Generic Drug(s)

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

16.38 Group Application

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

16.39 Group Health Insurance Contract

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

16.40 Habilitation Services

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

16.41 Healthcare Management Program

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

16.42 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.

16.43 Hospice Care

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

16.44 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.

16.45 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.

16.46 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.

16.47 Initial Eligibility Period

The period determined by Select Health 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.

16.48 Lifetime Maximum

The maximum accumulated amount that Select Health will pay for certain Covered Services (as allowed by the Affordable Care Act) during that Member's lifetime. This includes all amounts paid on behalf of the Member under any prior health benefit plans insured by Select Health (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.

16.49 Limitation(s)

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

16.50 Major Diagnostic Tests

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

a. Cardiac nuclear studies or cardiovascular procedures such as coronary angiograms;

b. Gene-based testing and genetic testing;

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

d. Neurologic studies such as EMGs and nerve conduction studies.

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

16.51 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.

16.52 Medical Director

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

16.53 Medical Necessity/Medically Necessary

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

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

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

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

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

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

16.54 Member

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

16.55 Member Payment Summary

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

16.56 Mental Health/Substance Use Disorder

Emotional conditions or substance use disorder listed as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders, as periodically revised, and which require professional intervention, including FDA approved medication-assisted treatment therapies for opioid use disorder and therapies that support safe withdrawal from substance use disorder.

16.57 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.

16.58 Miscellaneous Medical Supplies (MMS)

Supplies that are disposable or designed for temporary use.

16.59 Out-of-Network Facility

Healthcare Facilities that are not under contract with Select Health.

16.60 Out-of-Network Pharmacies

Pharmacies that are not under contract with Select Health.

16.61 Out-of-Network Provider

Providers that are not under contract with Select Health.

16.62 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.

16.63 Oligodontia

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

16.64 Optional Benefit

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

16.65 Out-of-Pocket Maximum

The maximum amount specified in your Member Payment Summary that you must pay each Year to Providers and/or Facilities as Deductibles, Copays, and Coinsurance. Except when otherwise noted in your Member Payment Summary, Select Health will pay 100 percent of Allowed Amounts during the remainder of the Year once the Out-of-Pocket Maximum is satisfied. Some categories of Benefits may be subject to separate Out-of-Pocket 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.

16.66 In-Network Benefits

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

16.67 In-Network Facility

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

16.68 In-Network Pharmacies

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

16.69 In-Network Providers

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

16.70 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.

16.71 Plan

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

16.72 Plan Sponsor

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

16.73 Preauthorization (Preauthorize)

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

16.74 Premium(s)

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

16.75 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.

16.76 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 and required by the Affordable Care Act, Nevada law, and/or Select Health.

Some examples of these services are well-child exams, immunizations, pediatric vision screenings, colorectal cancer screenings, screening mammograms, HPV testing including DNA testing for high-risk strains, prostate cancer screenings, and Contraceptives as required by the ACA, and the insertion or injection of a long-acting reversible Contraceptive, at the request of a Member giving birth at a hospital, unless contraindicated or the insertion or injection would create an unreasonable risk of harm to the Member. Preventive services also include a Contraceptive that is medically necessary for you as determined by your Provider and evidenced through written documentation submitted to Select Health. A complete United States Preventive Services Task Force (USPSTF) list of preventive services can be found at https://www.uspreventiveservicestaskforce.org/.

16.77 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; and

e. Pediatrics.

16.78 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.

16.79 Provider

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

16.80 Qualified Medical Child Support Order (QMCSO)

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

16.81 Referral

A Primary Care Provider directing of a Member to a Secondary Care Provider.

16.82 Reformation (Reform)

Select Health's right to change Benefits or Premium.

16.83 Rehabilitation Services

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

16.84 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.

16.85 Residential Treatment Center

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

16.86 Respite Care

Care provided primarily for relief or rest from caretaking responsibilities.

16.87 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.

16.88 Secondary Care Provider (SCP) or Specialist

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

a. Cardiologists;

b. Dermatologists;

c. Neurologists;

d. Ophthalmologists;

e. Orthopedic Surgeons; and

f. Otolaryngologists (ENTs).

16.89 Service Area

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

The Select Health Value Service Area includes the following counties: Clark and Nye.

The Select Health Med Service Area includes the following counties: Clark and Nye.

16.90 Service(s)

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

16.91 Skilled Nursing Facility

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

a. Is being operated as required by law;

b. Is primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a Physician;

c. Provides 24 hours a day, seven days a week nursing service by or under the supervision of a Registered Nurse (R.N.); and

d. Maintains a daily medical record of each patient.

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

16.92 Sound Natural Teeth

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

16.93 Special Enrollment Right

An opportunity to enroll outside of your employer's Annual Open Enrollment period under which all available Plans are open under defined circumstances described in Section 3 - Enrollment.

16.94 Subscriber

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

16.95 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.

16.96 Wilderness Therapy

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

16.97 Year

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

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

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

SECTION 17 - OTHER PROGRAMS

In addition to your Benefits, Select Health may offer discount, wellness, and similar incentive programs to Members. Program information is available through the Select Health website or by contacting Select Health.

Protecting Your Privacy

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

We understand the importance and sensitivity of your personal health information, and we have security in place to protect it. Access to your information is limited to those who need it to perform assigned tasks. We restrict access to work areas and use locking filing cabinets and password-protected computer systems. We follow all federal and state laws that govern the use of your health information. We use your health information in written, oral, and electronic formats (and allow others to use it) only as permitted by federal and state laws. These laws give you certain rights regarding your health information.

We participate in organized healthcare arrangements (OHCAs) with other entities including but not limited to, Intermountain Healthcare entities, The Intermountain Life and Health Benefit Plan, and the University of Utah Medical Group (with respect to certain defined pediatric specialty services). These OHCA members share information for treatment, payment and healthcare operations to improve, manage, and coordinate your care.

To learn more about activities and see a current list of all OHCA members, visit **https://selecthealth.org/plans/individual/services/Pages/ohca.aspx**.

YOUR HEALTH INFORMATION RIGHTS

You may:

- Review and get a paper copy of your policy or claims records as allowed by law, usually within 30 days of your request (you can also ask us to provide a copy in electronic form, and we will do that if we can readily produce it).
- Request and be provided a paper copy of our current Notice of Privacy Practices, or receive an electronic copy by email if you have agreed to receive an electronic copy.
- Ask us to contact you at a specific address or phone number if contacting you at your current address or phone number could endanger you.
- Request and receive an accounting, as specified by law, of certain situations when your information was shared without your consent.
- Receive a notice if SelectHealth or one of its Business Associates causes a breach of your unsecured information.
- Report a privacy concern and be assured that we will investigate your concern thoroughly, supporting you appropriately, and not retaliate against you in any way (in fact, SelectHealth will provide you with information on how to report any privacy concerns to the SelectHealth Privacy Coordinator, the Intermountain Corporate Privacy Office, or the Office for Civil Rights, U. S. Department of Health and Human Services).
- Request in writing other restrictions on the use of your health information or amendments to your health information if you think it is wrong, though we may not always be able to grant these requests.

HOW YOUR HEALTH INFORMATION IS USED

Common Uses of Health Information

As we provide health insurance benefits, we will gather some of your health information. The law allows us to use or share this health information for the following purposes.

- To receive payment of health coverage premiums and to determine and fulfill our responsibility to provide you benefits. For example, to make coverage determinations, administer claims, and coordinate benefits with other coverage you may have.
- To improve the overall Intermountain system as well as to help better manage your care. For example, Intermountain has programs in place to manage the treatment of chronic conditions, such as diabetes or asthma, and as part of these programs, we share information with affiliated providers and Intermountain Healthcare to facilitate improved coordination of the care you may receive for these conditions.
- To support healthcare providers in providing treatment.
- To share in limited circumstances health information with your plan sponsor. However, SelectHealth will only do so if the plan sponsor specifically requests health information for the administration of your health plan and agrees in writing not to use your health information for employment-related actions or decisions.
- To identify health-related services that may be beneficial to your health and then contact you about these services.
- To request your support for improving healthcare by contributing to one of Intermountain's charitable foundations. (If you don't want to be contacted for this purpose or other fundraising communications, call Intermountain's Privacy Office at **800 442-4845** to let us know).
- To improve our services to you by allowing companies with whom we contract, called "business associates," to perform certain specialized work for us. The law requires these business associates to protect your health information and obey the same privacy laws that we do.
- To perform a very limited, specific type of healthrelated research, where the researcher keeps any patient-identifiable information safe and confidential. Intermountain reviews every research request to make sure your privacy is appropriately protected before sharing any health information.
- To law enforcement, but only as authorized by law (e.g., to investigate a crime against SelectHealth or any of its members).

Required Uses of Health Information

The law sometimes requires us to share information for specific purposes, including the following:

- To the Department of Health to report communicable diseases, traumatic injuries, or birth defects, or for vital statistics, such as a baby's birth.
- To a funeral director or an organ-donation agency when a patient dies, or to a medical examiner when appropriate to investigate a suspicious death.
- To state authorities to report child or elderly abuse.
- To law enforcement.
- To a correctional institution, if a member is an inmate, to ensure the correctional institution's safety.
- To the Secret Service or NSA to protect, for example, the country or the President.
- To a medical device's manufacturer, as required by the FDA, to monitor the safety of a medical device.
- To court officers, as required by law, in response to a court order or a valid subpoena.
- To governmental authorities to prevent serious threats to the public's health or safety.
- To governmental agencies and other affected parties, to report a breach of health-information privacy.
- To a worker's compensation program if a person is injured at work and claims benefits under that program.

Uses According to Your Requests

Your preferences matter. If you let us know how you want us to disclose your information in the following situation, we will follow your directions. You decide if you want us to share any health or payment information related to your care with your family members or friends. Please let us know what you want us to share. If you can't tell us what health or payment information you want us to share, we may use our professional judgment to decide what to share with your family or friends for them to be able to help you.

Uses with Your Authorization

Any sharing of your health information, other than as explained above, requires your written authorization. For example, we will not use your health information unless you authorize us in writing to:

- share any of your health information with marketing companies.
- sell any of your health information.

You can change your mind at any time about sharing your health information. Simply notify us in writing. Please understand that we may not be able to get back health information that was shared before you changed your mind.

SPECIAL LEGAL PROTECTIONS FOR CERTAIN HEALTH INFORMATION

SelectHealth complies with federal laws that require extra protection for your health information if you receive treatment in an addiction treatment program, or from a psychotherapist who keeps notes on your therapy that are kept outside of your regular medical record.

SelectHealth is prohibited from using or disclosing genetic information for underwriting purposes.

IF YOU STILL HAVE QUESTIONS

Our Privacy Coordinator can help you with any questions you may have about the privacy of your health information. He can also address any privacy concerns you may have about your health information and can help you fill out any forms that are needed to exercise your privacy rights.

This privacy notice became effective on May 26, 2015. We may change this privacy notice at any time, and we may use new ways to protect your health information. We always post our current privacy notice on **selecthealth.org**.

You can request a copy of this notice by visiting our website or calling our Privacy Office at **801-442-7253**.

This notice of privacy practices describes the practices of SelectHealth and of our employees and volunteers. (For more information about the specific privacy practices of Intermountain Healthcare and its employees or volunteers working in its hospitals, clinics, doctors' offices or service departments, please contact them directly by visiting **intermountainhealthcare.org**, or by calling Intermountain's Privacy Office at **800-442-4845**.)

SELECTHEALTH MEMBER RIGHTS AND RESPONSIBILITIES

YOUR RIGHTS

You have the right to:

- Receive information about our services, providers, and members' rights and responsibilities.
- Receive considerate, courteous care and treatment with respect for personal privacy and dignity.
- Receive accurate information regarding your rights and responsibilities and benefits in member materials and through telephone contact.
- Be informed by your provider about your health so you may make thoughtful decisions before you receive treatment.
- Candidly discuss with your healthcare provider appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage. We do not have policies that restrict dialogue between provider and patient, and we do not direct providers to restrict information regarding treatment options.
- Participate with providers in decisions involving your health and the medical care you receive.
- Express concerns about SelectHealth and the care we provide, and receive a response in a reasonable period of time.
- Request a second opinion.
- Refuse recommended medical treatment.
- Select or change your primary care provider.
- Make recommendations regarding our members' rights and responsibilities policy.
- Have reasonable access to appropriate medical services regardless of your race, religion, nationality, disability, sex, or sexual orientation, and 24-hour access to urgent and emergency care.
- Receive care provided by or be referred by your primary care provider.
- Have all medical records and other information kept confidential.
- Have all claims paid accurately and in a timely manner.

YOUR RESPONSIBILITIES

You have the responsibility to:

- Treat all our providers and personnel at SelectHealth courteously.
- Read all plan materials carefully as soon as you enroll and ask questions when necessary.
- Ask questions and make certain you understand the explanation and instructions you are given.
- Understand the benefits of your plan and understand not all recommended medical treatment is eligible for coverage.
- Follow plans and instructions for care that have been agreed upon with the provider.
- Express constructively your opinions, concerns, and complaints to the appropriate people at SelectHealth.
- Follow the policies and procedures of your plan, and when appropriate, seek a referral from your primary care provider to SelectHealth providers or call SelectHealth for assistance.
- Ask questions and understand the consequences of refusing medical treatment.
- Communicate openly with your healthcare provider, develop a patient-provider relationship based on trust and cooperation, and participate in developing mutually agreed-upon treatment goals.
- Read and understand your plan benefits and limitations and call us with any questions.
- Keep scheduled appointments or give adequate notice of cancellation.
- Obtain services consistently according to the policies and procedures of your plan.
- Provide all pertinent information needed by your provider to assess your condition and recommend treatment.
- Use our providers when applicable, carry your ID Card, and pay copay/coinsurance amounts at the time of service.

P.O. Box 30192
Salt Lake City, UT 84130-0192

selecthealth.org