Summary Plan Description

Myriad Genetics, Inc. Employer Plan (SelectHealth Med® Network)

2024

Select Health

Select Health

MED NETWORK

Administered by SelectHealth

SCHEDULE OF BENEFITS

	IN-NETWORK When using In-Network Providers, you are responsible to pay the amounts in this column.	**OUT-OF-NETWORK** When using Out-of-Network Providers, you are responsible to pay the amounts in this column.
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5,6]	**IN-NETWORK**	**OUT-OF-NETWORK**
Self Only Coverage, 1 person enrolled - per calendar Year		
Deductible	$1,000	$1,500
Out-of-Pocket Maximum	$4,000	$4,500
Family Coverage, 2 or more enrolled - per calendar Year		
Deductible - per person/family	$1000/$2000	$1500/$3000
Out-of-Pocket Maximum - per person/family	$4000/$7150	$4500/$9000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)		
INPATIENT SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Medical, Surgical and Hospice[4]	20% after Deductible	30% after Deductible
Hospital Level Care at Home[4]	20% after Deductible	Not Covered
Skilled Nursing Facility[4] - Up to 60 days per calendar Year	20% after Deductible	30% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4] Up to 60 days per calendar Year for all therapy types combined	20% after Deductible	30% after Deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after Deductible	30% after Deductible
PROFESSIONAL SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP)[1]	$40	30% after Deductible
Primary Care Provider (PCP) Virtual Visits[1]	$40	Not Covered
Specialist/Secondary Care Provider (SCP)[1]	$50	30% after Deductible
Allergy Tests	See Office Visits Above	Not Covered
Allergy Treatment and Serum	20%	Not Covered
Major Surgery	20% after Deductible	30% after Deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after Deductible	30% after Deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Provider (PCP)[1]	Covered 100%	30% after Deductible
Specialist/Secondary Care Provider (SCP)[1]	Covered 100%	30% after Deductible
Adult and Pediatric Immunizations	Covered 100%	30% after Deductible
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	30% after Deductible
Diagnostic Tests: Minor	Covered 100%	30% after Deductible
Other Preventive Services	Covered 100%	30% after Deductible
VISION SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Preventive Eye Exams	Covered 100%	30% after Deductible
All Other Eye Exams	$50	30% after Deductible
OUTPATIENT SERVICES[4]	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Facility	10% after Deductible	30% after Deductible
Ambulatory Surgical Center	10% after Deductible	30% after Deductible
Imaging Center	20% after Deductible	30% after Deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after Deductible	See In-Network Benefit
Emergency Room	$150	See In-Network Benefit
Intermountain InstaCare® Facilities, Urgent Care Facilities	$40	30% after Deductible
Intermountain KidsCare® Facilities	$40	Not Available
Intermountain Connect Care®	$40	Not Available
Radiation	20% after Deductible	30% after Deductible
Dialysis	20% after Deductible	30% after Deductible
Diagnostic Tests: Minor[2]	Covered 100%	30% after Deductible
Diagnostic Tests: Major[2]	20% after Deductible	30% after Deductible
Hospice, Outpatient Private Nurse	20% after Deductible	30% after Deductible
Home Health Up to 130 visits per calendar Year	20% after Deductible	30% after Deductible
Outpatient Cardiac Rehab	Covered 100%	30% after Deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational Up to 60 visits per calendar year for all therapy types combined	$40	30% after Deductible

See other side for additional benefits

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SCHEDULE OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
MISCELLANEOUS SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Durable Medical Equipment (DME)[4]	20% after Deductible	30% after Deductible
Miscellaneous Medical Supplies (MMS)[3]	20% after Deductible	30% after Deductible
Wig - *$500/calendar year*	20% after Deductible	30% after Deductible
Hearing Aids - *$2500/every 3 calendar year per ear*	20% after Deductible	30% after Deductible
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Maternity and Adoption[4,7]	See Professional, Inpatient or Outpatient	30% after Deductible
Cochlear Implants or Auditory Osseointegrated Devices[2,4] *One device every 36 months per ear*	See Professional, Inpatient or Outpatient	Not Covered
Infertility - *Select Services* *(Max Plan Payment $5,000 lifetime)*	*50% after Deductible	Not Covered
TMJ (Temporomandibular Joint) Services	See Professional, Inpatient or Outpatient	30% after Deductible
Chiropractic	$40 (Up to 20 visits per calendar Year)	
OTHER BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Mental Health and Chemical Dependency[4]		
Office Visits	$40	30% after Deductible
Virtual Visits	$40	30% after Deductible
Inpatient	20% after Deductible	30% after Deductible
Outpatient	20% after Deductible	30% after Deductible
Residential Treatment[2]	20% after Deductible	30% after Deductible
Injectable Drugs, Chemotherapy, and Specialty Medications[4]	20% after Deductible	30% after Deductible
Bariatric Surgery *(Up to one surgery/lifetime)*[4]	20% after Deductible	Not Covered
PRESCRIPTION DRUGS		
Prescription Drugs - *Not Administered by Select Health*	Not Covered	

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

2 Refer to your Summary Plan Description for more information.

3 Frequency and/or quantity limitations apply to some Preventive care and MMS Services.

4 Preauthorization is required for certain Services. Benefits may be reduced or denied if you do not preauthorize certain Services with Out-of-Network Providers. Please refer to Section 11--" Healthcare Management", in your Summary Plan Description, for details.

5 All Deductible/Copay/Coinsurance amounts are based on the Allowed Amount and not on billed charges. Out-of-Network Providers or Facilities may not accept the Allowed Amount for Covered Services. When this occurs, you may be responsible for Excess Charges.

6 Certain Services as noted on this document and in your Summary Plan Description are not subject to the Deductible.

7 The plan provides a $4000 adoption indemnity as outlined by the state of Utah. Medical Deductible, Copay, or Coinsurance listed under the benefit applies and may exhaust the benefits prior to any plan payments.

* Not applied to Medical Out-of-Pocket Maximum.

All Covered Services obtained outside the United States, except for routine, Urgent, or Emergency conditions require preauthorization.

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

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Self Only Coverage, 1 person enrolled - per calendar Year		
Deductible	$2,000	$3,500
Out-of-Pocket Maximum	$4,000	$4,500
Family Coverage, 2 or more enrolled - per calendar Year		
Deductible	$4,000	$7,000
Out-of-Pocket Maximum	$7,150	$9,000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)		
INPATIENT SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
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Table of Contents

Section 1 – Introduction

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

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

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

1.4 **Your Agreement**. As a condition to enrollment and to receiving Benefits, you (the Participant) and every other Member enrolled through your coverage (your Dependents) agree to the managed care features that are a part of the Plan and all of the other terms and conditions of the Plan.

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

1.6 **Administration**. 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 the Plan.

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

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

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

1.10 **Questions**. If you have questions about your Benefits, call Select Health 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 **Disclaimer**. 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 Plan, the terms of the Plan will control.

b. Any changes or modifications to Benefits must be provided in writing and signed by the Plan Administrator.

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

Section 2 – Eligibility

2.1 **General**. Your employer as Plan Sponsor decides which categories of its employees, retirees, and their Dependents are Eligible for Benefits, and establishes the other Eligibility requirements of the Plan. These Eligibility requirements are described in the Myriad Genetics, Inc. Health and Welfare Benefit Plan Wrap Document and this section. In order to become and remain Eligible to participate in the Plan, you and your Dependents must continuously satisfy these requirements.

2.2 **Participant Eligibility**. You are Eligible for Benefits if you meet the definition of eligible employee defined in the Myriad Genetics, Inc. Health and Welfare Benefit Plan Wrap Document. Leased employees and independent contractors are not eligible for coverage under the Plan.

2.3 **Dependent Eligibility**. Dependents are:

2.3.1 **Spouse**. Your lawful spouse. Eligibility may not be established retroactively.

2.3.2 **Qualifying Domestic Partners**. Myriad Genetics, Inc. recognizes domestic partners and their Dependent children as Eligible under the Plan. In addition to references in this section, see the Myriad Genetics, Inc. Health and Welfare Benefit Plan Wrap Document for the definition of and Eligibility requirements affecting domestic partners and their Dependent children under the Plan.

2.3.3 **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.

2.3.4 **Disabled Children**. Unmarried Dependent children who meet all of the Eligibility requirements in Subsection 2.3.2 may enroll or remain enrolled as Dependents after reaching age 26 as long as they:

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

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

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

The Plan may require you to provide proof of the above elements 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 only to the minimum extent required by applicable law.

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

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

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

c. The period to which the order applies.

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

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

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

Section 3 – Enrollment

3.1 **General**. You may enroll yourself and your Dependents (including a qualifying domestic partner and Dependents of a qualifying domestic partner) in the Plan during the Initial Eligibility Period, under a Special Enrollment Right, or, if offered by your employer, during an Annual Open Enrollment. The Initial Eligibility Period is 31 days.

3.2 **Enrollment Process**. You and your Dependents are responsible for obtaining and submitting to your employer evidence of Eligibility and all other information required by the Plan in the enrollment process on forms specified by your employer. You enroll yourself and any Dependents by completing, signing, and submitting these forms and any other required enrollment materials to your employer.

3.3 **Effective Date of Coverage**. If you properly enroll, 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 first day of the next Plan year.

3.3.2 **Newly Eligible Employees**. Coverage you elect as a newly Eligible employee will take effect on your date of hire if you submit properly completed enrollment materials to your employer in a timely manner.

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**. The Plan 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 contributions). One exception to this rule exists: if a Dependent is enrolled on another group health plan and the Annual Open Enrollment periods of the two plans do not coincide, the Dependent may voluntarily drop their coverage under their 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 the Plan as soon as reasonably possible. Proof of loss of other coverage must be submitted before any Benefits will be paid.

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

3.4.2 **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, or by entering into a qualifying domestic partnership, then you may enroll the Dependent (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 or certification of domestic partnership (there is an exception for enrolling a newborn, adopted child, or child placed for adoption, under legal guardianship, or certification of domestic partnership if enrolling the child does not change the cost of coverage, as explained in Section 3.5 Enrolling a Newborn, Adopted Child, or Child Placed for Adoption, Under Legal Guardianship or Certification of Domestic Partnership).

If you properly enroll under this Special Enrollment Right, coverage will be effective:

a. As of the date of marriage;

b. As of the date of birth;

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

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

e. As of the later of:

i. The effective date of the guardianship court order, testamentary appointment, or certification of domestic partnership; or

ii. The date the guardianship court order, testamentary appointment, or certification of domestic partnership is received by the Plan.

3.4.3 **Qualification for a Subsidy Through Utah's Premium Partnership**. You and/or your Eligible Dependents who qualify for a subsidy through the state Medicaid program to purchase health insurance may enroll in the Plan if application is made within 60 days of receiving written notification of eligibility for the subsidy. If you timely enroll, the Effective Date of coverage is the first of the month following date of enrollment.

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

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

3.5 **Enrolling a Newborn, Adopted Child, or Child Placed for Adoption, Under Legal Guardianship or Certification of Domestic Partnership**

You must enroll your newborn, adopted child, child placed for adoption, child under legal guardianship, or child as the result of a certification of domestic partnership according to the following requirements:

a. If enrolling the child requires an additional cost of coverage, you must enroll the child within 60 days of the child's birth, adoption, or placement for adoption, under legal guardianship, or as the result of a certification of domestic partnership.

b. If enrolling the child does not require an additional cost of coverage, you must enroll the child within 31 days from the date Select Health mails notification that a claim for Services was received for the child.

If the child is not enrolled within these time frames, then you may not enroll the child until an Annual Open Enrollment or if you experience an event that creates a Special Enrollment Right.

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

3.6 **Temporary Leave of Absence**. If you are granted a temporary leave by your employer, you and any Dependents may continue to be enrolled in the plan as long as approved under the Myriad Genetics Time Away From Work leave policy. If you are on an unpaid leave of absence, you will lose coverage after 30 days absence.

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

a. You and your enrolled Dependents may continue your coverage to the minimum extent required by the FMLA as long as you arrange with your employer to pay the applicable employee contributions towards the cost of coverage;

b. If your employee contributions 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 on the date you return to employment if the applicable contributions are paid to the Plan within 30 days. The Plan 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 the Plan as an FMLA leave of absence.

Section 4 – Termination

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

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

4.2.1 **Loss of Eligibility**. If you and/or your enrolled Dependents lose Eligibility, then coverage will terminate at the end of the month in which the loss of Eligibility occurred. When a Dependent child ceases to be a Dependent, coverage will terminate at the end of the month in which Dependent status is lost. When a loss of Eligibility is not reported in a timely fashion as required by the Plan, and applicable law prevents the Plan from retroactively terminating coverage, the Plan has the discretion to determine the prospective date of termination. The Plan also has the discretion to determine the date of termination for Rescissions.

4.2.2 **Fraud or Misrepresentation**.

a. Made During Enrollment.

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

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

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

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

4.2.4 **Domestic Partners**. You may terminate the coverage of a Domestic Partner when: 1) the Domestic Partner dies; 2) the Domestic Partnership ends and you submit a "Declaration of Termination of a Domestic Partnership" to your Employer; 3) the Domestic Partner marries; or 4) you stop sharing the same principal residence with the Domestic Partner. Once you terminate the coverage of a Domestic Partner, you must wait 12 months from the termination of such partnership to provide coverage for a former or new Domestic Partner.

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

4.2.6 **Court or Administrative Order**. In cases of court or administrative orders that grant a divorce or annul/declare void a marriage, subject to 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 **Receiving Treatment at Termination**. All Benefits under the Plan terminate when the Plan terminates, including coverage for you or your Dependents hospitalized or otherwise within a course of care or treatment. All Services received after the date of termination are your responsibility and not the responsibility of the Plan no matter when the condition arose and despite care or treatment anticipated or already in progress.

Section 5 – Continuation Coverage

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

- **a.** Termination of your employment for any reason except gross misconduct. Coverage may continue for you and/or your Eligible Dependents;
- **b.** A reduction in your hours. Coverage may continue for you and/or your Eligible Dependents;
- **c.** Your death. Coverage may continue for your Eligible Dependents;
- **d.** Your divorce or legal separation. Coverage may continue for your Eligible Dependents;
- **e.** Your becoming entitled to Medicare. Coverage may continue for your Eligible Dependents; and
- **f.** Your covered Dependent child's ceasing to be a Dependent child under the Plan. Coverage may continue for that Dependent.

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

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

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

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

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

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

However, if a qualifying individual is disabled (as determined under the Social Security Act) at the time of your termination or reduction in hours or becomes disabled at any time during the first 60 days of continuation coverage, continuation coverage for the qualifying individual and any non-disabled Eligible Dependents who are also entitled to continuation coverage may be extended to 29 months provided the qualifying individual, if applicable, notifies the Plan Administrator in writing within the 18-month continuation coverage period and within 60 days after receiving notification of determination of disability.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Active duty;

b. Active duty for training;

c. Initial active duty training;

d. Inactive duty training;

e. Full-time National Guard duty,

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

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

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

Section 6 – Providers/Networks

6.1 **Providers and Facilities**. 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/Chemical Dependency (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 **In-Network Providers and Facilities**. You receive a higher level of Benefits (known as In-Network Benefits) when you obtain Covered Services from an In-Network Provider or Facility. Refer to your Schedule of Benefits for details.

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

6.1.3 **Other Networks**. You receive In-Network Benefits when you obtain Services 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**. Providers contract independently with Select Health or an affiliated network and are not agents or employees of Select Health or the Plan. They are entitled and required to exercise independent professional medical judgment in providing Covered Services. Select Health and its affiliated network(s) make a reasonable effort to credential In-Network Providers and Facilities, but do 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 or the Plan, are solely responsible for their actions, or failures to act, in providing Services to you.

Providers and Facilities are not authorized to speak on behalf of Select Health or the Plan or to cause Select Health or the Plan 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 the Plan.

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

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

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

6.3.2 **Payments to Members**. The Plan reserves the right to make payments directly to you or your Dependents instead of to 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 neither Select Health nor the Plan interferes with those relationships. Select Health is only involved in decisions about what Services will be covered and paid for by the Plan. Decisions about your Services should be made between you and your Provider without reference to coverage under the Plan.

6.5 **Continuity of Care**. 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 In-Network 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 90 days), or until you or your Dependent is transferred to another In-Network Provider or Facility, whichever occurs first. 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 (any trimester); and

e. determined to have a life expectancy of 6 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, must remain in the Service Area, and agree to do all of the following:

a. Accept Select Health's 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.

Section 7 – About Your Benefits

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

7.2 **Schedule of Benefits**. Your Schedule of Benefits lists important information about the Plan. This includes information about Copay, Coinsurance, and/or Deductible requirements, Preauthorization requirements, visit limits, Limitations on the use of Out-of-Network Providers and Facilities, and expenses that do not count against the 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 and all rights under the Plan will be immediately terminated for you or your Dependents.

7.4 **Medical Necessity**. To qualify for Benefits, Covered Services must be Medically Necessary. Medical Necessity is determined by the Medical Director of 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 Plan changes.

7.6 **Calendar-Year or Plan-Year Basis**. Your Schedule of Benefits will indicate if your Benefits are calculated on a calendar-Year or plan-Year basis. Out-of-Pocket Maximums, Limitations, and Deductibles that are calculated on a calendar-Year basis start over each January 1st. Out-of-Pocket Maximums, Limitations, and Deductibles that are calculated on a plan-Year basis start over each Year on the renewal date of the Plan.

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

7.8 **Two Benefit Levels**.

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

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

7.9 **Emergency Conditions**. 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 **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.

7.11 **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.

7.12 **Out-of-Area Benefits and Services**. Except as otherwise noted in this Plan, Out-of-Network Benefits apply for Covered Services rendered by Out-of-Network Providers or Facilities outside of Select Health's Service Area.

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.

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

7.14 **Deductible Waiver**. In addition to the Services listed on your Schedule of Benefits, 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.

Section 8 – Covered Services

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

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

- **a.** Log in to your Select Health account at selecthealth.org;
- **b.** Refer to your Provider & Facility Directory; or
- **c.** Call Member Services at 800-538-5038.

8.1 **Facility Services**.

8.1.1 **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.

8.1.2 **Inpatient Hospital**.

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

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

8.1.3 **Nutritional Therapy**. Medical nutritional therapy Services are covered up to three visits per Year. Diabetic counseling is not covered under this benefit.

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

8.1.5 **Skilled Nursing Facility**. Only when Services cannot be provided adequately through a home health program, limited to 60 days per calendar year.

8.1.6 **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

(iv) Services for congenital Oligodontia or Anodontia.

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

(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.

See the Schedule of Benefits for Plan payment information. Preauthorization is required.

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 **Diabetic Education**. Services and supplies are covered for diabetic self-management training and education at the Physician fee benefit. Preauthorization is required.

8.2.5 **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.

8.2.6 **Genetic Counseling**. Only when rendered by an In-Network Provider.

8.2.7 **Genetic Testing**. Genetic testing at a Myriad company is covered at 100% of the Allowed Amount for In-Network Providers and 100% of the billed amount for Out-of-Network Providers.

Genetic testing at a non-Myriad company will be paid according to Select Health's Medical Policy: 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

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

8.2.8 **Home Visits**.

8.2.9 **Infertility**. Treatment of infertility is covered, as outlined on the Schedule of Benefits, and includes Services related to cryogenic or other preservation, storage, and thawing (or comparable preparation of egg, sperm, or embryo); in-vitro fertilization; artificial insemination; embryo transfer or other artificial means of conception; and fertility drugs and other medications associated with fertility treatment.

Services to diagnoseinfertility is covered, including fulguration of ova ducts, hysteroscopy, hysterosalpingogram, certain laboratory tests, diagnostic laparoscopy, and some imaging studies.

8.2.10 **Major Surgery**.

8.2.11 **Mastectomy/Reconstructive Services**. In accordance with the Women's Health and Cancer Rights Act (WHCRA), the Plan covers mastectomies and reconstructive surgery after a mastectomy. If you are receiving Benefits in connection with a mastectomy, coverage for reconstructive surgery, including modifications or revisions, will be provided according to 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.

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

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

8.2.14 **Office Visits**. For consultation, diagnosis, and treatment. Office visits at a retail clinic are covered 100% after the primary care Physician copay. All other services billed at a retail clinic will take the appropriate benefit based on the Service billed.

8.2.15 **Preventive Services**. Preventive Services are covered both In-Network and Out-of-Network.

8.2.16 **Sleep Studies**.

8.2.17 **Sterilization Procedures**.

8.3 **Miscellaneous Services**.

8.3.1 **Adoption Indemnity Benefit**.

The Plan provides an adoption indemnity Benefit. In order to receive this Benefit, the child must be placed with you for adoption within 90 days of the child's birth. You must submit a claim for the Benefit within one year from the date of placement.

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

This Benefit is subject to Coinsurance, Copays, and Deductibles applicable to the maternity Benefit as indicated in your Schedule of Medical Benefits.

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

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

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

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

c. Either:

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

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

8.3.4 **Arthritis Testing**. Arthritis testing at a Myriad company is covered at 100% of the Allowed Amount for In-Network Providers and 100% of the billed amount for Out-of-Network Providers. Arthritis testing at a non-Myriad company will be paid according to Select Health's Medical Policy.

8.3.5 **Bariatric Surgery**. Only when rendered at a Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program accredited facility. Refer to your Schedule of Benefits and "Bariatric Surgery Benefits" in "Appendix A – Additional Benefits" for details.

8.3.6 **Blood Bank Services and Supplies**. Blood bank services and supplies are covered. Blood bank storage expenses are not covered.

8.3.7 **Chemotherapy, Radiation Therapy, and Dialysis**. Covered as outlined on the Schedule of Benefits. Dialysis is covered up to 42 treatments per calendar year.

8.3.8 **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.

8.3.9 **Cochlear Implants and Osseointegrated Auditory Devices**. Only in limited circumstances that satisfy Select Health criteria.

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

- **a.** Only when used in conjunction with an otherwise covered condition and when:
  - **(i)** Prescribed by a Provider;
  - **(ii)** Primarily used for medical purposes and not for convenience, personal comfort, or other nontherapeutic purposes;
  - **(iii)** Required for Activities of Daily Living;
  - **(iv)** Not for duplication or replacement of lost, damaged, or stolen items; and
  - **(v)** Not attached to a home or vehicle.
- **b.** Batteries only when used to power a wheelchair, 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. The Plan will not provide payment for rental costs exceeding the purchase price. For covered rental DME that is subsequently purchased, cumulative rental costs are deducted from the purchase price.

Wigs are covered as part of the durable medical equipment benefit up to $500 per calendar year for any diagnosis. The benefit limit is based on the paid amount. Fitting and sales tax are not covered. See the Schedule of Benefits for additional information.

8.3.11 **Eye Exams**. Routine eye exams are covered once every 2 years.

8.3.12 **Habilitation Therapy Services**. When Mental Health/Chemical Dependency is a Covered Service, day/visit limits for Habilitation Services, if indicated on your Schedule of Benefits, do not apply when the primary diagnosis is Mental Health/Chemical Dependency.

8.3.13 **Hearing Aids**. Hearing aids are covered every 3 years for each ear or both combined. Ear molds, fittings, and adjustments are covered and apply to the benefit limit. (Hearing aid exams, batteries, and cords are not covered.) See the Schedule of Benefits for Plan payment information. You may be balance billed.

8.3.14 **Home Healthcare**. Home healthcare is covered, up to 130 visits per Member per calendar year, when:

- **a.** 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.

Services of home health aids are covered if provided by a licensed home health agency or facility. See Schedule of Benefits for additional information.

8.3.15 **Hospice Care**. Hospice/respite care is covered up to 14 combined inpatient/outpatient days per Lifetime.

8.3.16 **Injectable Drugs and Specialty Medications**. Certain injectable drugs or specialty medications rendered during a Hospital stay or rendered in a Provider's office may be covered under the medical plan. Infused drugs must be administered by an In-Network Provider. Certain injectable drugs and specialty medications must be obtained from an In-Network specialty pharmacy.. Call Member Services to determine if this is the case and to obtain information on participating drug vendors.

Prescription Drug Benefits are provided by Express Scripts. Please refer to the literature prepared by Express Scripts for information about Injectable Drugs and Specialty Medications.

8.3.17 **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.

8.3.18 **Neurodevelopmental Therapy**. Outpatient neurodevelopmental therapy is covered, limited to 40 visits per calendar year. Services must be to restore or improve function for a claimant with a neurodevelopmental delay. Covered services include only physical therapy and occupational therapy. Preauthorization is required.

8.3.19 **Organ Transplants**.

a. Only if 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.

Travel and Lodging Reimbursement

Travel and lodging are reimbursable up to a maximum of $4,000 per Year for covered Services that cannot be accessed locally; this includes travel and lodging for abortion services. Travel and lodging are only eligible for reimbursement when Services are rendered at the nearest Provider or Facility that can accommodate the procedure and there are no Facilities or Providers who can render those Services within 100 miles of the Member's home address.

Reimbursable expenses include lodging, airfare, train fare, rental car use, or mileage for personal vehicle use according to the following guidelines:

a. Coach airfare and train fare;

b. Mileage for personal vehicle use will be reimbursed at the applicable medical mileage rate listed on www.irs.gov and will be based on MapQuest distance results (this does not apply to mileage used for rental car use);

c. Lodging is reimbursed at billed charges and is limited to $50 per day for the patient or $100 per day for the patient and one companion (if the patient is under age 19, two companions may accompany the patient); and

d. Reimbursement requires supporting documentation including receipts.

Benefits will be reimbursed upon the submission to the Plan of dated receipts showing the Service provided, the cost of the service, and the name, address, and phone number of the Service Provider.

The Plan Administrator reserves the right not to reimburse any such expenses that it, in its sole discretion, deems inappropriate, excessive, or not in keeping with the intent of the provision.

The following services are not reimbursable:

- Meals;
- Alcohol;
- Clothing;
- Entertainment;
- Gasoline;
- Gift Cards;
- Hotel Incidentals;
- Laundry Services;
- Non-Legible Receipts;
- Personal Hygiene Items;
- Shoes/slippers;
- Souvenirs;
- Telephone bills/calls/phone cards;
- Tobacco; or
- Valet Services.

8.3.20 **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.

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

8.3.22 **Palliative Care/Pain Management/Pain Clinic Services**. Palliative care is covered up to 30 visits per calendar year. Preauthorization is required.

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

8.3.24 **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/Chemical Dependency is a Covered Service, day/visit limits for Rehabilitation Services, if indicated on your Schedule of Benefits, do not apply when the primary diagnosis is Mental Health/Chemical Dependency.

8.3.25 **TeleHealth**. Services are covered in accordance with Select Health's medical policy. Except for Mental Health/Chemical Dependency, telehealth Services are only covered 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.

8.3.26 **Temporomandibular Joint (TMJ)**.

8.3.27 **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.

8.3.28 **Vein Procedures**. Only when performed at an accredited vein clinic or facility.

8.3.29 **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

Prescription Drug Benefits are provided by Express Scripts and are incorporated into this SPD by reference. Please refer to the literature prepared by Express Scripts for the specifics of your prescription drug benefits.

Section 10 – Limitations and Exclusions

Unless otherwise noted in your Schedule of Benefits or Appendix A – "Additional Benefits," 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; or
- **c.** When the pregnancy is not viable.

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 a 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**. The following cancer therapies are not covered:

a. Neutron beam therapy; and

b. Proton beam therapy, except in the following limited circumstances:

- **(i)** Chordomas or chondrosarcomas arising at the base of the skull or along the axial skeleton without distant metastases;
- **(ii)** Other central nervous system tumors located near vital structures;
- **(iii)** Pituitary neoplasms;
- **(iv)** Uveal melanomas confined to the globe (not distant metastases); or
- **(v)** In accordance with 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.** Services that are covered by, or would have been covered if you or your Dependents had enrolled and maintained coverage in automobile insurance, including no-fault type coverage up to the minimum amount required by law. In the event of a claim, you should provide a copy of the Personal Injury Protection (PIP) documentation from the automobile insurance carrier.
- **b.** Services that are covered by, or would have been covered if your employer had enrolled and maintained coverage in, Workers' Compensation insurance.
- **c.** Services for which you have obtained a payment, settlement, judgment, or other recovery for future payment intended as compensation.
- **d.** Services received by you or one of your Dependents while incarcerated in a prison, jail, or other correctional facility at the time Services are provided, including care provided outside of a correctional facility to a person who has been arrested or is under a court order of incarceration.

10.14 **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 aid exams, batteries, and cords**.

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

10.20 **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.

10.21 **Prescription Medications Administered in a Physician's Office/Infusion Center or Facility**. The following are not covered:

- **a.** Oral, injectable or infused drugs under the medical benefit that are typically included in a pharmacy benefit formulary.
- **b.** Certain off-label drug usage, unless the use has been approved by a Select Health Medical Director or clinical pharmacist;
- **c.** Compound drugs when alternative products are available commercially;
- **d.** Cosmetic health and beauty aids;
- **e.** Drugs not on your Formulary;
- **f.** Infertility drugs;
- **g.** 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)** Nationally recognized compendium sources currently utilized by Select Health;
  - **(iv)** National Comprehensive Cancer Network (NCCN); or
  - **(v)** As defined within Select Health's Preauthorization criteria or medical policy.
- **h.** Pharmaceuticals approved by the Food and Drug Administration as a medical device;
- **i.** Prescription Drugs used for cosmetic purposes; and
- **j.** Travel-related medications, including preventive medication for the purpose of travel to other countries. See Immunizations in Section 10 – "Limitations and Exclusions."

10.22 **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 5 years of the cause or onset of the injury, illness, or therapeutic intervention, or a planned, staged series of Services (as specifically documented in the Member's medical record) is initiated within the five-year period; or
  - **(v)** to revise a scar, whether acquired through injury or surgery, except when the primary purpose is to improve or correct a functional impairment.
- **b.** Treatment for venous telangiectasia (spider veins).

10.23 **Related Provider Services**. Services provided, ordered, and/or directed for you or your Dependent by an immediate family member are not covered.

10.24 **Respite Care**. Respite Care is not covered.

10.25 **Robot-Assisted Surgery**. Direct costs for the use of a robot for robot-assisted surgery are not covered.

10.26 **Sexual Dysfunction**. Services related to sexual dysfunction are not covered.

10.27 **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.

10.28 **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; or
- **cc.** Whole body scanning.

10.29 **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.

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

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

Section 11 – Healthcare Management

The Plan works to manage costs while protecting the quality of care. The Plan's Healthcare Management Program reviews three aspects of medical care: appropriateness of the care setting, Medical Necessity, and appropriateness of Hospital lengths of stay. You benefit from this process because it reduces unnecessary medical expenses, enabling the Plan to manage health care costs for you. The Healthcare Management process takes several forms.

11.1 **Preauthorization**. Preauthorization is prior approval from Select Health for certain Services and is considered a Preservice Claim (refer to Section – 12 "Claims and Appeals"). Preauthorization is not required when this Plan is your secondary plan. 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 two days for a normal delivery or longer than four days 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, or an Emergency Condition;
- **e.** Bariatric surgery;
- **f.** Certain advanced imaging including Magnetic Resonance Imaging (MRI), Computerized Tomography (CT) scans, Positron Emission Tomography (PET) scans, and cardiac imaging;
- **g.** Certain genetic testing;
- **h.** Certain Home Healthcare;
- **i.** Certain medical oncology drugs;
- **j.** Certain radiation therapies;
- **k.** Certain sleep studies;
- **l.** Certain ultrasounds;
- **m.** Certain vein procedures;
- **n.** Cochlear implants and Osseointegrated Auditory Devices;
- **o.** Continuous glucose monitors;
- **p.** Dental anesthesia, surgery, and Services to treat dental accidents;
- **q.** Diabetic education;
- **r.** Hospice Care, and Private Duty Nursing;
- **s.** Hospital level care at home;
- **t.** Hysterectomy;
- **u.** Insulin pumps;
- **v.** Joint replacement;
- **w.** Neurodevelopmental therapy;
- **x.** Outpatient Rehabilitative, and Habilitative Services after 20 visits per therapy type, per Year;

y. Organ transplants;

z. Pain management/pain clinic Services;

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

bb. 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 $5,000.

cc. Tonsillectomy.

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

11.1.5 **Statement of Rights Under the Newborns' and Mothers' Health Protection Act**. The Plan Sponsor generally may not, under federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

11.2 **Case Management**. If you have certain serious or chronic conditions (such as spinal cord injuries, diabetes, asthma, or premature births), 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, the Plan may in its discretion extend or add Benefits that are not otherwise expressly covered or are limited by the Plan. In making this decision, the Plan will consider the medical appropriateness and cost effectiveness of the proposed exception.

When making such exceptions, the Plan reserves the right to specify the Providers, Facilities, and circumstances in which the additional care will be provided and to limit payment for additional

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

11.4 **Second Opinions/Physical Examinations**. After enrollment, 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. The Plan 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. Medical policies do not supersede the express provisions of the SPD. Coverage decisions are subject to all terms and conditions of the Plan, including specific Exclusions and Limitations. Because medical policies are based on constantly changing science, they are periodically reviewed and updated by Select Health. For questions about the medical policies of Select Health, 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**. Any of the following: a Rescission of coverage or a denial, reduction, or termination of a claim for Benefits, or a failure to provide or make payment for such a claim in whole or in part, including determinations related to a Claimant's Eligibility, the application of a review under Select Health Healthcare Management Program, and determinations that particular Services are Experimental and/or Investigational or not Medically Necessary or appropriate.

12.2.2 **Appeals**. Review by 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 Select Health Appeals and Grievances 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 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 **Independent Review Organization (IRO)**. An entity that conducts independent External Reviews.

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

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

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

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

12.2.14 **Urgent Preservice Claim**. Any Preservice Claim that, if subject to the normal timeframes for determination, could seriously jeopardize your life, health or ability to regain maximum function or that, in the opinion of your treating Physician, would subject you to severe pain that could not be adequately managed without the requested Services. Whether a claim is an Urgent Preservice Claim will be determined by an individual acting on behalf of 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.

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

12.3.1 **Urgent Preservice Claims**. In order to file an Urgent Preservice Claim, you must provide 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.

12.3.2 **Other Preservice Claims**. The procedure for filing most Preservice Claims (Preauthorization) is set forth in Section 11 – "Healthcare Management." If there is any other Benefit that would be subject to a Preservice Claim, you may file a claim for that Benefit by contacting Select Health 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 15 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 15-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.

12.3.3 **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 Select Health 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.

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.

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

12.5 **Formal Appeals**. If you are not satisfied with the result of working with Select Health 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. As the delegated claims review fiduciary under the Plan, Select Health will conduct a full and fair review of your Appeal.

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

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

12.5.2 **Form and Timing**. All requests for an Appeal of an Adverse Benefit Determination (other than those involving an Urgent Preservice Claim) must be in writing and should include a copy of the Adverse Benefit Determination and any other pertinent information that you want 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:

Mail:

Select Health Appeals and Grievances Department

P.O. Box 30192

Salt Lake City, Utah 84130-0192

Email: appeals@imail.org

Fax: 801-442-0762

Online: selecthealth.org/resources

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.

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.

12.5.3 **Appeals Process**. The Appeals process includes both mandatory and voluntary reviews.

You must exhaust all mandatory reviews before you may pursue civil action under ERISA Section 502(a). It is your choice, however, whether or not to seek voluntary review, and you are not required to do so before pursuing civil action. The Plan agrees that any statute of limitations or other legal defense based on timeliness is suspended during the time that any voluntary Appeal is pending. Your decision whether or not to seek voluntary review will have no effect on your rights to any other Benefits. 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 under ERISA Section 502(a). Failure to properly pursue the mandatory Appeals process may result in a waiver of the right to challenge Select Health's original decision.

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

Mandatory Review

Your Appeal will be investigated by the Select Health 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. To request an External Review, you must complete the External Review Request Form. For a copy of this form, or for other questions, contact the Select Health Appeals and Grievances Department. An External Review request must be made within 180 days from the date the Appeals and Grievances Department notifies you of the Final Internal Adverse Benefit Determination. An authorization to obtain medical records may be required. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. The IRO will provide written notice of its decision within 45 days after receipt of the request. There is no additional cost for requesting an External Review.

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

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

Voluntary Internal Review

If you choose to pursue the voluntary internal review process, you may request a review of your Appeal. Depending on the nature of the Appeal, it will be considered by the Administrative and Clinical Appeal Review Committee. Such a request must be made in writing to the Appeals 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.

12.5.5 Postservice Appeals. The process for appealing a Postservice Claim provides one mandatory review, possible voluntary reviews, and the right to pursue civil action 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 External Review Request Form. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. For a copy of this form, or for other questions, contact the Select Health Appeals and Grievances Department. An External Review request must be made within 180 days from the date 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 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.

Section 13 – Other Provisions Affecting Your Benefits

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

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

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

13.2 **Subrogation, Reimbursement and Recovery**.

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, a 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, 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 the Plan; and/or b) the claims are excluded from coverage under this Plan. Each Member agrees to reimburse the Plan for such conditional payments when a final determination is made by Select Health that the Plan is not responsible for the payment of such claims.

13.2.2 **The Plan'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 and the Plan have the right to recover Benefits paid under this Plan and are 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 and the Plan are 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 and the Plan are 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.

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

13.2.3 Agreement by Members.

As a condition to receiving Benefits under the Plan, you and your Dependent(s) agree (a) that the Plan and Select Health are automatically subrogated to, and have 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 and the Plan are 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 and the Plan's rights described in this section 13.2; (d) not to spend or otherwise disburse funds received under a settlement agreement or from an insurance company or other Recovery Party until such time as Select Health has been paid or reimbursed for the amounts due to Select Health or the Plan under this section 13.2; (e) to cooperate with Select Health and the Plan to effectuate the terms of this section 13.2 and to do whatever may be necessary to secure the recovery by the Plan or 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 the Plan's and Select Health's rights under this Section 13.2 and not to take any action that prejudices Select Health's or the Plan's rights under this Section 13.2, including settling a dispute with a Recovery Party without protecting Select Health's and the Plan'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 the Plan 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. The Plan's and 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 and the Plan until Select Health's and the Plan's rights under this section 13.2 have been satisfied.

The Plan and 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 is 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 or the Plan do 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 and/or the Plan shall have the right to intervene in any lawsuit, threatened lawsuit, or settlement negotiation involving a Recovery Party for purposes of asserting and collecting the Plan's restitution and other interests described in this section 13.2. Select Health and/or the Plan shall have the right to bring a lawsuit against, or assert a counterclaim or cross-claim against, you (or your agent or attorney) for purposes of collecting their 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 and the Plan are entitled to institute these actions in their own names 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 the Plan's interest. You and your Dependents must notify Select Health before filing any suit or settling any claim so as to enable the Plan and/or Select Health to participate in the suit or settlement to protect and enforce Select Health's and/or the Plan'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 the Plan and/or 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 and/or the Plan or their designated agents in asserting their 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. The Plan will have the right to recover any payment made in excess of the obligations of the Plan. This right of recovery will apply to payments made to you, your Dependents, your employer, Providers, or Facilities. If an excess payment is made by the Plan to you, you agree to promptly refund the amount of the excess. The Plan may, at its sole discretion, offset any future Benefits against any overpayment. The Plan may recover excess payment made to a provider by withholding other amounts payable to the provider for any Plan Participant or Dependent.

Section 14 – Participant Responsibilities

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

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

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

14.3 **Other Coverage**. Notify the Plan if you or your Dependents obtain other healthcare coverage. This information is necessary to accurately process and coordinate your claims.

14.4 **Information/Records**. Provide the Plan all information necessary to administer your coverage, including the medical history and records for you and your Dependents and, if requested, your social security number(s).

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

Section 15 – Plan Administrator

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

In addition, the Plan Administrator may:

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

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

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

Section 16 – Definitions

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

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

16.2 **Affordable Care Act (ACA)**. The Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 and associated regulations.

16.3 **Allowed Amount**. The dollar amount allowed by the Plan for a specific Covered Service.

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

16.5 **Annual Open Enrollment**. A period of time each year that may be 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 **Approved Clinical Trials**. A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease (any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted) and is described in any of the following:

a. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

i. The National Institutes of Health.

ii. The Centers for Disease Control and Prevention.

iii. The Agency for Health Care Research and Quality.

iv. The Centers for Medicare & Medicaid Services.

v. Cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

vii. Any of the following if the appropriate review and approval through a system of peer review has been attained:

1) The Department of Veterans Affairs.

2) The Department of Defense.

3) The Department of Energy.

b. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

c. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

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

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

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

16.12 **Continuation Coverage**. COBRA Coverage.

16.13 **Contraceptive**. A Service for a woman that temporarily or permanently prevents pregnancy by interfering with ovulation, fertilization, or implantation. The Food and Drug Administration identifies the following contraceptive methods: sterilization surgery; surgical sterilization implant; implantable rod; intrauterine device (IUD) copper; IUD with progestin; shot/injection; oral contraceptives (combined pill); oral contraceptives (progestin only); oral contraceptives extended/continuous use; patch; vaginal contraceptive ring; diaphragm; sponge; cervical cap; female condom; spermicide; and emergency contraception.

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

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

16.16 **Custodial Care**. Services provided primarily to maintain rather than improve a Member's condition or for the purpose of controlling or changing the Member's environment. Services requested for the convenience of the Member or the Member's family that do not require the training and technical skills of a licensed Nurse or other licensed Provider, such as convalescent

care, rest cures, nursing home services, etc. Services that are provided principally for personal hygiene or for assistance in daily activities.

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

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

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

16.20 **Durable Medical Equipment (DME)**. Medical equipment that is able to withstand repeated use and is generally not useful in the absence of an illness or injury.

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

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

16.23 **Emergency Condition(s)**. A condition 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.

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

16.25 **Employer's Plan**. The group health plan sponsored by your employer.

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

16.27 **Excess Charges**. Charges from Providers and Facilities that exceed the Allowed Amount for Covered Services. 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.

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

16.29 **Experimental and/or Investigational**. A Service for which one or more of the following apply:

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

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

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

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

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

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

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

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

16.37 **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.

16.38 **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.

16.39 **Injectable Drugs and Specialty Medications**. A class of drugs that may be administered orally, as a single injection, intravenous infusion or in an inhaled/nebulized solution. Injectable drugs and specialty medications include all or some of the following:

a. Are often products of a living organism or produced by a living organism through genetic manipulation of the organism's natural function

b. Are generally used to treat an ongoing chronic illness

c. Require special training to administer

d. Have special storage and handling requirements

e. Are typically limited in their supply and distribution to patients or Providers

f. Often have additional monitoring requirements

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

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

16.41 **In-Network Benefits**. The higher level of Benefits available to you when you obtain Covered Services from an In-Network Provider or Facility.

16.42 **In-Network Facility**. Facilities under contract with Select Health to accept Allowed Amounts as payment in full for Covered Services.

16.43 **In-Network Pharmacies**. Pharmacies under contract with Select Health to accept Allowed Amounts as payment in full for Covered Services.

16.44 **In-Network Providers**. Providers under contract with Select Health to accept Allowed Amounts as payment in full for Covered Services.

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

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

16.47 **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. imaging studies such as MRIs, CT scans, and PET scans;

b. neurologic studies such as EMGs and nerve conduction studies;

c. cardiac nuclear studies or cardiovascular procedures such as coronary angiograms; and

d. gene-based testing and genetic testing.

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

16.48 **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.

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

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

16.50 **Medical Director**. The Physician(s) designated as such by Select Health.

16.51 **Medical Necessity/Medically Necessary**. Services that a prudent healthcare professional would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

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

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

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

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

Medical Necessity is initially determined by the treating Physician and by Select Health's Medical Director or his or her designee. Final determinations of Medical Necessity rest with Select Health. 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.

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

16.53 **Mental Health/Chemical Dependency**. Emotional conditions or chemical dependency listed as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders, as periodically revised, and which require professional intervention.

16.54 **Minor Diagnostic Tests**. Tests not categorized as Major Diagnostic Tests. Examples of common minor diagnostic tests are:

- **a.** bone density tests
- **b.** certain EKGs
- **c.** echocardiograms
- **d.** common blood and urine tests
- **e.** simple x-rays such as chest and long bone x-rays
- **f.** spirometry/pulmonary function testing

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

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

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

16.58 **Out-of-Network Benefits**. A lower level of Benefits available for Covered Services obtained from an Out-of-Network Provider or Facility, even when such Services are not available through In-Network Providers or Facilities.

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

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

16.64 **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.

16.65 **Plan**. The Myriad Genetics, Inc. Employer Plan.

16.66 **Plan Administrator**. Myriad Genetics, Inc.

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

16.68 **Preauthorization (Preauthorize)**. Prior approval from Select Health for certain Services. Refer to Section 11 – "Healthcare Management" and your Schedule of Benefits.

16.69 **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.

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

16.71 **Primary Care Physician or Primary Care Provider (PCP)**. A general practitioner who attends to common medical problems, provides Preventive Services, and health maintenance. The following types of Physicians and Providers, and their associated physician assistants and nurse practitioners, are PCPs:

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

16.72 **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.

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

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

16.75 **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.

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

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

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

16.79 **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.

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

16.81 **Secondary Care Provider or Specialist (SCP)**. 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).

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

The Select Health Med® Service Area is the State of Utah and the State of Nevada.

Contact Member Services for additional information.

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

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

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

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

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

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

16.87 **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.

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

16.89 **Year**. Benefits are calculated on either a calendar-year or plan-year basis, as indicated on your Schedule of Benefits.

- **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 January 1 to December 31.

Section 17 – Other Programs

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

Section 18 – Your Rights Under the Employee Retirement Income Security Act (ERISA)

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

18.1 **Receive Information About Your Plan and Benefits.** Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all

documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

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

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

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

Section 19 – Specific Plan Information

19.1 **Plan Name**. Myriad Genetics, Inc. Employer Plan

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

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

19.4 **Plan Number**. 501

19.5 **Employer / Plan Sponsor**.

Myriad Genetics, Inc.
320 Wakara Way
Salt Lake City, Utah 84108
(801) 584-3600

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

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

19.7 **Plan Sponsor's Employer Identification Number**. 87-0494517

19.8 **Plan Administrator**.

Myriad Genetics, Inc.
320 Wakara Way
Salt Lake City, Utah 84108
(801) 584-3600

19.9 **Named Fiduciary**.

Myriad Genetics, Inc.
320 Wakara Way
Salt Lake City, Utah 84108
(801) 584-3600

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

Myriad Genetics, Inc.
320 Wakara Way
Salt Lake City, Utah 84108
(801) 584-3600

Service of process may also be made on the Plan Administrator.

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

Appendix A – Additional Benefits

Mental Health/Chemical Dependency Benefit

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

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

2. **Services requiring Preauthorization**. Preauthorization is required for the following mental health services that are not for Emergency Conditions:

a. Inpatient psychiatric/detoxification admissions;

b. Residential treatment after the third day of admission;

c. Day treatment;

d. Partial hospitalization after 20 visits; and

e. Intensive outpatient treatment after 35 visits.

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

3. **Exclusions**.

3.1 The following are not covered:

a. Behavior modification;

b. Counseling with a patient's family, friend(s), employer, school authorities, or others, except for approved Medically Necessary collateral visits, with or without the patient present, in connection with otherwise covered treatment of the patient's mental illness;

c. Education or training;

d. Long-term care;

e. Milieu therapy;

f. Rest cures;

g. Self-care or self-help training (nonmedical);

h. Surgical procedures to remedy a condition diagnosed as psychological, emotional, or mental; and

i. Services for conduct disorder.

Bariatric Surgery Benefits

1. **Your Bariatric Surgery Benefits**. The Plan provides limited Benefits for the following bariatric surgical Services when Preauthorized by Select Health:
   - **a.** Laparoscopic/open adjustable gastric banding;
   - **b.** Laparoscopic/open gastric bypass;
   - **c.** Laparoscopic/open vertical gastric banding; and
   - **d.** Biliopancreatic duodenal switch.

   Contact Select Health Member Services for a list of Covered Services.

2. **Limitations and Exclusions**.
   - **a.** Benefits are subject to a Lifetime Maximum amount stated on your Schedule of Benefits.
   - **b.** Coverage of these surgical Services requires that an In-Network Provider perform the services at a Facility approved by Select Health.
   - **c.** Specific criteria must be met in order to obtain Preauthorization; please call Member Services for details. If you fail to obtain Preauthorization, the procedure and any complications will not be covered.
   - **d.** You must be enrolled in the Plan for at least 12 consecutive months before you are eligible for bariatric surgery Benefits.
   - **e.** You must be 18 years of age or older to be eligible for Bariatric Surgery Benefits.

COVID-19 Assessment and Treatment Benefits

1. **<u>COVID-19 Testing, Assessment and Vaccination Benefits</u>**. The following are covered Services and paid by the Plan subject to the applicable Deductible, Copayment, and Out-of-Pocket Maximum requirements.

1.1 COVID-19 testing.*

*All Antigen OTC COVID-19 tests, including reimbursements, are paid through Express Scripts. The Member Customer Service phone number is 1-(844)-837-6653.

1.2 Assessment Services rendered in conjunction with COVID-19 related diagnoses (e.g., upper respiratory issues, flu-like symptoms, etc.)

a. By a Primary Care, Secondary Care, or urgent care Provider;

b. Through Intermountain Connect Care;

c. When billed separately in an emergency room setting; and

d. Rendered at a state or local Department of Health.

1.3 Vaccinations received to prevent COVID-19.

2. **<u>COVID-19 Treatment Benefits</u>**. Services rendered to treat COVID-19 are covered Services and paid by the Plan subject to the applicable Deductible, Copayment, and Out-of-Pocket Maximum requirements.


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Health