Regular Meeting of the

Board of Trustees of the Utah Transit Authority

Wednesday, May 6, 2020, 9:00 a.m.
Remote Electronic Meeting – No Anchor Location – Live-Stream at
https://www.youtube.com/results?search_query=utaride

NOTICE OF SPECIAL MEETING CIRCUMSTANCES DUE TO COVID-19 PANDEMIC:

In keeping with recommendations of Federal, State, and Local authorities to limit public gatherings in order to control the continuing spread of COVID-19, and in accordance with Utah Governor Gary Herbert's Executive Order on March 18, 2020 suspending some requirements of the Utah Open and Public Meetings Act, the UTA Board of Trustees will make the following adjustments to our normal meeting procedures.

- All members of the Board of Trustees and meeting presenters will participate electronically via phone or video conference.
- **Public Comment** will not be taken during the meeting but may be submitted through the means listed below. Comments submitted before 4:00 p.m. on Tuesday, May 5th will be distributed to board members prior to the meeting:
  - online at https://www.rideuta.com/Board-of-Trustees
  - via email at boardoftrustees@rideuta.com
  - by telephone at 801-743-3882 option 5 (801-RideUTA option 5) – specify that your comment is for the board meeting.
- Meeting proceedings may be viewed remotely through YouTube live-streaming. https://www.youtube.com/results?search_query=utaride

1.	**Call to Order & Opening Remarks**	**Chair Carlton Christensen**
2.	**Safety First Minute**	**Sheldon Shaw**
3.	**Consent**	**Chair Carlton Christensen**
	a. Approval of April 29, 2020 Board Meeting Minutes	
4.	**Agency Report**	**Carolyn Gonot**
	a. Ridership	
5.	**Financial Report – March 2020**	**Bob Biles**
6.	**Resolutions**	
	a. R2020-05-01 Resolution Authorizing the Request of Emergency Funding Reimbursement for Coronavirus Aid Relief through the Federal Emergency Management Agency (FEMA) Public Assistance (PA) Program	Mary DeLoretto
7.	**Contracts, Disbursements and Grants**	
	a. Change Order: Actuarial Services (Milliman)	Kent Millington

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

b. Change Order: Employer Health Insurance Agreement – Administrative Employees (Public Employers Health Plan) — Kim Ulibarri
c. Change Order: Employer Health Insurance Agreement – Bargaining Employees (Public Employers Health Plan) — Kim Ulibarri
d. Change Order: Employer Health Insurance Agreement – Administrative Employees (Select Health) — Kim Ulibarri
e. Change Order: Employer Health Insurance Agreement – Bargaining Employees (Select Health) — Kim Ulibarri
f. Real Estate Contract: Disposition of Real Property for Porter Rockwell Bridge Project - Parcels 215:B, 215:C, and 215:E (Utah Department of Transportation) — Paul Drake

8. Service and Fare Approvals

a. Fare Approval: Ogden Twilight Concert Series Tickets for Transit Agreement (Ogden City) — Monica Morton
b. Fare Approval: Salt Lake Twilight Concert Series Tickets for Transit Agreement (S&S Presents) — Monica Morton

9. Discussion Items

a. Rocky Mountain Power Memorandum of Understanding (MOU) — Mary DeLoretto, Hal Johnson
b. Proposed 2020 Budget Amendment Number 2 — Bob Biles

10. Other Business — **Chair Carlton Christensen**

a. Next meeting: May 20, 2020 at 9:00 a.m.

11. Adjourn — **Chair Carlton Christensen**

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

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

Be Proactive. Report Hazards.

UTA
SAFETY & SECURITY

MAY 2020

MEMORANDUM TO THE BOARD

TO: Utah Transit Authority Board of Trustees
FROM: Jana Ostler, Board Manager

BOARD MEETING DATE: May 6, 2020

SUBJECT:	**Approval of April 29, 2020 Board Meeting Minutes**
AGENDA ITEM TYPE:	**Consent**
RECOMMENDATION:	Approve the minutes of the April 29, 2020 Board of Trustees meeting
BACKGROUND:	A regular meeting of the UTA Board of Trustees was held electronically and broadcast live on YouTube on Wednesday, April 29, 2020 at 9:00 a.m. Minutes from the meeting document the actions of the Board and summarize the discussion that took place in the meeting. A full audio recording of the meeting is available on the Utah Public Notice Website and video feed is available on You Tube at https://www.youtube.com/results?search_query=utaride
ATTACHMENTS:	1) 2020-04-29_BOT_Minutes_unapproved

Minutes of the Meeting
of the
Board of Trustees of the Utah Transit Authority (UTA)
held remotely via phone or video conference
and broadcast live for the public via YouTube
April 29, 2020

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

Also participating were members of UTA staff.

Call to Order and Opening Remarks. Chair Christensen welcomed attendees and called the meeting to order at 9:01 a.m.

Public Comment. It was noted that online comment received for the meeting was distributed to the board prior to the meeting and will be included as an appendix to the minutes of the meeting.

Safety First Minute. Sheldon Shaw, UTA Director of Safety & Security, provided a brief safety message.

Consent Agenda. The consent agenda was comprised of:

a. Approval of April 15, 2020 Board Meeting Minutes

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

Agency Report.

Service Choices Update. Carolyn Gonot, UTA Executive Director, was joined by Laura Hanson, UTA Director of Planning. Ms. Gonot provided a brief recap on the service choices project, which was initiated in the spring of 2019 to inform the agency's

planning efforts. There has been significant public engagement on the project, with over 3,500 people providing input. The pandemic caused UTA to pause the initiative, as the outbreak has had a significant impact on service.

With respect to the pandemic, Ms. Gonot said the UTA workforce is dedicated and has remained relatively healthy. Ridership is about 30% of what is typical, and the agency is serving about 40,000 customers per day.

Ms. Gonot noted she has assembled a small internal task force to evaluate options for restoring service when restrictions are lifted. The service choices initiative will inform service adjustments over the next several months.

Ms. Gonot stated the agency will seek approval of a service plan this fall. She committed to providing updates to the board on this effort over the next several months. She also indicated the local advisory council would be informed and involved in the process.

Ms. Gonot concluded by saying staff would be out in the community over the next few days handing out masks in highly utilized areas of the UTA system

Discussion ensued. Questions on the method for determining service adjustments, assessment of routes across the service district, and communication efforts with communities to ascertain growth patterns were posed by the board and answered by staff.

The board indicated they would be willing to participate in the distribution of masks to riders.

Government Relations Report. Shule Bishop, UTA Government Relations Director, noted the state legislature recently held a special session. During the special session, House Bill 3008 Rail Fuel Sales Tax Amendments, which was vetoed by the governor after the regular legislative session, was revised and passed. The bill repeals the fuel tax credit given to railroads and channels funds generated by the tax to the Transit Transportation Investment Fund (TTIF) for rail crossing upgrades.

Mr. Bishop mentioned the possibility of another congressional stimulus package, though details are not currently known.

Mr. Bishop said the state may convene and interim session in May, during which assignments will be made for the master study list. It is likely there will also be another special session after state tax commission receives updated numbers. UTA is closely monitoring developments.

Discussion ensued. Questions on opportunities to address UTA's needs during the interim session and timeline for receiving numbers from the tax commission were posed by the board and answered by Mr. Bishop.

Chair Christensen suggested staff begin preparing now for discussion with legislators regarding the agency's needs.

Pension Committee Report. Trustee Millington remarked on the performance and diversification of UTA's pension plan. He then spoke about historical trends in the stock market and impacts to the pension fund from the current market conditions. Discussion ensued. Questions on the strategy for managing pension funds and market forecasts were posed by the board and answered by Trustee Millington.

Investment Report – First Quarter 2020. Bob Biles, UTA Chief Financial Officer, delivered a report on UTA's investment yields and benchmark comparisons for the first quarter of 2020. Discussion ensued. A question on trends in the Public Treasurers Investment Fund (PTIF) was posed by the board and answered by Mr. Biles.

Reserves Action – Authorization of Debt Reduction Reserve and Reallocation of Reserve Funds. Mr. Biles provided background on the June 2019 reserve policy, which made several changes to UTA's designated reserves, including the general operating and capital replacement reserves. In its April 8, 2020 meeting, the board discussed recent events that support changes to certain reserve accounts. They recommended the following adjustments:

Reserve *	Policy	12/31/20 Estimate	12/31/20 Revised
Designated Balances:			
General Operating	12% to 18% of budgeted operating expense	38,379,000	57,600,000
Service Stabilization	3% of budgeted operating expense	9,595,000	9,600,000
Capital Replacement	1% of physical assets	10,700,000	45,000,000
Debt Reduction	Savings from bond refundings	87,418,000	30,000,000
Total		$146,092,000	$142,200,000

Discussion ensued. Questions on capacity for the reserves to cover high fuel prices and funding mechanisms for the debt reduction reserve were posed by the board and answered by Mr. Biles.

Chair Christensen recommended establishing a mechanism to provide greater security in fuel budgets.

The board instructed Mr. Biles to prepare a resolution to officially establish the debt reduction reserve and bring it to the board for approval at a future meeting.

A motion to authorize a debt reduction reserve account to be held by the Authority and reallocate UTA reserve funds from the proceeds of bond refunding as outlined in the meeting packet was made by Trustee Holbrook and seconded by Trustee Millington. The motion carried unanimously.

Policy Approval – UTA Policy 1.1.11 – Ethics. Riana de Villiers, UTA Chief Internal Auditor, explained the revisions to policy, which combine several previously existing ethics-related policies into one. She noted significant changes or additions were made to reporting conflicts of interest, gifts, meals, and outside employment. Ms. de Villiers indicated employees would be informed of updates to the policy through formal communication channels, the learning management system, and in-person training.

A motion to approve UTA Policy 1.1.11 – Ethics was made by Trustee Holbrook and seconded by Trustee Millington. The motion carried unanimously.

Contracts, Disbursements, and Grants.

Contract: Computer-Aided Dispatch/Automatic Vehicle Location Sole Source Contract (Talrace, LLC). Dan Harmuth, UTA IT Director, was joined by Alisia Wixom, UTA IT Project Manager. Mr. Harmuth described the contract, which is for phase 2 software development for an updated computer-aided dispatch (CAD)/automatic vehicle location (AVL) system. The contract value of phase 2 is $199,980. Talrace, LLC satisfactorily completed work on phase 1 at a value of $82,500. Discussion ensued. Questions on the reasoning for creating the system in-house, lifespan of the new CAD/AVL system, intellectual property ownership, and capacity for growth within the system were posed by the board and answered by staff.

A motion to approve the contract was made by Trustee Millington and seconded by Trustee Holbrook. The motion carried unanimously.

Contract: Light Rail SD100 Low-Voltage Power Supply Overhaul (LES Services Electro-Techno Inc.). Eddy Cumins, UTA Chief Operating Officer, was joined by Kyle Stockley, UTA Manager of Vehicle Overhaul & Bus Support. Mr. Cumins explained the contract, which covers the overhaul of 26 low-voltage power supply (LVPS) units for light rail vehicles at a total contract value of $425,724.

A motion to approve the contract was made by Trustee Holbrook and seconded by Trustee Millington. The motion carried unanimously.

Contract: New Design Bus Stop Signs (Intermountain Traffic Safety). Nichol Bourdeaux, UTA Chief Communications & Marketing Officer, described the contract, which is for the production of new bus stop signs. The total contract value is $297,877.32. Discussion ensued. Questions on the portability of signs, adjustments for riders with color blindness, and timeline for installation were posed by the board and answered by Ms. Bourdeaux.

Trustee Holbrook requested a printed timeline for installation of signs across the service district.

A motion to approve the contract was made by Trustee Millington and seconded by Trustee Holbrook. The motion carried unanimously.

Change Order: South Temple and Main Street Curve Replacement – On-Call Maintenance Task Order #102 (Stacy and Witbeck, Inc.). Mr. Cumins was joined by David Hancock, UTA Director of Asset Management. Mr. Hancock detailed the change order for replacement of the rail at the curve at South Temple and Main Street in Salt Lake City, with work scheduled to take place over Memorial Day weekend. The total change order value is $705,257. Discussion ensued. A question on the timeline for rebidding the on-call contract was posed by the board and answered by Mr. Hancock.

A motion to approve the change order was made by Trustee Holbrook and seconded by Trustee Millington. The motion carried unanimously.

Revenue Contract: Volkswagen Eligible Mitigation Action Funding Agreement (Utah Department of Environmental Quality). Mary DeLoretto, UTA Chief Service Development Officer, explained the revenue contract, which awards $13,079,240 to UTA from the Volkswagen Diesel Emissions Environmental Mitigation Trust for up to

65% of the cost for replacement of 20 diesel vehicles with electric battery-operated vehicles and supporting charging infrastructure. Discussion ensued. A question on the vehicles to be removed from service was posed by the board and answered by Ms. DeLoretto.

A motion to approve the revenue contract was made by Trustee Millington and seconded by Trustee Holbrook. The motion carried unanimously.

Revenue Contract: Professional Services Agreement – Design of 650 South Main Street TRAX Station (Redevelopment Agency of Salt Lake City). Ms. DeLoretto described the revenue contract, which is for the design of a TRAX station to be located at 650 South Main Street in Salt Lake City. She noted the city will be paying all construction costs on the project.

A motion to approve the revenue contract was made by Trustee Millington and seconded by Trustee Holbrook. The motion carried unanimously.

Pre-Procurements. Todd Mills, UTA Sr. Supply Chain Manager, was joined by Mr. Stockley and Ms. Hanson. Mr. Mills indicated the agency intends to procure the following:

i. Police Vehicle Purchase
ii. SD160 Light Rail Vehicle Door Parts Purchase
iii. Light Rail Vehicle Seat Replacement
iv. Bus Plexiglass Barrier Purchase
v. Design for 650 South Main Street TRAX Station
vi. Provo to Santaquin Corridor Transit Options Analysis

Discussion ensued. Questions regarding bidding parts for the light rail vehicle doors, testing of light rail vehicle seat replacements, and design of plexiglass barriers were posed by the board and answered by staff.

Grant Application: USDOT Better Utilizing Investments to Leverage Development (BUILD) Grant Application for Future of FrontRunner First Steps: Double Tracking South Jordan to Draper. Ms. DeLoretto stated UTA's intention to apply for a BUILD grant to double track the FrontRunner line between the Draper and South Jordan stations and for wayfinding at the South Jordan, Draper, and Vineyard stations. Discussion ensued. A question regarding the impact of the northern Utah County double track project on the grant application was posed by the board and answered by Ms. DeLoretto.

Discussion Items.

UTA 2019 Onboard Survey Report. Ms. Bourdeaux was joined by G.J. LaBonty, UTA Manager of Customer Experience. Mr. LaBonty delivered a presentation detailing the 2019 onboard survey. The federally mandated survey collects data from UTA riders in areas such as gender, age, race, income, vehicles per household, transportation options available to riders, frequency of use, transfers, and modes of system access and egress.

Discussion ensued. Questions on transfers associated with ed passes, destination location tracking, and maximizing transit access to regional work centers were posed by the board and answered by staff.

Chair Christensen requested a comparison of 2015 to 2019 trip production and attraction.

Other Business.

Next Meeting. The next meeting of the board will be on Wednesday, May 6, 2020 at 9:00 a.m.

Closed Session. Chair Christensen indicated there were matters to be discussed in closed session relative to pending or reasonably imminent litigation. A motion to move into closed session was made by Trustee Holbrook and seconded by Trustee Millington. The motion carried unanimously. Chair Christensen called for a brief recess and indicated the closed session would convene at 11:10 a.m.

Open Session. A motion to return to open session was made by Trustee Holbrook and seconded by Trustee Millington. The motion carried unanimously and the board returned to open session at 11:43 a.m.

Adjournment. The meeting was adjourned at 11:44 a.m. by motion.

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

This document is not intended to serve as a full transcript as additional discussion may have taken place; please refer to the meeting materials, audio, or video located at https://secure.utah.gov/pmn/sitemap/notice/601365.html for entire content.

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

Appendix

Online Public Comment
to the
Board of Trustees of the Utah Transit Authority (UTA)
Board Meeting
April 29, 2020

Received April 27, 2020 from George Chapman:

comments to UTA Board for Wed. 29 April meeting

I urge UTA to follow HJR301 and not apply for the FrontRunner double tracking grant (and the EIS Pt of the Mt) to be discussed at the April 29 meeting. HJR301 "urges state agencies; state and local government entities; state boards, ...to: limit expenditures to essential costs during the remainder of the fiscal year ....avoid unnecessary spending during the remainder of the fiscal year ...refrain from committing to new or expanded expenditures for the fiscal year". HJR301 was enrolled April 17th.

These proposed projects do not have broad public support and, in these trying times where bus service is cut back 50%, project expenditures should be limited. These projects are unnecessary spending!

Please do not apply for this grant which would require/obligate UTA to spend almost a billion on projects instead of service.

I also remind UTA that there is a very small ridership at times on FrontRunner and UTA should not be spending inordinate amounts on running FrontRunner when passengers are under 50. An express bus is more efficient.

Finally, the Utah Public Notice Website is down and how can I get the epacket for Wednesday's meeting.

Received April 28, 2020 from an anonymous constituent:

Some items of feedback for the items listed on tomorrows agenda. I don't have all the background but just perspective as a rider.

Computer Aided Dispatch – This will hopefully bring some welcome upgrades. I have noticed sometimes when the little computers on the bus restart or boot up they were using an old version of Windows, hopefully this new version will allow the operating system be current with OS version and security. I like the feature that it can track cars in a train set, this would be helpful if a passenger reports an issue and only sees the car number inside or reports something later and only knew the time and place.

650 South TRAX Design – Hopefully a new station would not slow down travel time for passengers south of this station. Although, it might provide an opportunity to smooth out transfer traffic on the Courthouse platform. Designs could review options for skipping stops for certain lines or encouraging certain direction transfers to use certain platforms.

MEMORANDUM TO THE BOARD

TO: Utah Transit Authority Board of Trustees
FROM: Carolyn Gonot, Executive Director
PRESENTER(S): Carolyn Gonot, Executive Director

BOARD MEETING DATE: May 6, 2020

SUBJECT:	**Agency Report**
AGENDA ITEM TYPE:	**Report**
RECOMMENDATION:	Informational report for discussion
DISCUSSION:	Carolyn Gonot, UTA Executive Director will report on recent activities of the agency and other items of interest. - Ridership

MEMORANDUM TO THE BOARD

TO: Utah Transit Authority Board of Trustees
THROUGH: Carolyn Gonot, Executive Director
FROM: Bob Biles, Chief Financial Officer
PRESENTER(S): Bob Biles, Chief Financial Officer

BOARD MEETING DATE: May 6, 2020

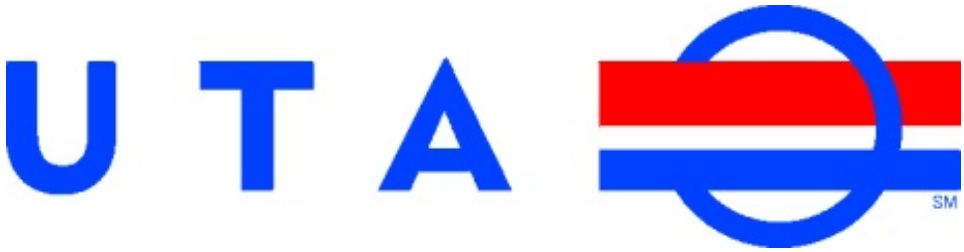
SUBJECT:	**Financial Report - March 2020**
AGENDA ITEM TYPE:	**Report**
RECOMMENDATION:	Informational report for discussion
BACKGROUND:	The Board of Trustees Policy No. 2.1, Financial Management, directs the Chief Financial Officer to present monthly financial statements stating the Authority's financial position, revenues, and expense to the Board of Trustees as soon as practical with monthly and year-to-date budget versus actual report to be included in the monthly financial report. The March 2020 Monthly Financial Statements have been prepared in accordance with the Financial Management Policy and are being presented to the Board. Also provided, is the monthly Board Dashboard which summarizes key information from the March Monthly Financial Statements.
DISCUSSION:	At the May 6 meeting, the CFO will review the Board Dashboard key items, sales tax collections, and operating expense variances and receive questions from the Board of Trustees.
ATTACHMENTS:	• March 2020 Monthly Financial Statements • March 2020 Board Dashboard

Utah Transit Authority

Financial Statement

(Unaudited)

March 31, 2020



KEY ITEM REPORT
(UNAUDITED)
As of March 31, 2020

EXHIBIT 1-1

		2020 YTD ACTUAL	2020 YTD BUDGET	VARIANCE FAVORABLE (UNFAVORABLE)	% FAVORABLE (UNFAVORABLE)
1	Sales Tax	$ 83,535,228	$ 77,954,640	$ 5,580,588	7%
2	Passenger Revenue	12,829,323	13,812,315	(982,992)	-7%
3	Other Revenue	18,970,410	20,874,073	(1,903,663)	-9%
4	Total Revenue	115,334,961	112,641,028	2,693,933	2%
5	Net Operating Expenses	(72,375,088)	(78,888,248)	6,513,160	8%
	Net Operating Income (Loss)	42,959,873	33,752,780	9,207,093	27%
6	Debt Service	46,258,495	45,728,740	(529,755)	-1%
7	Other Non-Operating Expenses	1,106,138	1,541,878	435,740	28%
8	Sale of Assets	(31,436)	-	31,436	
9	Contribution to Capital Reserves	$ (4,373,324)	$ (13,517,839)	$ 9,144,514	-68%
10	Amortization	(864,383)			
11	Depreciation	34,142,464			
12	Total Non-cash Items	$ 33,278,081			

GOALS

RIDERSHIP

	2019 Actual	March 2020	March 2019	Difference	2020 YTD	2019 YTD	Difference
13	44,239,223	2,618,050	3,763,319	-1,145,269	10,193,685	11,041,078	-847,393

OPERATING SUBSIDY PER RIDER -

			SPR
14	Net Operating Expense	$	72,375,088
15	Less: Passenger Revenue	-	(12,829,323)
16	Subtotal		59,545,765
17	Divided by: Ridership	÷	10,193,685
18	Subsidy per Rider	$	5.84

SUMMARY FINANCIAL DATA
(UNAUDITED)
As of March 31, 2020

EXHIBIT 1-2

BALANCE SHEET

		3/31/2020	3/31/2019
	CURRENT ASSETS		
1	Cash	$ 11,589,707	$ 13,761,605
2	Investments (Unrestricted)	120,016,337	98,433,968
3	Investments (Restricted)	194,860,121	135,327,399
4	Receivables	64,225,969	60,900,694
5	Receivables - Federal Grants	21,022,256	15,199,304
6	Inventories	36,718,683	35,840,354
7	Prepaid Expenses	1,086,652	1,452,483
8	TOTAL CURRENT ASSETS	$ 449,519,725	$ 360,915,807
9	Property, Plant & Equipment (Net)	2,922,082,124	3,056,885,774
10	Other Assets	182,413,169	149,550,552
11	TOTAL ASSETS	$3,554,015,018	$3,567,352,133
12	Current Liabilities	$ 47,645,606	$ 25,045,535
13	Other Liabilities	36,647,192	59,548,540
14	Net Pension Liability	131,548,114	131,069,664
15	Outstanding Debt	2,484,371,494	2,416,506,888
16	Equity	853,802,612	935,181,506
17	TOTAL LIABILITIES & EQUITY	$3,554,015,018	$3,567,352,133

RESTRICTED AND DESIGNATED CASH AND CASH EQUIVALENTS RECONCILIATION

	RESTRICTED RESERVES		
18	Debt Service Reserves	33,339,485	34,304,301
19	2018 Bond Proceeds	27,821,620	41,399,757
20	2019 Bond Proceeds	71,312,742	
21	Debt Service Interest Payable	42,546,814	35,937,936
22	Box Elder County ROW (sales tax)	6,844,166	7,173,997
23	Joint Insurance Trust	6,889,118	4,168,050
24	Davis County Escrow	1,143,315	
25	SL County Escrow	332,158	572,016
26	Amounts held in escrow	4,630,703	3,997,125
27	TOTAL RESTRICTED RESERVES	$ 194,860,121	$ 127,553,182
	DESIGNATED GENERAL AND CAPITAL RESERVES		
28	General Reserves	$ 36,379,794	$ 36,660,000
29	Service Sustainability Reserves	9,166,000	$ 15,272,000
30	Capital Reserve	10,700,000	10,700,000
31	Debt Reduction Reserve	75,360,250	53,373,497
32	TOTAL DESIGNATED GENERAL AND CAPITAL RESERVES	$ 131,606,044	$ 116,005,497
33	TOTAL RESTRICTED AND DESIGNATED CASH AND EQUIVALENTS	$ 326,466,165	$ 243,558,679

SUMMARY FINANCIAL DATA
(UNAUDITED)
As of March 31, 2020

EXHIBIT 1-3

REVENUE & EXPENSES

		ACTUAL Mar-20	ACTUAL Mar-19	YTD 2020	YTD 2019
	REVENUE				
1	Passenger Revenue	$ 3,657,053	$ 5,736,318	$ 12,829,323	$ 13,753,002
2	Advertising Revenue	208,333	204,165	625,000	612,500
3	Investment Revenue	452,572	697,927	1,179,383	1,476,391
4	Sales Tax	37,440,089	28,753,587	83,535,228	70,424,623
5	Other Revenue	909,025	185,592	2,127,353	467,420
6	Fed Operations/Preventative Maint.	5,234,114	5,046,652	15,038,674	15,025,559
7	TOTAL REVENUE	$ 47,901,186	$ 40,624,241	$115,334,961	$101,759,495
	OPERATING EXPENSE				
8	Bus Service	$ 9,101,284	$ 8,076,555	$ 26,998,007	$ 25,081,330
9	Commuter Rail	1,855,353	1,784,135	5,803,338	5,573,004
10	Light Rail	2,861,082	3,340,671	8,965,447	9,712,212
11	Maintenance of Way	1,584,784	1,434,613	4,735,238	4,313,546
12	Paratransit Service	1,991,232	1,582,581	5,709,759	5,090,788
13	RideShare/Van Pool Services	227,799	242,681	760,836	736,200
14	Operations Support	4,144,041	4,114,428	11,946,963	11,740,979
15	Administration	2,299,471	2,782,949	7,455,500	7,049,228
16	TOTAL OPERATING EXPENSE	$ 24,065,046	$ 23,358,613	$ 72,375,088	$ 69,297,287
17	NET OPERATING INCOME (LOSS)	$ 23,836,140	$ 17,265,628	$ 42,959,873	$ 32,462,208
	NON-OPERATING EXPENSE (REVENUE)				
18	Planning & Development	$ 356,146	$ 325,901	$ 1,106,138	$ 1,044,877
19	Bond Principal	2,160,000	1,176,235	19,220,000	10,669,536
20	Bond Interest	8,633,992	7,964,237	23,604,123	23,892,711
21	Bond Interest UTCT	164,215		494,957	
22	Bond Cost of Issuance/Fees	772,817	-	774,317	1,500
23	Lease Cost	654,208	778,171	2,165,098	2,000,910
24	Sale of Assets	(31,436)	-	(31,436)	(896,094)
25	TOTAL NON-OPERATING EXPENSE	$ 12,709,942	$ 10,244,544	$ 47,333,197	$ 36,713,440
26	CONTRIBUTION TO CAPITAL RESERVES	$ 11,126,198	$ 7,021,084	$ (4,373,324)	$ (4,251,232)
	OTHER EXPENSES (NON-CASH)				
27	Bond Premium/Discount Amortization	(506,357)	(1,316,757)	(2,526,562)	(3,857,661)
28	Bond Refunding Cost Amortization	274,240	682,154	1,459,451	2,046,461
29	Future Revenue Cost Amortization	67,576	67,577	202,728	202,729
30	Depreciation	11,655,160	10,289,073	34,142,464	34,290,790
31	NET OTHER EXPENSES (NON-CASH)	$ 11,490,619	$ 9,722,047	$ 33,278,081	$ 32,682,319

ACTUAL REPORT
(UNAUDITED)
As of March 31, 2020

EXHIBIT 1-4

CURRENT MONTH

		ACTUAL Mar-20	BUDGET Mar-20	VARIANCE FAVORABLE (UNFAVORABLE)	% FAVORABLE (UNFAVORABLE)
	REVENUE				
1	Passenger Revenue	$ 3,657,053	$ 4,855,662	$ (1,198,609)	-25%
2	Advertising Revenue	208,333	209,154	(821)	0%
3	Investment Revenue	452,572	756,163	(303,591)	-40%
4	Sales Tax	37,440,089	31,859,502	5,580,587	18%
5	Other Revenue	909,025	704,722	204,303	29%
6	Fed Operations/Preventative Maint.	5,234,114	5,524,721	(290,607)	-5%
7	TOTAL REVENUE	$ 47,901,186	$ 43,909,924	$ 3,991,262	9%
	OPERATING EXPENSE				
8	Bus Service	$ 9,101,284	$ 9,323,957	$ 222,673	2%
9	Commuter Rail	1,855,353	2,175,499	320,146	15%
10	Light Rail	2,861,082	3,175,589	314,507	10%
11	Maintenance of Way	1,584,784	1,571,706	(13,078)	-1%
12	Paratransit Service	1,991,232	2,108,818	117,586	6%
13	RideShare/Van Pool Services	227,799	274,840	47,041	17%
14	Operations Support	4,144,041	4,188,463	44,422	1%
15	Administration	2,299,471	3,230,931	931,460	29%
16	TOTAL OPERATING EXPENSE	$ 24,065,046	$ 26,049,803	$ 1,984,757	8%
17	NET OPERATING INCOME (LOSS)	$ 23,836,140	$ 17,860,121	$ 5,976,019	33%
	NON-OPERATING EXPENSE (REVENUE)				
18	Planning & Development	$ 356,146	$ 550,822	$ 194,676	35%
19	Bond Principal	2,160,000	2,160,000	-	0%
20	Bond Interest	8,633,992	8,633,992	-	0%
21	Bond Interest UTCT	164,215	166,776	2,561	2%
22	Bond Cost of Issuance/Fees	772,817	16,600	(756,217)	-4556%
23	Lease Cost	654,208	790,300	136,092	17%
24	Sale of Assets	(31,436)	-	31,436	
25	TOTAL NON-OPERATING EXPENSE	$ 12,709,942	$ 12,318,490	$ (391,452)	-3%
26	CONTRIBUTION TO CAPITAL RESERVES	$ 11,126,198	$ 5,541,631	$ 5,584,567	-101%
	OTHER EXPENSES (NON-CASH)				
27	Bond Premium/Discount Amortization	(506,357)			
28	Bond Refunding Cost Amortization	274,240			
29	Future Revenue Cost Amortization	67,576			
30	Depreciation	11,655,160			
31	NET OTHER EXPENSES (NON-CASH)	$ 11,490,619			

BUDGET TO ACTUAL REPORT
(UNAUDITED)
As of March 31, 2020

EXHIBIT 1-5

YEAR TO DATE

		ACTUAL Mar-20	BUDGET Mar-20	VARIANCE FAVORABLE (UNFAVORABLE)	% FAVORABLE (UNFAVORABLE)
	REVENUE				
1	Passenger Revenue	$ 12,829,323	$ 13,812,315	$ (982,992)	-7%
2	Advertising Revenue	625,000	627,462	(2,462)	0%
3	Investment Revenue	1,179,383	1,599,583	(420,200)	-26%
4	Sales Tax	83,535,228	77,954,640	5,580,588	7%
5	Other Revenue	2,127,353	2,109,722	17,631	1%
6	Fed Operations/Preventative Maint.	15,038,674	16,537,306	(1,498,632)	-9%
7	TOTAL REVENUE	$ 115,334,961	$ 112,641,028	$ 2,693,933	2%
	OPERATING EXPENSE				
8	Bus Service	$ 26,998,007	$ 27,663,742	$ 665,735	2%
9	Commuter Rail	5,803,338	6,479,553	676,215	10%
10	Light Rail	8,965,447	9,551,636	586,189	6%
11	Maintenance of Way	4,735,238	4,620,413	(114,825)	-2%
12	Paratransit Service	5,709,759	6,242,092	532,333	9%
13	RideShare/Van Pool Services	760,836	824,520	63,684	8%
14	Operations Support	11,946,963	12,629,645	682,682	5%
15	Administration	7,455,500	10,876,647	3,421,147	31%
16	TOTAL OPERATING EXPENSE	$ 72,375,088	$ 78,888,248	$ 6,513,160	8%
17	NET OPERATING INCOME (LOSS)	$ 42,959,873	$ 33,752,780	$ 9,207,093	27%
	NON-OPERATING EXPENSE (REVENUE)				
18	Planning & Development	$ 1,106,138	$ 1,541,878	$ 435,740	28%
19	Bond Principal	19,220,000	19,220,000	-	0%
20	Bond Interest	23,604,123	23,604,123	-	0%
21	Bond Interest UTCT	494,957	515,618	20,661	4%
22	Bond Cost of Issuance/Fees	774,317	18,100	(756,217)	-4178%
23	Lease Cost	2,165,098	2,370,899	205,801	9%
24	Sale of Assets	(31,436)	-	31,436	
25	TOTAL NON-OPERATING EXPENSE	$ 47,333,197	$ 47,252,519	$ (80,679)	0%
26	CONTRIBUTION TO CAPITAL RESERVES	$ (4,373,324)	$ (13,499,739)	$ 9,126,414	68%
	OTHER EXPENSES (NON-CASH)				
27	Bond Premium/Discount Amortization	(2,526,562)			
28	Bond Refunding Cost Amortization	1,459,451			
29	Future Revenue Cost Amortization	202,728			
30	Depreciation	34,142,464			
31	NET OTHER EXPENSES (NON-CASH)	$ 33,278,081			

BUDGET TO ACTUAL REPORT
(UNAUDITED)
As of March 31, 2020

EXHIBIT 1-5A

YEAR TO DATE

		ACTUAL Mar-20	BUDGET Mar-20	VARIANCE FAVORABLE (UNFAVORABLE)	% FAVORABLE (UNFAVORABLE)
	OPERATING EXPENSE				
1	Board of Trustees	$ 633,584	$ 757,056	$ 123,472	16%
2	Chief Communications and Marketing Officer	1,790,030	2,706,641	916,611	34%
3	Chief Finance Officer	3,027,739	3,305,859	278,120	8%
4	Chief Operating Officer	60,188,192	62,828,159	2,639,967	4%
5	Chief People Officer	1,687,753	2,018,703	330,950	16%
6	Chief Service Devlopment Officer	1,332,806	1,809,004	476,198	26%
7	Executive Director	4,821,122	7,004,704	2,183,582	31%
8	TOTAL OPERATING EXPENSE	$ 73,481,226	$ 80,430,127	$ 6,948,901	9%
9	Total Operating Expense (Exhibit 1-5, line 16)	72,375,088	78,888,248		
10	Planning & Development (Exhibit 1-5, line 18)	1,106,138	1,541,878		
11	TOTAL EXHIBIT 1-5	73,481,226	80,430,127		

CAPITAL PROJECTS
(UNAUDITED)
As of March 31, 2020

EXHIBIT 1-6

		2020 ACTUAL	ANNUAL BUDGET	PERCENT
	EXPENSES			
1	REVENUE AND NON-REVENUE VEHICLES	$ 186,495	$ 32,041,871	0.6%
2	INFORMATION TECHNOLOGY	343,983	6,531,838	5.3%
3	FACILITIES, MAINTENANCE & ADMIN. EQUIP.	108,720	2,750,000	4.0%
4	CAPITAL PROJECTS	3,559,032	38,347,444	9.3%
5	AIRPORT STATION RELOCATION	16,958	13,000,000	0.1%
6	STATE OF GOOD REPAIR	2,895,421	18,574,194	15.6%
7	DEPOT DISTRICT	609,493	40,936,916	1.5%
8	OGDEN/WEBER STATE BRT	681,230	28,197,076	2.4%
9	TIGER	38,184	11,169,660	0.3%
10	TOTAL	$ 8,439,516	$ 191,548,999	4.4%
	REVENUES			
11	GRANT	$ 898,109	$ 39,362,901	2.3%
12	STATE CONTRIBUTION	625,000	3,700,000	16.9%
13	LEASES (PAID TO DATE)	-	30,340,470	0.0%
14	BONDS	128,740	61,611,076	0.2%
15	LOCAL PARTNERS	164,621	13,415,957	1.2%
16	UTA FUNDING	6,623,046	43,118,595	15.4%
17	TOTAL	$ 8,439,516	$ 191,548,999	4.4%

FAREBOX RECOVERY & SPR
(UNAUDITED)
As of March 31, 2020

EXHIBIT 1-7

BY SERVICE

	CURRENT MONTH		YEAR TO DATE	
	Mar-20	Mar-19	2020	2019
UTA				
Fully Allocated Costs	24,065,049	23,358,613	72,375,088	69,297,287
Passenger Farebox Revenue	3,657,053	5,736,112	12,829,323	13,753,230
Passengers	2,618,050	3,763,319	10,193,685	11,041,078
Farebox Recovery Ratio	15.2%	24.6%	17.7%	19.8%
Actual Subsidy per Rider	$7.80	$4.68	$5.84	$5.03
BUS SERVICE				
Fully Allocated Costs	11,914,962	11,091,402	35,468,230	33,285,370
Passenger Farebox Revenue	1,533,764	2,326,764	5,203,971	5,519,881
Passengers	1,320,665	1,751,802	4,984,178	5,158,580
Farebox Recovery Ratio	12.9%	21.0%	14.7%	16.6%
Actual Subsidy per Rider	$7.86	$5.00	$6.07	$5.38
LIGHT RAIL SERVICE				
Fully Allocated Costs	6,342,724	6,866,962	19,425,915	19,647,722
Passenger Farebox Revenue	777,288	1,456,058	3,101,518	3,521,102
Passengers	924,603	1,417,872	3,654,330	4,130,677
Farebox Recovery Ratio	12.3%	21.2%	16.0%	17.9%
Actual Subsidy per Rider	$6.02	$3.82	$4.47	$3.90
COMMUTER RAIL SERVICE				
Fully Allocated Costs	3,213,379	3,174,178	9,881,077	9,443,929
Passenger Farebox Revenue	582,609	989,141	2,267,586	2,501,223
Passengers	235,489	436,191	1,092,787	1,273,252
Farebox Recovery Ratio	18.1%	31.2%	22.9%	26.5%
Actual Subsidy per Rider	$11.17	$5.01	$6.97	$5.45
PARATRANSIT				
Fully Allocated Costs	2,161,347	1,841,410	6,233,315	5,670,388
Passenger Farebox Revenue	428,784	613,113	1,223,676	1,169,876
Passengers	45,590	67,411	176,878	199,144
Farebox Recovery Ratio	19.8%	33.3%	19.6%	20.6%
Actual Subsidy per Rider	$38.00	$18.22	$28.32	$22.60
RIDESHARE				
Fully Allocated Costs	432,637	384,660	1,366,551	1,249,878
Passenger Farebox Revenue	334,608	351,036	1,032,572	1,041,148
Passengers	91,703	90,043	285,511	279,426
Farebox Recovery Ratio	77.3%	91.3%	75.6%	83.3%
Actual Subsidy per Rider	$1.07	$0.37	$1.17	$0.75

FAREBOX RECOVERY & SPR
(UNAUDITED)
As of March 31, 2020

EXHIBIT 1-8

BY TYPE

	CURRENT MONTH		YEAR TO DATE	
	Mar-20	Mar-19	2020	2019
FULLY ALLOCATED COSTS				
Bus Service	$11,914,962	$11,091,402	$35,468,230	$33,285,370
Light Rail Service	$6,342,724	$6,866,962	$19,425,915	$19,647,722
Commuter Rail Service	$3,213,379	$3,174,178	$9,881,077	$9,443,929
Paratransit	$2,161,347	$1,841,410	$6,233,315	$5,670,388
Rideshare	$432,637	$384,660	$1,366,551	$1,249,878
UTA	$24,065,049	$23,358,613	$72,375,088	$69,297,287
PASSENGER FAREBOX REVENUE				
Bus Service	$1,533,764	$2,326,764	$5,203,971	$5,519,881
Light Rail Service	$777,288	$1,456,058	$3,101,518	$3,521,102
Commuter Rail Service	$582,609	$989,141	$2,267,586	$2,501,223
Paratransit	$428,784	$613,113	$1,223,676	$1,169,876
Rideshare	$334,608	$351,036	$1,032,572	$1,041,148
UTA	$3,657,053	$5,736,112	$12,829,323	$13,753,230
PASSENGERS				
Bus Service	1,320,665	1,751,802	4,984,178	5,158,580
Light Rail Service	924,603	1,417,872	3,654,330	4,130,677
Commuter Rail Service	235,489	436,191	1,092,787	1,273,252
Paratransit	45,590	67,411	176,878	199,144
Rideshare	91,703	90,043	285,511	279,426
UTA	2,618,050	3,763,319	10,193,685	11,041,078
FAREBOX RECOVERY RATIO				
Bus Service	12.9%	21.0%	14.7%	16.6%
Light Rail Service	12.3%	21.2%	16.0%	17.9%
Commuter Rail Service	18.1%	31.2%	22.9%	26.5%
Paratransit	19.8%	33.3%	19.6%	20.6%
Rideshare	77.3%	91.3%	75.6%	83.3%
UTA	15.2%	24.6%	17.7%	19.8%
ACTUAL SUBSIDY PER RIDER				
Bus Service	$7.86	$5.00	$6.07	$5.38
Light Rail Service	$6.02	$3.82	$4.47	$3.90
Commuter Rail Service	$11.17	$5.01	$6.97	$5.45
Paratransit	$38.00	$18.22	$28.32	$22.60
Rideshare	$1.07	$0.37	$1.17	$0.75
UTA	$7.80	$4.68	$5.84	$5.03

SUMMARY OF ACCOUNTS RECEIVABLE
(UNAUDITED)
As of March 31, 2020

EXHIBIT 1-9

	Classification	Total	Current	31-60 Days	61-90 Days	90-120 Days	Over 120 Days
1	Federal Government [1]	$ 21,022,256	$ 21,022,256	$ -	$ -	$ -	$ -
2	Local Contributions [2]	59,081,019	59,081,019	-	-	-	-
3	Warranty Recovery	1,043,591	1,043,591	-	-	-	-
4	Product Sales and Development	902,176	617,913	249,948	29,176	269	4,870
5	Pass Sales	413,822	289,530	66,717	8,421	16,399	32,755
6	Property Management	101,062	55,293	22,104	-	-	23,665
7	Vanpool/Rideshare	114,857	5,431	26,593	20,417	11,704	50,712
8	Capital Development Agreements	1,112,265	1,111,906	-	-	-	359
9	Mobility Management	100	-	-	-	-	100
10	Paratransit	11,250	11,250	-	-	-	-
11	Other [3]	1,445,827	1,445,827	-	-	-	-
12	Total	$ 85,248,225	$ 84,684,016	$ 365,362	$ 58,014	$ 28,372	$ 112,461

Percentage Due by Aging

13	Federal Government [1]	100.0%	0.0%	0.0%	0.0%	0.0%
14	Local Contributions [2]	100.0%	0.0%	0.0%	0.0%	0.0%
15	Warranty Recovery	100.0%	0.0%	0.0%	0.0%	0.0%
16	Product Sales and Development	68.5%	27.7%	3.2%	0.0%	0.5%
17	Pass Sales	70.0%	16.1%	2.0%	4.0%	7.9%
18	Property Management	54.7%	21.9%	0.0%	0.0%	23.4%
19	Vanpool/Rideshare	4.7%	23.2%	17.8%	10.2%	44.2%
20	Capital Development Agreements	100.0%	0.0%	0.0%	0.0%	0.0%
21	Mobility Management	0.0%	0.0%	0.0%	0.0%	100.0%
22	Paratransit	100.0%	0.0%	0.0%	0.0%	0.0%
23	Other	100.0%	0.0%	0.0%	0.0%	0.0%
24	Total	99.3%	0.4%	0.1%	0.0%	0.1%

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

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

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

SUMMARY OF APPROVED DISBURSEMENTS OVER $200,000
FROM MARCH 1, 2020 THROUGH MARCH 31, 2020
(UNAUDITED)

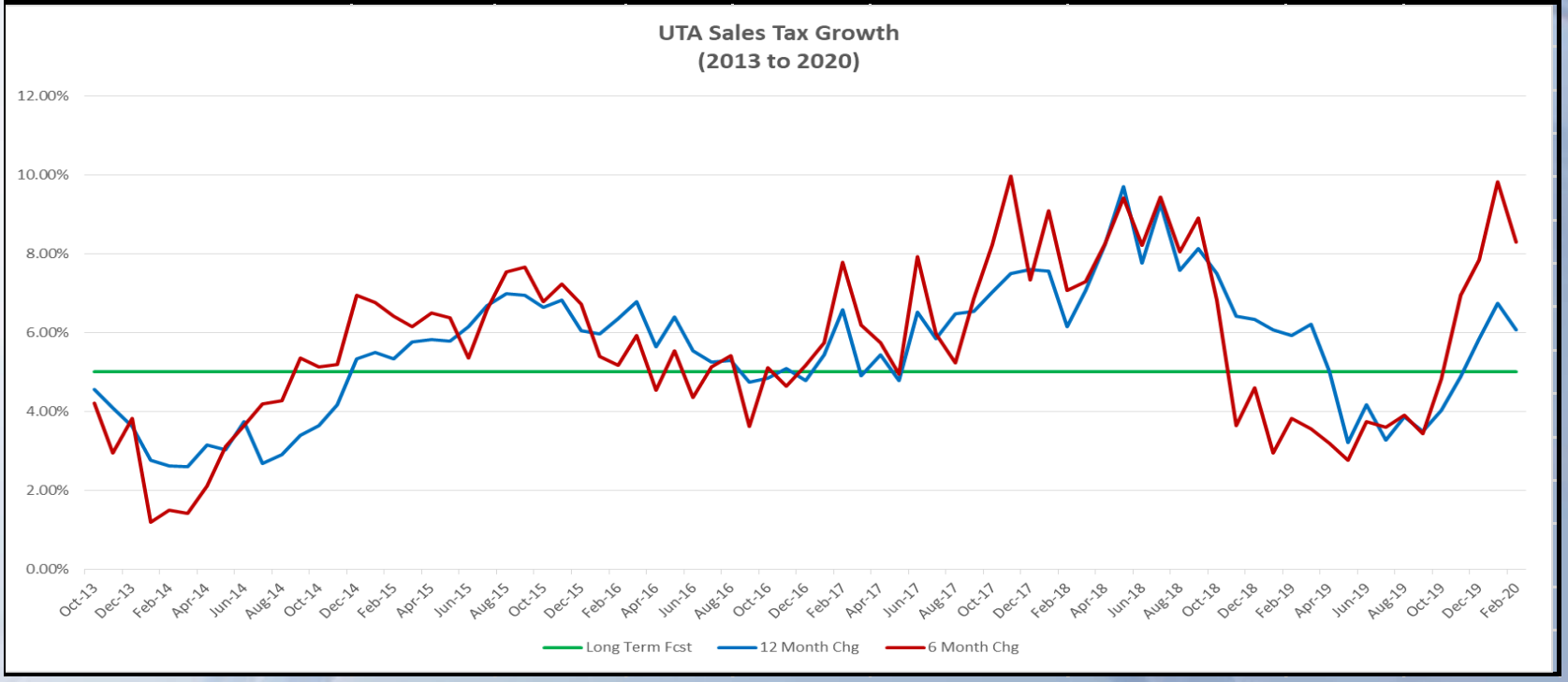
EXHIBIT 1-10

Contract # and Description		Contract Date	Vendor	Check #	Date	Check Total
R2018-05-09			ROCKY MOUNTAIN POWER	351860	3/5/2020	$ 216,537.41
ITEM#8(c)			SIEMENS MOBILITY, INC.	883495	3/25/2020	306,722.48
15-1383TB	DIESEL AND UNLEADED FUEL	10/1/2015	KELLERSTRASS OIL	883496	3/5/2020	437,750.70
R2018-05-09			ROCKY MOUNTAIN POWER	352094	3/12/2020	274,337.77
1198	PROVIDER AGREEMENT FOR MEDICAID	1/1/2015	UTAH DEPARTMENT OF HUMAN SERVICES	352095	3/12/2020	782,818.53
19-8695	UVU PED CROSSING OVER I-15	43480	UTAH DEPARTMENT OF TRANSPORTATION	352096	3/12/2020	2,000,000.00
14-1109TH	ADA PARATRANSIT AND ROUTE DEVIATION	9/1/2014	MV PUBLIC TRANSPORTATION	883551	3/12/2020	253,518.59
15-1383TB	DIESEL AND UNLEADED FUEL	10/1/2015	KELLERSTRASS OIL	883552	3/12/2020	270,269.41
R2018-05-09			ROCKY MOUNTAIN POWER	352260	3/26/2020	282,168.80
15-1383TB	DIESEL AND UNLEADED FUEL	10/1/2015	KELLERSTRASS OIL	883650	3/26/2020	286,808.06
15-1406JH	SD100 and 160 EHU & BRAKE CALIPER KITS	5/11/2016	SIEMENS MOBILITY, INC.	883651	3/26/2020	662,112.00

UTA Board Dashboard

March 2020

Financial Metrics	Mar Actual	Mar Budget	Fav/ (Unfav)	%	YTD Actual	YTD Budget	Fav/ (Unfav)	%
Sales Tax (Feb '20 mm $)	$ 22.0	$ 23.3	$ (1.32)	-5.7%	$ 50.4	$ 46.2	$ 4.28	9.3%
Fare Revenue (mm)	$ 3.7	$ 4.9	$ (1.20)	-24.7%	$ 12.8	$ 13.8	$ (0.98)	-7.1%
Operating Exp (mm)	$ 24.1	$ 26.0	$ 1.98	7.6%	$ 72.4	$ 78.9	$ 6.51	8.3%
Subsidy Per Rider (SPR)	$ 7.80	$ 5.88	$ (1.92)	-32.7%	$ 5.84	$ 5.88	$ 0.04	0.7%
UTA Diesel Price ($/gal)	$ 1.59	$ 2.50	$ 0.91	36.4%	$ 1.77	$ 2.50	$ 0.73	29.1%
Operating Metrics	**Mar Actual**	**Mar-20**	**F/ (UF)**	**%**	**YTD Actual**	**YTD 2018**	**F/ (UF)**	**%**
Ridership (mm)	2.62	3.76	(1.1)	-30.4%	10.19	11.04	(0.8)	-7.7%
Alternative Fuels	**CNG Price** (Diesel Gal Equiv)		$ 1.85					



MEMORANDUM TO THE BOARD

TO: Utah Transit Authority Board of Trustees
THROUGH: Carolyn Gonot, Executive Director
FROM: Mary DeLoretto, Chief Service Development Officer
PRESENTER(S): Mary DeLoretto, Chief Service Development Officer
Eddy Cumins, Chief Operating Officer

BOARD MEETING DATE: May 6, 2020

SUBJECT:	**R2020-05-01 Resolution Authorizing the Request for Emergency Funding Reimbursement of Coronavirus Aid Relief through the Federal Emergency Management Agency (FEMA) Public Assistance (PA) Program**
AGENDA ITEM TYPE:	**Resolution**
RECOMMENDATION:	Approve Resolution 2020-05-01 authorizing the Executive Director to execute grants from the FEMA Public Assistance (PA) Program and for UTA to submit future requests for reimbursement for emergency related life-saving protective measures and restoring public infrastructure.
BACKGROUND:	On Friday March 6, 2020 Governor Gary R. Herbert issued an executive order declaring a state of emergency in response to the evolving outbreak of novel coronavirus. The PA Grant Program is to support communities' recovery from major disasters. Funding eligibility includes life-saving emergency protective measures and restoring public infrastructure.
DISCUSSION:	Contact has been made with the Utah Division of Emergency Management and UTA received instruction to register with FEMA and submit the relevant documentation to be able to request reimbursement for emergency related costs. Eligible items include activities directed by a health official and activities directly related to the emergency i.e. labor, materials and supplies, equipment and contract work. Ongoing reimbursement requests will be in response to future needs for the emergency.
ALTERNATIVES:	This historic funding ensures that our public transportation system can continue to provide essential transit service to our communities.
FISCAL IMPACT:	The required match for the PA funding program is 75% federal 25% local match. The match will come from UTA's ongoing operating budget, or would need to be programmed in UTA's capital project budget if there are eligible capital expenses. The resolution limits permissible expenses applied to the FEMA PA Program to not exceed the approved 2020 Operating or Capital Budgets.

ATTACHMENTS:	• Resolution 2020-05-01 - Authorizing the Request for Emergency Funding Reimbursement of Coronavirus Aid Relief through the Federal Emergency Management Agency (FEMA) Public Assistance (PA) Program

RESOLUTION OF THE BOARD OF TRUSTEES OF THE UTAH TRANSIT AUTHORITY AUTHORIZING THE REQUEST FOR EMERGENCY FUNDING REIMBURSEMENT OF CORONAVIRUS AID RELIEF THROUGH THE FEDERAL EMERGENCY MANAGEMENT AGENCY PUBLIC ASSISTANCE PROGRAM

R2020-05-01 May 6, 2020

WHEREAS, the Utah Transit Authority (the "Authority") is a large public transit district organized under the laws of the State of Utah and was created to transact and exercise all of the powers provided for in the Utah Limited Purpose Local Government Entities – Local Districts Act and the Utah Public Transit District Act; and

WHEREAS, on March 6, 2020, Utah Governor Gary Herbert declared a State of Emergency in Utah due to the Novel Coronavirus COVID-19 pandemic; and

WHEREAS, the Federal Emergency Management Agency (FEMA) established the Public Assistance (PA) Program to support communities' recovery from major disasters; and

WHEREAS, the funding eligibility for the FEMA PA Program includes reimbursement to the authority for a portion of expenses related to life-saving emergency protective measures and restoring public infrastructure; and

WHEREAS, the Utah Division of Emergency Management instructed the Authority to register with FEMA and submit relevant documentation to be able to receive reimbursement for certain qualifying expenses related to the current State of Emergency; and

WHEREAS, the Board of the Authority desires to delegate authority to the Executive Director to submit requests for reimbursement of all qualifying expenses for emergency related life-saving protective measures and restoring public infrastructure.

NOW, THEREFORE, BE IT RESOLVED by the Board of the Authority:

1. That the Board authorizes the Executive Director to begin immediate registration with the FEMA Public Assistance (PA) Program for coronavirus aid relief.

2. That the Board authorizes the Executive Director to begin submission of requests for reimbursement of all qualifying expenses for emergency

related life-saving protective measures and restoring public infrastructure for:

a. Expenses allowed or permissible under the FEMA PA Program; and

b. Expenses that do not exceed the approved 2020 Operating or Capital Budgets.

3. That the Board instructs the Executive Director and/or her designee to report regularly to the Board as to the status of all reimbursement requests to the FEMA PA Program.

4. That the Board hereby ratifies all actions previously taken by the Authority's management, staff, and counsel to prepare for and obtain reimbursement under the FEMA PA Program.

5. That the corporate seal be attached hereto.

Approved and adopted this 6th day of May 2020.

_____
Carlton Christensen, Chair
Board of Trustees

ATTEST:

_____ (Corporate Seal)

Robert K. Biles, Secretary/Treasurer

Approved As To Form:

_____
Legal Counsel

MEMORANDUM TO THE BOARD

TO: Utah Transit Authority Board of Trustees
THROUGH: Carolyn Gonot, Executive Director
FROM: Kent J. Millington, Pension Committee Chair
PRESENTER(S): Kent J. Millington, Pension Committee Chair

BOARD MEETING DATE: May 6, 2020

SUBJECT:	**Actuarial Services (Milliman)**	
AGENDA ITEM TYPE:	**Expense Contract Change Order**	
RECOMMENDATION:	Approve award and authorize the Executive Director to carry-out the contract extension and associated disbursements.	
BACKGROUND:	This is a contract renewal for Actuarial Services for UTA's Pension Fund between Utah Transit Authority (UTA), and Milliman.	
DISCUSSION:	Milliman has been providing actuarial services to UTA since 2014. Their services were competitively compared to other firms and proved to be more technically sound for the applicable pricing (Best Overall Value). The base contract includes a clause that allows for automatic renewal for the period of October 2019 through October 2020. This renewal occurred automatically. UTA has taken action to cancel the next renewal and plans to conduct an open competition in the Fall.	
CONTRACT SUMMARY:	Contractor Name: Milliman Actuarial Services	
	Contract Number: UT-14-01JL	Existing Contract Value: $192,300
	Base Contract Effective Dates: 10/15/2014 – 10/31/2019	Extended Contract Dates: 11/01/2019 – 10/31/2020
	Amendment Amount: $46,400	New/Total Amount Contract Value: $238,700
	Procurement Method: RFP	Funding Sources: Local
ALTERNATIVES:	Milliman was compared to other firms through the competitive bidding process, which allowed the selection committee to determine that they provided the best overall value. In the instance the contract extension is denied, UTA would need to activate the competitive bidding process per procurement regulations. Overall, this could cause a	

	delay in the 2020 actuarial reports to the pension committee which may impact funding projections.
FISCAL IMPACT:	Funded through the UTA Pension Account and paid by Advanced CFO
ATTACHMENTS:	• Milliman Actuarial Services Original Contract

CONSULTING SERVICES AGREEMENT

This Agreement is entered into between Milliman, Inc. ("Milliman") and the Utah Transit Authority ("UTA") as of October 15th, 2014 ("Effective Date"). UTA has engaged Milliman to perform consulting services subject to the terms and conditions of this Agreement, RFP UT-14-01JL, and Milliman's proposal dated August 26, 2014, which is attached as Exhibit A and which is incorporated by this reference. These terms and conditions will apply to all subsequent engagements of Milliman by UTA unless specifically disclaimed in writing by both parties prior to the beginning of the engagement. Milliman and UTA agree as follows.

1. **TERM.** Subject to the provisions for termination as hereinafter provided, this Agreement shall be effective from Effective Date through October 31, 2019 and shall automatically renew for another one (1) year term thereafter unless either party provides notice to the other of its intent to terminate this Agreement not less than thirty (30) days before the end of the then current term.

2. **BILLING TERMS.** UTA acknowledges the obligation to pay Milliman for services rendered, whether arising from UTA's request or otherwise necessary as a result of this engagement, at Milliman's hourly billing rates for the personnel utilized, as reflected in Exhibit A plus all reasonable out-of-pocket expenses incurred. Milliman will bill UTA periodically for services rendered and expenses incurred. All invoices are payable upon receipt. Milliman reserves the right to stop all work if any bill goes unpaid for 60 days. In the event of such termination, Milliman shall be entitled to collect the outstanding balance, as well as charges for all services and expenses incurred up to the date of termination.

3. **TOOL DEVELOPMENT.** Milliman shall retain all rights, title and interest (including, without limitation, all copyrights, patents, service marks, trademarks, trade secret and other intellectual property rights) in and to all technical or internal designs, methods, ideas, concepts, know-how, techniques, generic documents and templates that have been previously developed by Milliman or developed during the course of the provision of the Services provided such generic documents or templates do not contain any UTA Confidential Information or proprietary data ("Milliman Tools"). Rights and ownership by Milliman of Milliman Tools shall not extend to or include all or any part of UTA's proprietary data or Confidential Information. To the extent that Milliman may include in the materials any Milliman Tools, Milliman agrees that UTA shall be deemed to have a fully paid up license to make copies of Milliman Tools as part of this engagement for its internal business purposes and provided that such Milliman Tools cannot be modified or distributed outside the Company without the written permission of Milliman or except as otherwise permitted hereunder.

4. **LIMITATION OF LIABILITY AND INDEMNIFICATION.** Milliman will perform all services in accordance with applicable professional standards. The parties agree that Milliman, its officers, directors, agents and employees, shall not be liable to Company, under any theory of law including negligence, tort, breach of contract or otherwise, for any damages in excess of ten million dollars ($10,000,000.00). The existence of multiple claims will not expand or increase the foregoing limitation. In no event shall Milliman be liable for lost profits of UTA or any other type of incidental or consequential damages.

The foregoing limitations shall not apply in the event of the intentional fraud or willful misconduct of Milliman.

Milliman shall indemnify, hold harmless and, not excluding UTA's right to participate at its own cost and expense, defend UTA, its officers, officials, agents, and employees from and against all liabilities, claims, actions, damages, losses, and expenses including, without limitation reasonable attorneys' fees and costs (hereinafter referred collectively as "claims") for loss or damage to tangible or intangible property stemming from third party claims alleging gross negligence, fraud or willful misconduct by Milliman or any of its owners, officers, directors, agents, employees or subcontractors in their performance of services under this Agreement. This indemnity includes any claim or amount arising out of the failure of Milliman to conform to any law, statute, ordinance, rule, regulation or court decree. It is the specific intention of the parties that UTA shall, in all instances, except for claims arising primarily from the negligent or willful acts or omissions of UTA, be indemnified by Milliman as agreed above. It is agreed that Milliman will be responsible for primary loss investigation, defense and judgment costs where this indemnification is applicable. In consideration of the award of this contract, Milliman agrees to waive all rights of subrogation against UTA, its officers, officials, agents and employees for losses arising from the work performed by Milliman for UTA.

5. **DISPUTES.** If any dispute occurs between the parties, they shall attempt in good faith to resolve the dispute by informal negotiations between senior level executives with decision making from each party. If such negotiation fails after a good-faith effort has occurred, only then may a party institute litigation. If a party files a lawsuit, and if both a state and a federal court have subject matter jurisdiction over all of the claims to be filed, then the party shall file such suit in federal district court. Both parties agree to waive the right to a trial by jury.

6. **AMENDMENT.** This Agreement constitutes the entire agreement and understanding between the parties with respect to the transactions contemplated herein and may not be modified or amended except in writing signed by both parties.

7. **CHOICE OF LAW.** The construction, interpretation, and enforcement of this Agreement shall be governed by the substantive contract law of the State of Utah without regard to its conflict of laws provisions. In the event any provision of this agreement is unenforceable as a matter of law, the remaining provisions will stay in full force and effect.

8. **NO THIRD PARTY DISTRIBUTION.** Milliman's work is prepared solely for the internal business use of UTA. To the extent that Milliman's work is not subject to disclosure under applicable public records laws, Milliman's work may not be provided to third parties without Milliman's prior written consent. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work product, and Milliman may include a legend on its reports so stating. UTA agrees not to remove any such disclaimer language from Milliman's work. Milliman's consent to release its work product to any third party may be conditioned on the third party signing a release agreement, subject to the following exception(s): (a) UTA may provide a copy of Milliman's work, in its entirety, to the UTA's professional service advisors who are subject to a duty of confidentiality and who agree to not use Milliman's work for any purpose other than to benefit the UTA; and (b) UTA may provide a copy of Milliman's work, in its entirety, to other governmental entities, as required by law. No third party recipient of Milliman's work product should

rely upon Milliman's work product. Such recipients should engage qualified professionals for advice appropriate to their own specific needs.

9. **DATA RELIANCE.** In performing the services Milliman will rely on data and other information provided by UTA and other sources. Milliman cannot warrant the correctness, accuracy or completeness of data supplied by UTA or third parties at Company's direction, nor can Milliman be responsible for data not provided in a timely manner. If the underlying data or information is inaccurate or incomplete, the results of Milliman's analysis may likewise be inaccurate or incomplete. In that event, the results of Milliman's analysis may not be suitable for the intended purpose.

10. **FORCE MAJEURE.** Neither Milliman nor UTA will be liable for any delay or failure in performance of this Agreement resulting directly or indirectly from any cause beyond their control, including, without limitation, acts of nature, acts of war, governmental actions, fire, labor strikes, work stoppages, civil disturbances, interruptions or unavailability of power or other utilities, unavailability of communications facilities, failure of electronic or mechanical equipment, failure of communication lines or equipment, or other interconnection problems, or failure of Milliman's suppliers.

11. **TERMINATION.** Either party may, upon giving thirty (30) days written notice to the other party, choose to terminate this Agreement absent a demonstration of cause. However, in the event UTA chooses to terminate this Agreement and any project(s) are outstanding and unfinished as of the effective date of termination, such termination shall not become effective until Milliman has delivered the completed project(s), unless the termination notice specifically states otherwise. For clarity, any terms of this Agreement which by their nature extend beyond its termination shall remain in full force and effect following termination.

12. **CONFIDENTIALITY.** Any information received from UTA will be considered "Confidential Information." However, information received from UTA will not be considered Confidential Information if (a) the information is or comes to be generally available to the public through no fault of Milliman, (b) the information was independently developed by Milliman without resort to information from UTA, or (c) Milliman appropriately receives the information from another source who is not under an obligation of confidentiality to UTA. Milliman agrees that Confidential Information shall not be disclosed to any third party.

13. **INSURANCE REQUIREMENTS.** Milliman, as an independent contractor, shall be responsible to provide and pay the cost of all its employees' benefits. For the duration of this Agreement and at its own expense, Milliman shall procure and maintain until all of its obligations have been discharged, including any warranty periods under this Agreement are satisfied, insurance against claims for injury to persons or damage to property which may arise from or in connection with the performance of the work hereunder by Milliman, its agents, representatives, employees or subcontractors.

    The insurance requirements herein are minimum requirements for this Agreement and in no way limit the indemnity covenants contained in this Agreement. UTA in no way warrants that the minimum limits contained herein are sufficient to protect Milliman from liabilities that might arise out of the performance of the work under this Agreement by Milliman, its agents, representatives, employees or subcontractors and Milliman is free to purchase additional insurance as may be determined necessary.

13.1 Minimum Scope and Limits of Insurance. Milliman shall provide coverage with limits of liability not less than those stated below. An excess liability policy or umbrella liability policy may be used to meet the minimum liability requirements provided that the coverage is written on a "following form" basis.

13.2 Commercial General Liability – Occurrence Form
Policy shall include bodily injury, property damage and broad form contractual liability coverage.

General and Products – Completed Operations Aggregate	$2,000,000
Personal and Advertising Injury	$1,000,000
Each Occurrence	$1,000,000

The policy shall be endorsed to include the following additional insured language: "The Utah Transit Authority shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of Milliman".

13.3 Worker's Compensation and Employers' Liability

Workers' Compensation	Statutory
Employers' Liability	
Each Accident	$100,000
Disease – Each Employee	$100,000
Disease – Policy Limit	$500,000

Policy shall contain a waiver of subrogation against UTA. This requirement shall not apply when a contractor or subcontractor is exempt under UCA, and when such contractor or subcontractor executes the appropriate waiver form.

13.4 Professional Liability (Errors and Omissions Liability). The policy shall cover professional misconduct or lack of ordinary skill for those positions defined in the Scope of Services of this contract.

Each Claim	$1,000,000
Annual Aggregate	$2,000,000

In the event that the professional liability insurance required by this Agreement is written on a claims-made basis, Milliman warrants that any retroactive date under the policy shall precede the effective date of this Agreement; and that either continuous coverage will be maintained or an extended discovery period will be exercised for a period of three (3) years beginning at the time work under this Agreement is completed.

13.5 Acceptability of Insurers. Insurance is to be placed with insurers duly licensed or authorized to do business in the State of Utah and with an "A.M. Best" rating of not less than A-VII. UTA in no way warrants that the above-required minimum insurer rating is sufficient to protect Milliman from potential insurer insolvency.

13.6 Verification of Coverage. Milliman shall furnish UTA with certificates of insurance (ACORD form or equivalent approved by UTA) as required by this Agreement. The certificates for each insurance policy are to be signed by the person authorized by that insurer to bind coverage on its behalf. All certificates and any required endorsements are to be received and approved by UTA before work commences. Each insurance policy required by this Agreement must be in effect at or prior to commencement of work

under this Agreement and remain in effect for the duration of the project. Failure to maintain the insurance policies as required by this Agreement or to provide evidence of renewal is a material breach of contract. All certificates required by this Agreement shall be sent directly to the Contract Manager. UTA reserves the right to request complete copies of all insurance policies required by this Agreement be made available to UTA for review at any time with reasonable notice.

14. **CONTRACT MANAGER.** The UTA Contract Administrator for this Agreement is Ms. Linda Knudsen (lknudsen@rideuta.com, 801.287.2235), or designee. All questions and correspondence relating to the contractual aspects of this Agreement should be directed to Troy Hamilton (thamilton@rideuta.com, 801.287,2321), or designee.

15. **NOTICES.** Any notice given in connection with this Agreement shall be given in writing and shall be delivered either by hand to the party or by certified mail, return receipt requested, to the party at the party's address stated herein. Any party may change its address stated herein by giving notice of the change in accordance with this paragraph.

UTA:

Utah Transit Authority
ATTN: Grants & Contracts Administrator
669 West 200 South
Salt Lake City, UT 84101
Phone: (801) 262-5626

With copy to:

Utah Transit Authority
ATTN: Office of General Counsel
669 West 200 South
Salt Lake City, UT 84101

MILLIMAN:

MILLIMAN, INC.

By: _____
Name: Matt Larrabee
Title: Principal, Consulting Actuary
Date: October 15, 2014

UTAH TRANSIT AUTHORITY

By: _____
Name: Necia D Christensen
Title: Pension Comm Chair
Date: 10-21-14

By: _____
Name: CFO - Treasurer
Title: Robert K. Biles

Date: 10/20/14

APPROVED AS TO FORM:

UTA Legal Counsel

EXHIBIT A

RFP and MILLIMAN PROPOSAL
(dated August 26, 2014)

REQUEST FOR PROPOSALS

Cover Sheet

General Information			
Project Name	Pension Actuarial Consulting Services		
Project Description	The UTA Pension Committee seeks to retain the services of a qualified actuary to provide consulting services for its retirement plans.		
Project Start Date/Length	Start Date: October 1, 2014 Contract Length: Multi-year agreement for up to five (5) years with an option for an additional two (2) years.		
UTA Project Manager	Linda Knudsen		
Funding Source	X Local	☐ State	☐ Federal
Procurement Process Information			
RFP No.	UT-14-01JL		
Contract Administrator	Janalee Hansen 669 West 200 South Salt Lake City, Utah 84101 (801) 287-2395 jhansen@rideuta.com **All communications regarding this RFP must be in writing and addressed to the Contract Administrator.**		
Evaluation Criteria: • Firm and Personnel - Capabilities • Proposed Costs/Fees • Actuarial Consulting - Qualifications and Experience • Valuation Services - Qualifications and Experience • Administrative, Plan Design and Compliance Consulting - Qualifications and Experience • Additional Services • References	This is a **best value** procurement. Evaluation Criteria are listed in descending order of importance. See Part 2 for more information on the proposal content and rating method.		

RFP Schedule:

A)	Issue Request for Proposals	July 28, 2014
B)	Deadline to submit Questions and Request for Approved Equals or Changes to UTA	August 7, 2014, 12:00 noon MDT
C)	Last day for UTA to issue addenda and clarifications	August 14, 2014
D)	**Deadline to submit Proposals**	**August 26, 2014, 2:00 pm MDT**
E)	Presentations/Interviews/Problem-Solving Exercises(optional)	TBD

Included as part of this RFP		
Part 1 – Project Specific Information		
Part 2 – Procurement Process Information		
Part 3 – Standard Solicitation Terms		
Part 4 – Standard Contract Terms / Sample Contract		
Part 5 – Forms		
Proposal Contents		
Page Limit Cover pages, table of contents, divider tabs, resumes, Appendices, the Price Proposal, and required forms do not count toward the page limit.	None	

Submittal Instructions

- One (1) original and five (5) copies of the Proposal in a sealed box/envelope marked "Pension Actuarial Services UT-14-01JL", and
- One electronic copy of the Proposal. No fax or email submissions will be accepted.

Required Forms To be considered responsive, Proposals must include the forms, declarations, and certifications below:		
• Joint Venture • Subcontractors • Addenda • Signature		

UTA

REQUEST FOR PROPOSALS

Part 1 – Project Specific Information

1.0 SCOPE OF SERVICES

The Utah Transit Authority Pension Committee, Trustees of the Utah Transit Authority Employee Retirement Plan and Trust Agreement, intends to obtain a contract for consulting services for its retirement plans. The areas of desired services are as follows:

Actuarial Consulting
Valuation Services
Plan Design and Compliance Consulting
Additional Services

The Utah Transit Authority Pension Committee (Pension Committee) administers a $136 million defined benefit pension plan. The defined benefit plan currently has 1,956 active participants, 283 terminated vested participants, and 390 retired participants and beneficiaries.

The Pension Committee requires that proposals respond to the specifications listed in this document. UTA requests that responses be in the same order as they are found in the specifications. Generic proposals will not be evaluated further unless they specify, by title, the areas of evaluation criteria as listed in this request for proposal.

The Pension Committee would be interested in knowing what other services you provide not listed in this RFP that may be of interest to the Committee. (See Section 3.4)

Copies of the Actuarial Valuation and Review as of January 1, 2014 and Audited Financial Statements for the year ended December 31, 2013 have been included with this RFP.

2.0 SPECIFICATIONS

The Pension Committee is interested in obtaining proposals for actuarial consulting, valuation services, plan design, and compliance consulting services for its retirement plan. The Pension Committee is also interested in entering into a multi-year agreement for up to five years with an option for an additional two years.

3.0 PROPOSED SERVICES TO BE PROVIDED

3.1 Actuarial Consulting

Provide your qualifications and experience in the following actuarial consulting items. Include examples of your leadership.

3.11 Appear at selected meetings for discussion of actuarial standards and/or the principles used in the determination of the funding requirement and in the pricing of collective bargaining agreements. Utah Transit Authority desires to be fully funded by 2033 and would like to have a level percent of pay funding to achieve this goal.

3.12 Give an annual report to the Trustees of the defined benefit plan.

3.13 Develop and provide various tables and factors needed by the defined benefit plan. These include, but are not limited to, mortality tables, present value factors and survivor benefit factors. Periodically a spreadsheet will need to be updated and provided to the plan administrator for the purpose of calculating present values.

3.2 Valuation Services

3.21 Actuarial valuations shall be performed each year as of January 1.

A. Reports for these valuations shall be delivered to UTA, by the Contractor, no later than eight (8) weeks after UTA has delivered complete data for the valuation to the Contractor.

B. When an Experience Analysis is performed, if it results in the adoption of any assumption which differs from those used for the prior valuation, the Contractor shall produce valuation results using both the old and new assumptions.

C. If an Experience Analysis is not performed, the Contractor shall use the same actuarial assumptions that were used for the prior valuation. If analysis of the current data during the performance of the valuation indicates any material variations from those assumptions, the Contractor shall be expected to discuss the variations in the valuation report and present an estimate of the effect on the normal cost and/or on the unfunded actuarial liability of the plan.

3.22 Valuation reports shall contain sufficient explanatory text to permit a reasonable understanding of the actuarial assumptions, cost methods and conclusions by competent actuaries and by persons knowledgeable in the public pension field. This shall include, but not be limited to, a summary of the plan, description of actuarial assumptions and cost methods, display of age groups and service matrices for active members and display of retired lives by age groups, and types of benefits. All text and schedules shall be prepared in accordance with GASB principles and reporting requirements.

3.23 GASB 67 & 68 calculations shall be performed each year as of December 31.

3.3 Administrative, Plan Design and Compliance Consulting

3.31 Give consultation for general retirement plan design and compliance with regulatory agencies that have jurisdiction over public plans.

3.32 Provide consultation and advisory services on any technical, policy, legal, tax related, or administrative problems arising during the course of operations.

3.33 Assist in maintaining a Qualified Plan under IRS Code, as applied to public employers.

3.34 Assist in maintaining compliance with ERISA or other Labor Standards, as applied to public employers.

3.35 Assist in amending the defined benefit plan document and writing understandable language for the Summary Plan Description.

3.36 Make recommendations from time to time relative to possible improvements in the financing and benefit structure of the defined benefit plan and to give effect to new developments in the retirement industry.

3.37 Give consultation and advisory services in the policy and administrative problems of implementing new collective bargaining agreements.

3.4 Additional Services

3.41 Experience Analysis Services:
Actuarial gain/loss Experience Analyses shall be performed on an as needed basis.

3.42 Disability Benefit amounts will need to be calculated occasionally.

3.43 Provide calculations on special benefit cases. The pension administrator may on occasion request the actuary to perform an individual benefit calculation. The situation would arise most often in the case of a Qualified Domestic Relations Order or for a participant that has retired and then returned to work. A new benefit calculation would be required to determine the new benefit amount when the participant retires the second time.

3.44 Develop an online interactive benefit calculator for active participants. This calculator should include single life annuity, joint and survivor annuity, life annuity with ten year term certain, lump sum and cost of permissive service credit calculations.

3.45 Give consultation on and perform certain work in pricing proposed benefit changes in the collective bargaining agreement. Statement of the firm's ability to perform pricing analysis of proposed plan changes that may be considered during the collective bargaining negotiations, complete with actuarial certificate showing assumptions, pricing base, actuarial implications on total program, cost and alternative funding techniques. UTA will provide 48 hours' notice for these services (but may on special occasions, such as during bargaining sessions, require working estimates immediately.)

3.46 Assist with the development of any new retirement plans.

UTA

REQUEST FOR PROPOSALS

Part 2 – Procurement Process Information

A. PROPOSAL FORMAT

Proposals must adhere to the following format:

- Proposals should be printed primarily on 8 ½ by 11 inch paper. 11 by 17 inch paper may be used for charts, tables, and schedules. No text should be included on 11 by 17 inch size paper except for text that is required for the interpretation of the chart, table, or schedule.
- Proposals should be bound along the left edge.
- Proposals should be printed in a minimum of 12-point font.
- If a Proposal is submitted in double-sided format, both sides of the page will be counted against the Page Limit.

Failure to follow the format described above may result in the Proposal being deemed non-responsive.

B. PROPOSAL CONTENT

Proposals must address the following information in the order listed below: *Please answer each question below and* **describe in detail** *how proposer would accomplish each task. Include timeline and price structure as needed.*

The Proposal should consist of the following sections:

Tab 1: Cover Letter

Provide a cover letter indicating the firm's willingness to enter into an agreement with the UTA Pension Committee. An officer of the company who has the authority to commit the firm to the proposed project must sign this letter. Proposals will include the full name, legal status (corporation, state of incorporation, partnership, proprietorship, etc.), business address of the Offeror, and telephone number. Please include one or two **e-mail addresses where you could be notified of an oral interview**. The proposal must be signed by a principal of the business who is authorized to execute any subsequent contract. The name of the principal and his/her business title will be included in the signature element in either type or print.

Tab 2: Firm Experience and Actuarial Capability

a. The firm's name, home office address and telephone number, and the address and telephone number of the office providing the services under the contract.

b. General description of the firm, including size, number of employees, primary business (consulting, pension planning, insurance, etc.), other business or services, type of organization (franchise, corporation, partnership, etc.) and other descriptive material.

c. State which of the firm's offices will service this account and indicate if the valuation service is performed in a centralized location or if it is performed at the same office that services the account.

d. Describe your firm's experience and qualifications in plan design and compliance consulting.

e. Describe your firm's advantage over other firms and explain why the UTA Pension Committee should hire your firm.

f. Describe the steps your firm will take in transitioning from the current actuarial consultant to your firm.

Tab 3: Assigned Personnel and Qualifications

a. Identify the personnel who shall be performing consulting services under the contract.

b. Provide brief summary information regarding the professional and experience qualifications of the personnel providing the consulting services under the contract.

Tab 4: Pricing and Fees

a. Please indicate pricing for the services requested. If some services are billed at an hourly rate, indicate which services those are and provide the hourly rates.

b. Provide annual fee for the Scope of Services listed in Sections 3.1 – 3.3

c. If you propose additional services, such services should be outlined and separately priced in your proposal.

d. Provide fees for additional services listed in Section 3.4

Tab 5: References

a. Provide a list of public employee retirement systems for which the personnel you propose to perform consulting services currently provide consulting services and an indication of the type of consulting services provided and type of plan covered. Include system name, approximate number of participants and number of years firm has been retained. For three (3) public employee retirement systems (of comparable size to UTA's) included on the list, provide the address, telephone number, name and title of person(s) responsible for the administration of the system so UTA may contact them for a reference.

Tab 6: Forms

a. Joint Venture
b. Subconsultants
c. Addenda
d. Signature

Proposal forms are supplied for the purpose of listing the Proposer's team or individual data. The Proposer shall supply the data in the appropriate form. A Proposer's failure to follow the format specified may be considered non-responsive.

C. RATING OF PROPOSALS

The UTA Pension Committee will make the award to the responsible Proposer(s) on the basis of what is determined by its evaluation committee to be the best value to UTA, following a selection process in which both price and qualitative components of each proposal are evaluated.

Each Proposal will be evaluated based upon a scoring system from 1 to 100. The scoring will be done based upon how well the proposal meets the evaluation criteria set forth in the Cover Letter of this RFP, in the sole discretion of the UTA Pension Committee.

UTA

REQUEST FOR PROPOSALS

Part 3 – Procurement Terms and Conditions

A. INSTRUCTIONS TO PROPOSERS

i. Submission of Proposals.

Proposals will be received at UTA, 669 West 200 South, Salt Lake City, UT 84101 by the UTA Contract Administrator, and will be time/date stamped upon receipt at that location. Any Proposal received after the Deadline to Submit Proposals listed on the RFP Cover Sheet may be considered non-responsive. It is the responsibility of the Proposer to ensure that its Proposal arrives at the designated location and person by the specified time.

ii. Minimum Standards.

This RFP sets forth the minimum requirements that all Proposals must meet. Failure to submit Proposals in accordance with this RFP may render the Proposal unacceptable or non-responsive. UTA may, in its sole discretion, waive minor irregularities in a Proposal that do not alter the quality or quantity of the information provided.

iii. Confidential, Protected, and Public Information

In accordance with Utah Code Section 63G-2-305(6) of the Government Records Access and Management Act (GRAMA) and UTA's Procurement Standard Operating Procedures (SOPs), procurement information related to this procurement will not be made public until after execution of the Contract with the successful Proposer. Procurement information includes the Proposals submitted by Proposers in response to this RFP and any accompanying documentation, as well as records maintained by UTA during the procurement process.

UTA will maintain a process to ensure confidentiality for the duration of this procurement. If the Proposer submits information in its Proposal that it believes is "trade secret," the Proposer must follow the procedure set forth in Section 63G-2-309 of GRAMA.

Additionally, for ease of Proposal evaluation, UTA requests that each Proposer also follow the steps identified below:

a) Clearly mark all trade secret information as such in its Proposal at the time the Proposal is submitted and include a cover sheet stating "DOCUMENT CONTAINS TRADE SECRET INFORMATION" and identifying each section and page which has been so marked;

b) Include a statement with its Proposal justifying the Proposer's determination that certain records are trade secret information for each record so defined;

c) In addition to the Proposal copies submitted in accordance with the Submittal Instructions on the RFP Cover Sheet, submit one hard and one electronic copy of the Proposal that has all the trade secret information deleted from the Proposal and

label such copy of the Proposal **"Public Copy."** If a Proposer submits a Proposal containing no trade secret information, no "Public Copy" need be submitted. However, any Proposer that submits a Proposal containing no trade secret information must so certify in a cover letter to its Proposal and still must submit one electronic copy of the Proposal; and

d) Defend any action seeking release of the records it believes to be trade secret information and indemnify, defend, and hold harmless UTA and the State of Utah and its agents and employees from any judgments awarded against UTA and its agents and employees in favor of the party requesting the records, including any and all costs connected with that defense. This indemnification survives UTA's cancellation or termination of this procurement or award and subsequent execution of the Contract. In submitting a Proposal, the Proposer agrees that this indemnification survives as long as the trade secret information is in possession of UTA.

All records pertaining to this procurement will become public information after execution of the Contract, unless such records are identified as trade secret information as specified above. No liability will attach to UTA for the errant release of trade secret information by UTA under any circumstances.

iv. Submitting Questions to UTA

Questions must be submitted via email. All questions must be directed to the Contract Administrator identified on the RFP Cover Sheet. Questions must be received no later than the Deadline to submit Questions and Requests for Approved Equals or Changes listed on the RFP Cover Sheet.

UTA's answers to timely questions will be issued by the Contract Administrator no later than the Last day for UTA to issue Addenda and Clarifications, listed on the RFP Cover Sheet. Answers will be issued to all firms or persons that have submitted a Letter of Interest, without attribution.

v. Requests for Approved Equals or Changes

Requests for Approved Equals, Changes, or other exceptions to the RFP (collectively, "Requests") must be submitted via email. All Requests must be directed to the Contract Administrator identified on the RFP Cover Sheet. Requests must be received no later than the Deadline to submit Questions and Requests for Approved Equals or Changes listed on the RFP Cover Sheet.

Whenever a brand, manufacturer, or product name is indicated in this RFP, they are included only for the purpose of establishing identification and a general description of the item. Wherever such names appear, the term "or approved equal" is considered to follow.

Any request for an approved equal or request for change of the RFP must be fully supported with technical data, test results, or other pertinent information as evidence that the substitute offered is equal or better than the RFP requirement.

UTA's responses to timely Requests will be issued by the Contract Administrator no later than the Last day for UTA to issue Addenda and Clarifications, listed on the RFP Cover Sheet. Responses will be issued to all firms or persons that have submitted a Letter of Interest, without attribution.

It should be understood that specifying a brand name, components, and/or equipment in this RFP will not relieve the Proposer from its responsibility to provide the product in accordance with the performance warranty and contractual requirements. The Proposer shall notify UTA of any inappropriate brand name, component, and/or equipment that may be called for in this RFP and shall propose a suitable substitute for consideration.

vi. Addenda to the Request for Proposals

UTA reserves the right to make changes to the RFP, by issuing a written addendum to the RFP which will be issued to all firms or individuals that have communicated to the UTA Contract Administration, in writing, their interest in submitting a Proposal.

vii. Multiple or Alternative Proposals

Submission of multiple or alternative Proposals, except as specifically called for in the RFP, may render all such Proposals non-responsive and may cause the rejection of some or all of such Proposals.

viii. Withdrawal of Proposals

A Proposer may withdraw its Proposal before the Proposal due date without prejudice to itself by submitting a written request for its withdrawal to UTA's Grants and Contracts Administrator. If a Proposer withdraws its Proposal prior to the Proposal due date, UTA will return the Proposal, including the Proposal Security, to the Proposer.

ix. Cost of Proposals

The Utah Transit Authority is not liable for any costs incurred by Proposers in the preparation, presentation, or negotiation of Proposals submitted in response to this RFP.

x. Examination of Request for Proposals

The submission of a Proposal constitutes an acknowledgment upon which UTA may rely that the Proposer has thoroughly examined and is familiar with the RFP, including any work site identified in the RFP, and has reviewed and inspected all applicable statutes, regulations, ordinances, and resolutions addressing or relating to the goods and services to be provided hereunder. The failure or neglect of a Proposer to receive or examine such documents, work sites, statutes, regulations, ordinances, or resolutions will in no way relieve the Proposer from any obligations with respect to the Proposer's Proposal or to any Contract awarded pursuant to this RFP. No reduction or modification in the Contractor's obligations will be allowed based upon a lack of knowledge or misunderstanding of this RFP, work sites, statutes, regulations, ordinances, or resolutions.

If an example contract is included in this RFP, submission of a Proposal constitutes an acknowledgment upon which UTA may rely that the Proposer has thoroughly examined and is familiar with such contract, and stands ready to execute such contract upon selection as the preferred Proposer by UTA.

xi. Firm Offer

Unless otherwise stated in this RFP, submission of a Proposal constitutes an offer to provide the goods or services described in the RFP, for the price set forth in the Proposal. Such offer must be good and firm for a period of ninety (90) days after the Deadline to Submit Proposals.

B. E-VERIFY

Each Proposer and each person signing on behalf of any Proposer certifies as to its own entity, under penalty of perjury, that the named Proposer has registered and is participating in the Status Verification System to verify the work eligibility status of the contractor's new employees that are employed in the State of Utah in accordance with applicable immigration laws including UCA Section 63G-12-302.

Signing the Proposal is deemed the Proposer's certification of compliance with all provisions of this employment status verification certification required by all applicable status verification laws including Utah Code Ann. § 63G-12-302.

The successful Proposer shall require that the following provision be placed in each subcontract at every tier: "The subcontractor shall certify to the main (prime or general) contractor by affidavit that the subcontractor has verified through the Status Verification System the employment status of each new employee of the respective subcontractor, all in accordance with applicable immigration laws including Section 63G-12-302 and to comply with all applicable employee status verification laws. Such affidavit must be provided prior to the notice to proceed for the subcontractor to perform the work."

UTA will not consider a proposal for award, nor will it make any award where there has not been compliance with this Section. Furthermore, non-compliance with this section is a material breach of the Contract.

C. SELECTION PROCESS

i. No Public Opening

This is an RFP and, as such, the Proposals submitted in response to this RFP will not be subject to a public opening.

ii. UTA's Procurement Options

Based on submitted information, UTA may do or take any of the following actions, without limitation:

- select a Proposer or Team of Proposers based solely on the written Proposals, with or without subsequent negotiations;
- ask for more information or Clarifications before making a selection;
- use Presentations/Interviews/Problem-Solving Exercises before making a selection;
- determine a Competitive Range, conduct Discussions, and/or request Best and Final Offers (BAFO) before making a selection;
- if a material error in the RFP is discovered during the evaluation process, UTA may issue an addendum to all Proposers that have submitted Proposals requesting revised Proposals based upon the corrected RFP.
- decline to accept any Proposal;
- re-advertise;
- cancel the procurement; or
- elect to otherwise procure the needed services in accordance with UTA policy and procedures.

The Utah Transit Authority reserves the right to negotiate price, scope, schedule, and other contract terms with the preferred Proposer after a selection is made.

iii. Checking References.

The Utah Transit Authority reserves the right to contact any reference specifically named by the Proposer in its Proposal or any other additional references as deemed appropriate by UTA, including references suggested by the Proposer's named references or references known to UTA through its own knowledge of the transportation industry.

iv. Requests for Clarification

The Proposer shall provide accurate and complete information to UTA. If information is incomplete, appears to include a clerical error, or is otherwise unclear, UTA may either (i) declare the Proposal non-responsive, (ii) evaluate the Proposal as submitted, or (iii) issue a Request for Clarifications to the

Proposer stating the information needed and a date and time by which the information must be provided. If the Proposer does not respond to the Request for Clarifications in a timely manner, or if the Proposer's response is deemed to be insufficient by UTA, in its sole discretion, then UTA may declare the Proposal non-responsive.

All requests for Clarification will be in writing via E-mail, responses submitted as per the instructions contained in the request for Clarification. Responses must be limited to answering the specific information requested by UTA.

v. Presentations / Interviews / Problem-Solving Exercises

The Utah Transit Authority may utilize presentations and/or interviews and/or problem-solving exercises during this procurement if, at the sole discretion of UTA, it is considered to be in UTA's best interest. If UTA determines that presentations and/or interviews and/or problem-solving exercises are in its best interest, UTA will notify all or a short-list of the most highly qualified Proposers of the decision to utilize presentations and/or interviews and/or problem-solving exercises and schedule the presentations and/or interviews and/or problem-solving exercises in such a way as to not unduly delay the procurement process.

The Utah Transit Authority reserves the right, in its sole discretion, to conduct multiple rounds of presentations and/or interviews and/or problem-solving exercises, if it deems necessary to do so, with one or more Proposers.

vi. Competitive Range

UTA may declare a Competitive Range including only those Proposers that have a reasonable chance of being selected. UTA will declare a Competitive Range, if it chooses to do so, after a careful analysis of the Proposals. Borderline Proposals will not be excluded from further consideration if the Proposers have a reasonable chance of being listed if meaningful Discussions are conducted and appropriate improvement is achieved.

vii. Discussions

The Utah Transit Authority may, at its sole discretion, conduct written and/or verbal Discussions with any of the Proposers in the Competitive Range regarding the content of their Proposal. If Discussions are held, they will be held with all Proposers in the Competitive Range.

viii. Best and Final Offers

Although UTA reserves the right to issue a request for Proposal revisions (including Best and Final Offers), UTA is under no obligation to do so. UTA may make its selection and award based on the initial Proposals submitted.

If UTA requests Proposal revisions and/or BAFOs, Proposers in the Competitive Range may be informed of and requested and/or allowed to revise their Proposals, including correction of any weaknesses, minor irregularities, errors, and/or deficiencies identified to the Proposers by UTA following initial evaluation of the Proposals. The request for Proposal revisions and/or BAFOs will allow adequate time for the Proposers to revise their Proposals. Upon receipt of the Proposal revisions and/or BAFOs, the process of evaluation will be repeated. The process will consider the revised information and re-evaluate and revise ratings as appropriate. Although this RFP allows for Proposal revisions and/or BAFOs, all efforts will be made to make a selection based on initial Proposals. If Discussions are held, UTA will attempt to limit the selection process to a single BAFO following Discussions. If a Proposal revision and/or BAFO is requested of a Proposer, and that Proposer opts to not submit a Proposal revision and/or BAFO, that Proposer's original Proposal or most recent Proposal revision, as appropriate, will be treated as its BAFO.

ix. Best Value Determination

This is a Best Value procurement, in which selection of a Proposer is based on the combination of price and qualitative components set forth on the RFP Cover Sheet. Accordingly, UTA might not select the Proposal with the lowest price, or the Proposal with the highest qualitative/ technical rating. UTA will select the responsible Proposer whose Proposal is deemed to be the most advantageous to UTA.

x. Negotiations

After selection but prior to award of the Contract, UTA may, at its sole discretion, either conduct negotiations with the successful Proposer or UTA may choose to not conduct negotiations with the successful Proposer and award the Contract to the successful Proposer based on its written Proposal and any additional information received during Discussions and Proposal revisions and/or BAFOs, if conducted.

If UTA and the selected Proposer are unable to reach a meeting of the minds on the scope, contractual terms, and/or price of the Contract, then UTA may, in its sole discretion, negotiate with the next most advantageous Proposer or choose to terminate the procurement in its entirety.

Once negotiations have been terminated with any Proposer, the negotiations may not be reopened with that Proposer under any circumstances.

If UTA receives only one responsive Proposal, UTA reserves the right to negotiate all elements of the Proposal and the Contract with the sole responsive Proposer, including, but not limited to, profit.

xi. Inclusion of RFP in Contract

At the time of execution of the Contract, the successful Proposer's Proposal may be included, in whole or in part, in the Contract.

xii. Notice to Unsuccessful Proposers

Following execution of the Contract between UTA and the successful Proposer, UTA will inform unsuccessful Proposers of the number of Proposals received by UTA and the name of the successful Proposer. UTA will attempt to give this notice promptly after the Contract execution. However, UTA's failure to give this notice will not be deemed to affect the validity of the Contract.

xiii. Debriefs

Upon request by an unsuccessful Proposer, UTA may, but is not required to, hold debriefs for the sole purpose of discussing, in a limited way, the strengths and weaknesses of an unsuccessful Proposal.

D. PROTESTS

Protests will be accepted only from Proposers whose direct economic interest has been adversely affected by those alleged actions/omissions of the Authority that form the basis of the protest. Protests can be filed in one of two circumstances: 1) Protests prior to receipt of bids, proposals or statement of qualification, or 2) Protests to Award of Contract. Protests will be determined in accordance with the laws of the State of Utah including, without limitation, the Utah Procurement Code. All protests shall be in writing and shall be submitted to the Authority as directed in these protest procedures. Protests that are not delivered to the appropriate persons or not delivered within the appropriate time limits (all as set forth in these procedures) shall be null and void and will not be considered by the Authority. A protest shall be deemed to be delivered pursuant to these procedures when actually received by the designated recipient

by hand delivery, by recognized overnight courier service or by certified or registered mail. All protests shall include:

- The name and address of the bidder/proposer;
- The appropriate contact person for the bidder/proposer to whom all protest correspondence shall be addressed;
- The solicitation or project number; and
- A detailed statement as to the nature of the protest including, without limitation, the factual and legal basis for the protest.

When Federal funds are involved, timely protests shall be disclosed to the regional office of FTA in accordance with FTA Circular C4220.1F, pg VII-2.)

1. Protests Prior to Receipt of Bids, Proposals or Statements of Qualification

All protests made prior to the receipt of bids, proposals or statements of qualification, including protests based upon allegedly restrictive specifications or alleged improprieties in any type or manner of the solicitation, shall be delivered to the Authority's Procurement Officer not less than seven (7) calendar days prior to the scheduled deadline for receipt of bids, proposals or statements of qualification as follows:

Utah Transit Authority
669 West 200 South
Salt Lake City, Utah 84101
Attn: Robert Biles, Chief Procurement Officer
CONTAINS TIME-SENSITIVE PROTEST MATERIALS

The Procurement Officer, or an agent designated by the Procurement Officer, will promptly make a determination in writing regarding the validity of the protest and whether or not the procurement process should be delayed beyond the scheduled date for receipt of bids, proposals or statements of qualification. If the Procurement Officer determines that the scheduled date should be delayed, all respondents to the solicitation who have furnished their name and address to the Authority shall be notified (through an Addendum to the IFB, RFP or RFQ) of the delay and the reason for the delay. If the protest, or any portion thereof, is determined by the Procurement Officer to have merit, the Procurement Officer will take all necessary action to address each allegedly restrictive specification, alleged impropriety or other meritorious objection in a manner consistent with applicable law and will provide notice of any resulting changes to the IFB, RFP or RFQ, or the procurement process, to all respondents to the solicitation who have furnished their name and address to the Authority. In such cases, the Authority shall not proceed with the procurement until it has remedied such issues to the satisfaction of the Procurement Officer.

ii. Protests to Award of Contract

All protests made to the Award of a Contract shall be delivered to the Procurement Officer not less than five (5) calendar days after the protestor received notice of the Authority's intent to Award a Contract (unless the protestor can demonstrate that its protest is based on facts and circumstances that the protestor could not have reasonably been aware of on the date notice of the intent to Award was delivered, in which case the commencement of the five-day period shall be tolled until the date when the protestor was or should have been aware of the facts and circumstances upon which the protest is based). All protests made to the Award of Contract shall be delivered as follows:

Utah Transit Authority
669 West 200 South
Salt Lake City, Utah 84101

Attn: Robert Biles, Chief Procurement Officer
CONTAINS TIME-SENSITIVE PROTEST MATERIALS

If the protest has been timely filed, the Procurement Officer, or an agent designated by the Procurement Officer, will promptly make a determination in writing regarding the validity of the protest and whether the Authority's decision regarding the Award should be reconsidered. The Authority shall provide notice of the protest to all bidders/proposers who submitted an IFB, RFP or RFQ (except, in the case of a two-step procurement, the Authority shall only provide notice to those who were deemed qualified or were "short-listed" to submit a bid/proposal for step two of the procurement). The Procurement Officer, or his or her designee, will respond to the protestor in writing and address each material issue raised by the protest in a timely manner. If the protest, or any portion thereof, is determined by the Procurement Officer to have merit, the Procurement Officer will take all necessary action to address the protested issues in a manner consistent with applicable law including, without limitation: (1) canceling the procurement; (2) canceling the procurement and reissuing a new IFB, RFP or RFQ; (3) rescinding the Award and requesting Best and Final Offers from qualified proposers; (4) determining that the objections, although meritorious, were immaterial to the decision to Award; or (5) taking such other actions as may be appropriate under the circumstances. Once the Procurement Officer becomes aware of a protest to the Award, the Authority will not take any further action to execute a Contract pursuant to the IFB, RFP or RFQ until seven (7) calendar days after the Award is upheld by the Procurement Officer, unless the Procurement Officer shall make a written determination that immediately executing the Contract is necessary to protect a substantial interest of the Authority.

iii. Administrative Appeals

In the event that a protestor receives an unfavorable decision from the Procurement Officer to its protest of Contract Award, the protestor shall have the right to appeal the Procurement Officer's decision by submitting a written appeal to the Chair of the Board of Trustees of the Authority, addressed as follows:

Chair, UTA Board of Trustees
c/o Utah Transit Authority
669 West 200 South
Salt Lake City, Utah 84101
Attn: Board Coordinator
CONTAINS TIME-SENSITIVE PROTEST MATERIALS

Any appeal must be delivered within five (5) calendar days of the date of the Procurement Officer's decision. The Chair will appoint a Protest Committee to review the appeal and the decision of the Procurement Officer. The Chair will determine the specific procedures that will be followed by the Protest Committee, including the date of any hearing deemed necessary by the Chair. After considering the appeal, the Protest Committee will notify the appellant and the Procurement Officer in writing in a prompt manner of its decision regarding the appeal. If the Protest Committee reverses the decision of the Procurement Officer, it shall have broad discretion to take any action it deems necessary to correct the determined defects in the Contract Award, consistent with applicable law and Authority policies. If the Protest Committee upholds the decision of the Procurement Officer, the Authority may proceed with Contract Execution seven (7) calendar days after the Authority provides notice of the Protest Committee's decision. The Authority may proceed without regard to the seven-day waiting period if the Procurement Officer shall make a written determination that immediately executing the Contract is necessary to protect a substantial interest of the Authority. The decision of the Protest Committee constitutes a final administrative decision of the Authority.

REQUEST FOR PROPOSALS

Part 4 – STANDARD CONTRACT TERMS / SAMPLE CONTRACT

A. CONTRACT WILL BE NEGOTIATED WITH THE SELECTED PROPOSER UPON AWARD.

The selected firm or firms must be willing to enter into a written Agreement with Utah Transit Authority.

B. CONTRACT AND PROPOSAL INFORMATION

Submitting a proposal acknowledges your firm has read, understands, and agrees to be bound by and fulfill the requirements and terms and conditions of this solicitation.

a. Firm Pricing: All fees and expenses are to remain firm through the contract period. Any revisions are subject to approval by the Authority.

b. Licensing: All applicable federal, state, and local licenses must be acquired before the contract is entered into. Licenses must be maintained throughout the entire contract period.

   Persons doing business as an Individual, Association, Partnership, Corporation, or otherwise shall be registered with the Utah State Division of Corporations and Commercial Code. NOTE: Forms and information on registration may be obtained by calling (801) 530-4849 or toll free at 877-526-3994, or by accessing: www.commerce.utah.gov.

c. Public Domain: Offerors are advised that Utah law provide that, upon full execution of a contract subsequent to an RFP, the contents of the awarded proposal accepted by the Authority shall be subject to public disclosure and may become public records subject to examination by any interested parties in accordance to the Government Records Access Management Act (GRAMA), Utah Code Ann. 63G-2-101 et seq. and County ordinance. Trade secrets and proprietary information, recognized by the Authority as such, may be protected from public disclosure if the Offeror clearly identifies in writing any part of their proposals that they claim to be proprietary information, trade secrets or other commercial information, or non-individual financial information that may be protected under GRAMA. Proposals in total will not be considered proprietary. All materials submitted by an Offeror in response to the RFPs will become the property of the Authority upon delivery and will be managed in accordance with GRAMA.

d. Insurance: If awarded the contract, Offerors will, at their sole cost and expense, secure and maintain during the term of the contract, including all renewal or additional terms, minimum insurance coverage as determined by Utah Transit Authority.

UTA

REQUEST FOR PROPOSALS

Part 5 – Forms

BID FORMS AND DECLARATIONS

TO: Janalee Hansen, Procurement Manager
Utah Transit Authority
669 West 200 South
Salt Lake City, Utah 84101

Having examined all the documents, general conditions and instructions, and work scope entitled **"Pension Actuarial Consulting Services"**, dated July 28, 2014 the undersigned requests consideration to furnish the services required by said documents exclusive of all Federal excise taxes, local sales and use taxes for the sum as mutually agreed to in the final contract documents.

A. JOINT VENTURE

The undersigned bidder/proposer is a joint venture which is comprised of the following persons, firms, or corporations. Enclosed is a copy of the Joint Venture Agreement entered into between the parties. Disadvantaged owned companies must be indicated in the column marked by a "D" below:

% of Contract	"D"	Firm Address
_____	___	_____
_____	___	_____
_____	___	_____
_____	___	_____
_____	___	_____

If there are no such persons, firms, or corporations, please so state in the following space:

Not a joint venture

B. SUBCONTRACTORS:

The undersigned bidder/proposer proposes to have the following work performed by subcontractors. Disadvantaged-owned companies must be indicated in the column marked by a "D".

LIST OF SUBCONTRACTORS

Item of Work	% of Contract	"D"	Proposed Subcontractor	Address
_____	_____	___	_____	
_____	_____	___	_____	
_____	_____	___	_____	

If there are no such persons, firms, or corporations, please so state in the following space:

No Subcontractors

The participation of disadvantaged-owned companies as shown above will be incorporated into any contract awarded as a result of this invitation or request.

The undersigned bidder/proposer does hereby certify that the above listed subcontractors have full knowledge that their names have been offered as subcontractors for the work, and the bidder/proposer further certifies that these subcontractors have consented to listing their names herein.

C. ADDENDA

The undersigned bidder/proposer acknowledges receipt of the following addenda:

Addendum No. 1 Date August 14, 2014

Addendum No.___ Date_____

Addendum No.___ Date_____

Addendum No.___ Date_____

Failure to acknowledge receipt of all addenda may cause the bid/proposal to be rejected as non-responsive.

D. SIGNATURE

The undersigned bidder/proposer certifies that it and each of its subcontractors possess an adequate supply of workers qualified to perform the work specified herein; that there is no existing or impending dispute between it and any labor organization; and that it is prepared to comply fully with prevailing wage requirements, minimum wages, maximum hours of work, and equal opportunity provisions contained in the general conditions of the contract.

This bid/proposal is submitted upon the declaration that neither I (we) nor, to the best of my (our) knowledge, none of the members of my (our) firm or company have either directly or indirectly entered into any agreement, participated in any collusion or otherwise taken any action in restraint of free competitive bidding/proposing in connection with this bid/proposal.

Dated at 12:45pm, this 15th day of October, 2014.

Signature of Bidder/Proposer:

If an individual:

doing business as_____.

By_____

If a partnership:

By_____, General Partner

If a corporation:  .

a private corporation,

By Matt Lamabee, President Principal

Attest:_____
Secretary *

* See attached "certification of corporate secretary"

If a joint venture:

joint venture comprised of:

_____

Name

_____

By

and

_____

Name

_____

By

Business Address of Bidder/Proposer:

111 SW Fifth Ave, Suite 3700

Address

Portland OR 97204

City, State, Zip Code (or Province and Country)

503 227 0634

Area Code and Telephone Number of Bidder/Proposer

Milliman

111 SW Fifth Avenue, Suite 3700
Portland, OR 97204
Tel +1 503 227 0634

950 West Bannock Street, Suite 510
Boise, ID 83702
Tel +1 208 342 3485

1400 Wewatta Street, Suite 300
Denver, CO 80202
Tel +1 303 299 9400

milliman.com

August 26, 2014

Ms. Janalee Hansen
Procurement Manager
Utah Transit Authority
669 West 200 South
Salt Lake City, UT 84101

Re: Pension Actuarial Consulting Services Proposal (UT-14-01JL)

Dear Ms. Hansen:

On behalf of the more than 150 colleagues of Milliman's Intermountain West and Portland offices, we are pleased to provide our proposal in response to the RFP noted above. We look forward to having the opportunity for an oral interview and to subsequently enter into an agreement with the UTA Pension Committee. As you will see from our proposal, we feel the reasons to select Milliman are numerous and compelling.

Please contact us if you have any questions or comments.

Sincerely,

Matt Larrabee
FSA, EA, MAAA
Principal & Consulting Actuary
Portland, OR
Matt.Larrabee@milliman.com
Tel: +1 503 227 0634

Bret D. Linton
FSA, FCA, EA, MAAA
Principal & Consulting Actuary
Boise, ID
Bret.Linton@milliman.com
Tel: +1 208 342 3485

Joel E. Stewart
ASA, EA, MAAA
Consulting Actuary
Denver, CO
Joel.Stewart@milliman.com
Tel: +1 303 299 9400

Milliman Proposal

Utah Transit Authority

Pension Actuarial Consulting Services Proposal (UT-14-01JL)

August 26, 2014

Milliman

Submitted by:

Matt Larrabee, FSA, EA, MAAA
Principal & Consulting Actuary
Tel: +1 503 227 0634
Matt.Larrabee@milliman.com

Bret Linton, FSA, FCA, EA, MAAA
Principal & Consulting Actuary
Tel: +1 208 433 9406
Bret.Linton@milliman.com

Joel Stewart, ASA, EA, MAAA
Consulting Actuary
Tel: +1 303 672 9003
Joel.Stewart@milliman.com

111 SW Fifth Avenue, Suite 3700
Portland, OR 97204
Tel +1 503 227 0634

950 West Bannock Street, Suite 510
Boise, ID 83702
Tel +1 208 342 3485

1400 Wewatta Street, Suite 300
Denver, CO 80202
Tel +1 303 299 9400

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Executive Summary

On behalf of the more than 150 colleagues of Milliman's Intermountain West and Portland offices, we are pleased to provide our services proposal for UTA. In our view, the reasons to select Milliman are numerous and compelling.

Exceptional UTA Consulting Team with Strong Local Ties

Milliman's UTA consulting team features three consultants who currently work with complex public systems that have combined liabilities in excess of $220 billion. In addition, each team member has experience consulting with systems of similar size to UTA. The strength and depth of our team means that a senior consultant familiar with UTA will always be available and meetings or calls can be scheduled at UTA's convenience rather than the actuary's.

Milliman's UTA team is led by Matt Larrabee from our Portland office. Matt heads the actuarial consulting teams for both Oregon PERS and the Florida Retirement System. He is regularly praised for his ability to explain actuarial issues in an approachable, unbiased way that is comprehensible to policy makers and other interested parties. Matt understands that you only get one chance to get your communications right with the current level of public scrutiny on retirement systems. He is on the Public Plans Subcommittee of the American Academy of Actuaries, which is the US actuarial profession's oversight body. This ensures that Matt's clients are up-to-date on emerging standards and best practices in the plan sponsor, accounting and actuarial communities.

Joel Stewart from our Denver office will also serve as a consulting actuary for UTA. Joel is experienced in presenting actuarial studies to retirement boards and committees. Client feedback often includes appreciation for his ability to break down complex concepts in a clear and concise manner. Joel serves on Milliman's GASB 67/68 Task Force, which assists our clients and consultants in the implementation of the new accounting standards.

Bret Linton from our Boise office, who will also serve UTA as a consulting actuary, has assisted systems such as the City of Dallas (Texas) and led the Judges' Retirement Pension Fund in Idaho. Even after relocating from Texas to Idaho, the City of Dallas continues to request Bret's consulting services because of his thoroughness and ability to explain difficult concepts.

Our consulting team has strong local ties. Matt graduated from Taylorsville High and the University of Utah, while Bret graduated from Woods Cross High and BYU.

Notably, Joel and Matt took over actuarial work from a competitor in 2013 for a plan that operates under similar funding rules to UTA (Diocese of Phoenix) and provided insightful consulting for both benefit design and long-term funding strategy in a cost-effective, timely manner. In a short period of time we turned a prospective client into a strong reference by improving the quality and depth of consulting while holding the line on fees.

Deep Resources of a Large, Independent National Firm

We have a wealth of resources to meet UTA's needs – that is one advantage of hiring a major national firm. UTA will immediately benefit from this depth by having Liz Weckstein as a member of its consulting team. Liz is an experienced compliance and plan document maintenance consultant who holds degrees in both law and mathematics.

Founded in Seattle over 60 years ago, Milliman now has more than 2,800 employees. We are independent, so we have no agenda other than providing correct and timely information to our clients. We will be around to engage in a long-term relationship without risk of acquisition, a change in focus or a cessation of operations due to litigation.

Our Portland, Boise and Denver offices collectively have more than 90 employees who specialize in employee benefits. Regionally, our western US pension actuarial consulting group works with large clients such as California Teachers (CalSTRS) and Los Angeles County (LACERA). Milliman also consults with a number of transit agencies including TriMet (Portland's analogue to UTA), Lane Transit District (Eugene, Oregon) and Salem (Oregon) Area Mass Transit District. Nationally, we have dedicated employee benefits research staff in Washington DC that keeps our clients and staff regularly updated on the evolving employee benefits landscape.

In addition to employee benefits, Milliman has major consulting practices in healthcare, property and casualty (including disability), life insurance & financial services and investment consulting.

Clear and Understandable Communication

In a game of free association, likely no one would respond to the word "actuary" with the phrase "clear and understandable". As a group we work extremely hard to overcome this profession-wide affliction. If the sponsor cannot understand the actuary's analysis, then decisions on key matters are made with less than complete information.

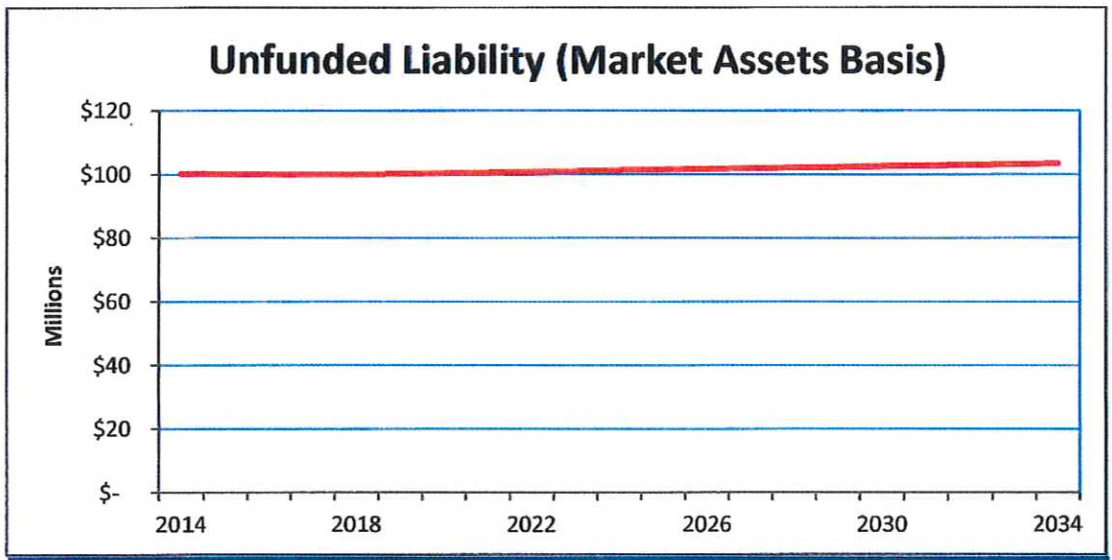
A Commitment to Timeliness

Even the clearest and most understandable communication is of no use to a sponsor if that communication shows up late. We know this and work closely with our clients from the commencement of a project to ensure that timelines are understood and met. Our general preference is to vet draft versions of key communications with our clients whenever possible and permissible. This approach accomplishes two goals. First, it optimizes the clarity and understandability of our communications. Second, it gives key personnel a preview of our analysis prior to finalization so that they can begin to communicate important concepts with policy makers in advance of key meetings.

A Fresh, Insightful Perspective and Assistance to UTA on Key Issues

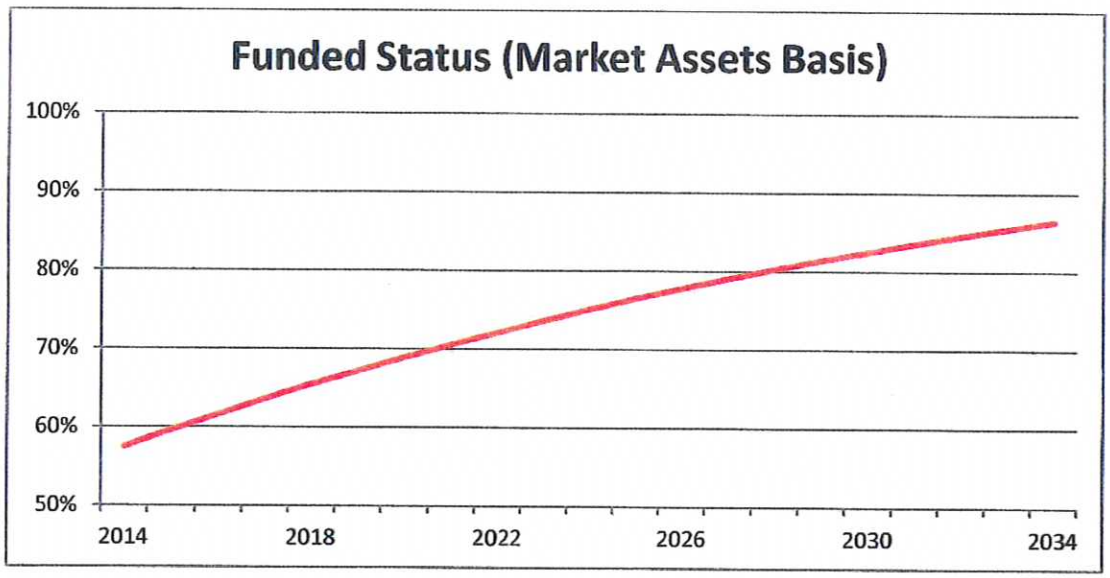
Reviewing the 2014 valuation report, a key objective appears to be improving funded status over time to improve benefit security for participants and ensure plan sustainability for UTA. Further, the RFP articulates a goal of reaching 100% funded status over 20 years. Unfortunately, the contribution rate calculation policy articulated in the 2014 valuation report will not achieve that stated goal if future experience follows assumptions and future contributions are made using that report's methodology. This is due to the "rolling" nature of how unfunded liability is amortized in the 2014 valuation methodology. That methodology pays slightly less than interest on the unfunded liability each and every year. This means that the unfunded liability, stated in non-inflation adjusted dollars, does not decrease over a 20-year period if experience follows assumption and contributions are made.

The chart below estimates the change in unfunded liability over 20 years, stated on a fair market value of assets basis, if future experience follows assumptions and contributions are made.



Source: 2014 Segal Valuation; Future contributions: Per calculation approach in 2014 valuation; Future experience: Per 2014 valuation assumptions, with benefit payments assumed to increase 2.5% annually

The chart below estimates the funded status of the program on the same basis.



While funded status does improve over 20 years, the improvement is solely due to the plan's actuarial liability becoming larger over time due to the effects of inflation, future benefits being earned, and future retirements, rather than due to a pay down of the unfunded liability. We would look forward to collaboratively working with UTA to identify policy alternatives to achieve its stated goals.

In addition to funded status improvement, our review of the 2014 valuation report indicated two other potential issues that would be on our priority list for discussion with UTA:

- *The Intersection of Lump Sum Assumptions, Demographics and Liquidity* – The 2014 valuation appears to lack an assumption that any voluntary lump sums are elected by retiring members in the future, even though lump sums are often a popular benefit distribution option. Demographically, half of the plan's active participant headcount and far more than half of its $175 million active participant actuarial liability are for employees age 50 or older. Given this, the potential exists for lump sums over the next five to 15 years to be at levels that cumulatively would constitute a significant percentage of current trust assets. We would work with UTA to perform sensitivity testing around lump sum election rates and then work closely with your investment team to assist them in planning and preparing for the right investment horizon. Accurate cash flow projections are a key component of sound investment and funding policy.

- *Analysis of Unused Leave, Sick and Vacation Pay at Time of Retirement* – The valuation currently appears to lack an assumption related to the average level of unused leave, sick and vacation pay accumulated by members at the time of retirement. We would intend to review this area with UTA and create an assumption if warranted. As with all of our work, the objective in such a review would be to estimate projected future benefits in as accurate a manner as possible. Accurate projected benefit modeling is a key component in setting sound funding policy, whereby rates remain stable if future experience follows assumption.

Knowledge of the Pension Plan Environment beyond the Public Sector

The level of scrutiny on public sector pension plans is very high, and there is no reason to think that pressure will ease anytime soon. With this increased attention, it is vital that public plan consulting actuaries are also knowledgeable about developments in the corporate and union (Taft-Hartley) plan environment. The time when public plans and their actuaries could view themselves as completely different animals from other plans with no use for knowledge or awareness of the broader retirement plan environment has drawn to a close. It is the duty of the actuaries to provide UTA timely and thoughtful perspectives on trends in public, union and corporate plans. This will assist you in dealing effectively and knowledgably with elected officials, the media and other interested parties. Ignorance of goings-on outside of the public plan environment cannot be viewed as a virtue or strength. UTA's Milliman consulting team has the needed knowledge in the corporate and union plan areas. This differentiates us from most, if not all, of our competitors.

Knowledge of and Sensitivity to UTA

UTA is a highly visible entity which is subject to scrutiny by a variety of interested parties such as program participants, union leadership, elected officials, print media and bloggers. To help UTA succeed in its mission, the program actuaries need to have more than just strong technical knowledge. In particular, the actuaries must be sensitive to the broader political, administrative, and economic environment in which the plan operates. This awareness makes the actuaries capable of communicating to interested parties in a concise, understandable way that will further enhance UTA's credibility and reputation. Our team is uniquely qualified to accomplish these objectives as demonstrated by our track record of working with the clients that we reference in this proposal.

Invested in Salt Lake City since 1991

In 2011, Milliman celebrated the 20th anniversary of our Salt Lake City office. The office, which focuses on health consulting, now has 13 employees. Milliman's long-term presence in Salt Lake City and commitment to the local economy distinguishes us from most, if not all, of our major competitors.

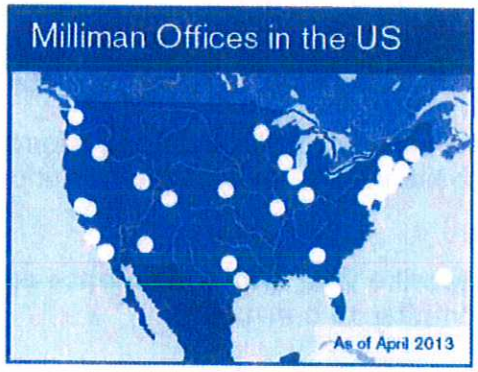
Firm Experience and Actuarial Capabilities

a. The firm's name, home office address and telephone number, and the address and telephone number of the office providing the services under the contract.

Milliman			
Home Office	*UTA Primary Service Offices*		*Supporting Office*
1301 Fifth Ave Suite 3800 Seattle, WA 98101	111 SW Fifth Ave. Suite 3700 Portland, OR 97204	1400 Wewatta St. Suite 300 Denver, CO 80202	950 W Bannock St. Suite 510 Boise, ID 83702
+1 206 624 7940	+1 503 227 0634	+1 303 299 9400	+1 208 342 3485

b. General description of the firm, including size, number of employees, primary business (consulting, pension planning, insurance, etc.), other business or services, type of organization (franchise, corporation, partnership, etc.) and other descriptive material.

Milliman is among the world's largest independent actuarial and consulting firms. Primary practice areas include employee benefits, actuarial, communication, compensation, risk management and economic consulting. We provide services strictly on a fee-for-service basis to nearly 9,000 private and public sector clients, including over 4,500 pension clients. We are known for our client-centered approach and technical expertise.



Milliman was founded in 1947 as a firm of actuarial consultants by Wendell Milliman and Stuart Robertson, who made independence, leading edge professional expertise and quality control the firm's guiding principles. Milliman employs approximately 2,800 people, including a professional staff of over 1,300 qualified actuaries and consultants.

Milliman is wholly owned and managed by approximately 400 principals, who have been elected in recognition of their technical, professional and business achievements. Our sole business is providing independent consulting services. We are not affiliated with any public accounting or brokerage firms. The consultants of the firm are not permitted to own stock in client organizations. In these ways, Milliman is able to provide analyses and opinions that are totally independent and objective.

Milliman is one of the largest actuarial consulting firms in the world. Our consultants achieve the highest credentials in their fields and are unmatched in the industry. We are dedicated to providing the best quality service to our clients. We pride ourselves on our responsiveness and customized solutions. Furthermore, while the results of actuarial analyses are necessarily complex, we pride ourselves on our ability to clearly communicate these results to our clients.

c. State which of the firm's offices will service this account and indicate if the valuation service is performed in a centralized location or if it is performed at the same office that services the account.

UTA Primary Service Offices		Supporting Office
111 SW Fifth Ave. Suite 3700 Portland, OR 97204	1400 Wewatta St. Suite 300 Denver, CO 80202	950 W Bannock St. Suite 510 Boise, ID 83702
+1 503 227 0634	+1 303 299 9400	+1 208 342 3485

The valuation for UTA will be performed by the Primary Offices (Portland and Denver) with assistance and review from the Supporting Office (Boise).

d. Describe your firm's experience and qualifications in plan design and compliance consulting.

As stated above, Milliman has been providing actuarial services, including actuarial services for public pension plans, since its foundation in 1947 when the Washington State Employee Retirement System retained Wendell Milliman to provide actuarial advice to the new Retirement Board. Each member of Milliman's UTA team has extensive experience consulting on benefit design and funding strategy for pension systems.

Given our expertise in serving public plans, the consultants that will service UTA have experience testifying before governing bodies and are experienced with, and sensitive to, the political climate at both the state and local levels of government. Public pension systems present unique challenges that can only be solved by experts with extensive public pension system experience.

In compliance consulting, UTA will benefit from having Liz Weckstein as a compliance expert. Liz, who has 20 years of experience with Milliman, has both a JD and an undergraduate degree in mathematics. Her sole area of focus is assisting clients with complex issues related to compliance and plan administration.

e. Describe your firm's advantage over other firms and explain why the UTA Pension Committee should hire your firm.

We believe that Milliman is best positioned to address UTA's needs based on several factors that we have previously highlighted in the executive summary of this proposal. The key areas where we feel Milliman differentiates itself from our competitors include:

- *Strength and Depth of a Consulting Team with Local Ties* – The ability of our consultants to communicate understandably, deliver on time, and be technically proficient is paramount. We believe the strength and depth our team is unmatched in those areas. Further, the local ties our team members have means that the opportunity to serve UTA would be a very personal privilege.
- *Communication Skills* – As noted in the Executive Summary, the UTA plan has a key issue to address related to funded status improvement. Our consulting team will do a superior job of explaining that issue (and others) understandably and providing policy alternatives. Time after time, our team has been complimented for its ability to explain difficult topics to Boards and staff. By simply speaking with clarity and by using visual examples, we have gained the confidence of many people who declare, "Now we understand." One Milliman client stated that "their strength is translating complex data into understandable concepts that we can share with those who are not as familiar with how the whole process works."
- *Knowledge Beyond Public Sector Pension Plans* – As noted earlier in this proposal, Milliman's expertise extends far beyond public sector pension plans. Over time this breadth of knowledge has become increasingly important to our public sector clients.
- *Firm with a Demonstrated Commitment to Salt Lake City* – Milliman has operated a Salt Lake City office since 1991 and our health-focused office currently has 13 employees. Milliman's commitment to the Salt Lake City business community is a long-term one.

- *Size* – As one of the largest actuarial firms in the nation, we are fully equipped to provide any service UTA may require. Our Intermountain West and Portland staff of over 90 employee benefits specialists allows us to handle any size or type of client and consistently deliver high quality, cost effective service. Our size also allows us to have experienced compliance experts like Liz Weckstein on staff to serve our clients. On a national level, our research department in Washington D.C. keeps our clients and staff continuously updated on the evolving employee benefits landscape.
- *Breadth of Service* – Beyond providing actuarial services, we also administer some of the largest defined benefit and defined contribution plans in the western US.
- *Publications and Research* – Milliman's *Insight* (insight.milliman.com) provides expert thinking from Milliman on a variety of actuarial consulting topics. In particular, Milliman regularly produces articles in a publication called *PERiScope* that caters to public employee retirement systems.

f. Describe the steps your firm will take in transitioning from the current actuarial consultant to your firm.

Milliman will work with UTA and the prior actuary to ensure a smooth transition process. Both Milliman's standard procedures and actuarial standards require a full replication of the prior actuary's valuation based on the same files and assumptions. This is necessary in order to assure both Milliman and UTA that the assets and liabilities are being valued in accordance with the data, assumptions, methodology, and benefit provisions for the system.

We will provide each responsible party with a comprehensive timetable and itemization of conversion tasks. Each task associated with the conversion, implementation, and communications program will be assigned to the appropriate party. Although we cannot guarantee the prior actuary's performance in the conversion process, Milliman will monitor and advise UTA of the progress of the conversion and alert you immediately if tasks are not completed by the assigned target date. Milliman will give UTA the highest priority to ensure that the transition will take place in the proposed manner and time frame.

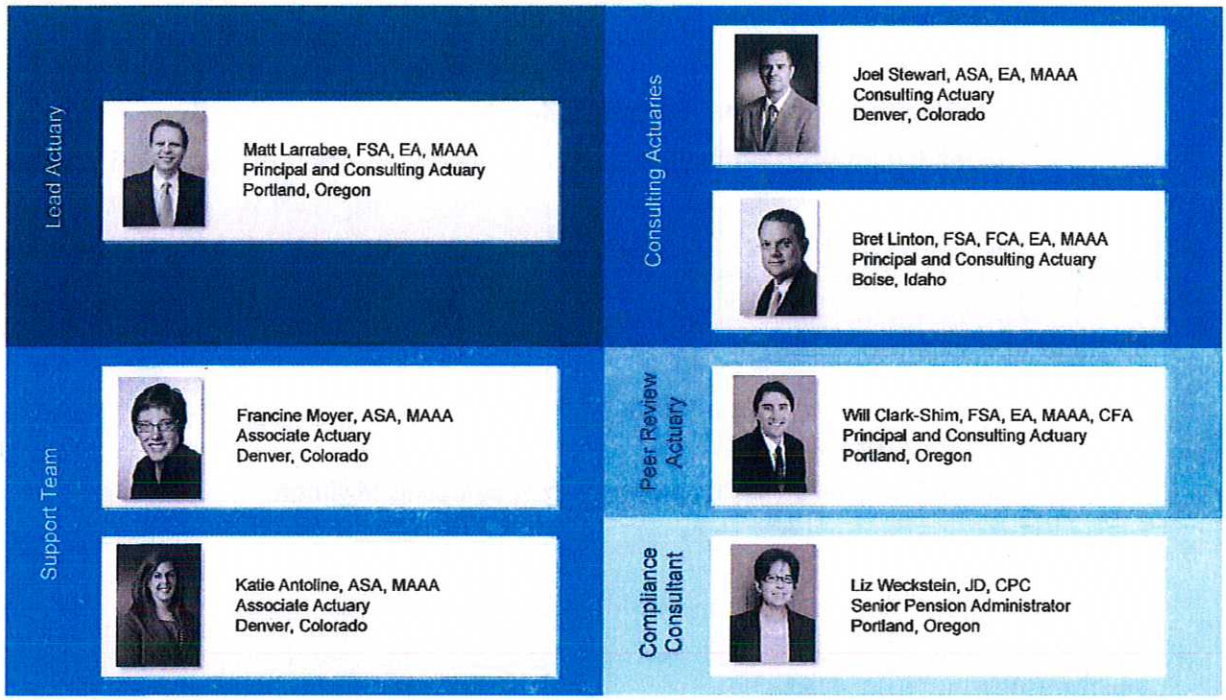
Having completed many transitions, be encouraged that the process for transferring and organizing data has become increasingly efficient over time. It will be important that we begin the process of transferring knowledge immediately.

We have provided a timeline on the following page for transitioning over to Milliman. We would strive to complete the full replication of the prior actuary's most recent actuarial valuation within two months of selecting Milliman.

Step	Description
1	**Kick-off meeting between Milliman and UTA personnel and legal counsel to discuss transition specifics, review plan history, plan needs and objectives, etc.** Goal: Completion within one week of selecting Milliman
2	**Finalize first Actuarial Events Calendar** Goal: Completion within two weeks of kick-off meeting, then updated quarterly
3	**Plan documents, prior valuation reports, prior government forms, etc. obtained from UTA or current actuary** Goal: Completion within three weeks of selecting Milliman
4	**Data history and detailed actuarial assumptions and methods obtained from current actuary** Goal: Completion within one month of selecting Milliman
5	**Replication valuation prepared by Milliman to replicate most recent actuarial valuation produced by current actuary** Goal: Completion within two months of selecting Milliman

Assigned Personnel and Qualifications

a. Identify the personnel who shall be performing consulting services under the contract.



b. Provide brief summary information regarding the professional and experience qualifications of the personnel providing the consulting services under the contract.

Matt Larrabee, FSA, EA, MAAA

Matt will serve as Lead Actuary. He will serve as a primary contact for UTA and will oversee the entire Milliman team and all aspects of Milliman's deliverables. Matt is a Principal and Consulting Actuary with Milliman's Portland office and has nearly 20 years of actuarial consulting experience with expertise in pension and retiree medical programs sponsored by governmental and corporate entities. He worked for the firm from 1998 to 2001 and rejoined in 2012 after serving as the Portland retirement practice leader of a major national competitor for six years.

Matt has consulted with a variety of plan types and sponsors. Of particular note, Matt serves as the consulting actuary for both the Oregon Public Employees Retirement System (OPERS) and the Florida Retirement System (FRS).

He assists his clients with a variety of matters, including actuarial valuations, financial reporting, contribution strategy, stakeholder communications, plan design, experience studies, legislative impact assessments, economic scenario analysis and plan administration. Matt's projects have included:

- Stochastic analysis of funding strategy alternatives for public sector systems
- Extensive plan design and legislative cost analysis for large public sector systems
- Plan redesign and consolidation analysis for an acquisitive corporate sponsor that had accumulated 10 widely different benefit designs at its U.S. locations
- Stochastic assessment of long-term property tax levy adequacy for a large pay-as-you-go public system
- Redesign and wind-down analysis for a pre-funded corporate retiree medical and life program covering a closed employee group
- Contribution strategy design consulting for a multiple-employer plan covering more than a dozen joint sponsoring employers of varying sizes and financial conditions
- Financial reporting under governmental (GASB), U.S. GAAP (FASB), international (IFRS), and statutory (SSAP) accounting standards

Presentations and Publications

Matt has been frequently quoted in the local media for his work with governmental sponsors. He is an experienced public speaker, and has had the honor of speaking at the annual National Association of State Retirement Administrators (NASRA) conference. Matt has also made numerous executive and board level presentations for his corporate clients. In 2012, Matt authored a Milliman article summarizing the effects of upcoming changes to pension plan financial reporting requirements on governmental entities.

Professional Designations

- Fellow, Society of Actuaries
- Enrolled Actuary under ERISA
- Member, American Academy of Actuaries

Affiliations

- Member, American Academy of Actuaries Public Plans Subcommittee
- Member of Milliman's Strategic Planning Group for Public Sector Plans

Education

- BS, Math, University of Utah
- BS, Electrical Engineering, University of Utah

Joel Stewart, ASA, EA, MAAA

Joel will serve as a Consulting Actuary. He is a Consulting Actuary in the Denver office of Milliman. He joined the firm in 1999 with three years of prior experience. Joel's area of expertise is in defined benefit pension plans. He specializes in valuations and administration, including benefit calculations, special studies for benefit changes, funding valuations, and FASB and GASB valuations. Joel is the defined benefit practice leader for the Denver office, and has primary responsibility for the Denver office's public sector, corporate and multiemployer clients.

Joel also serves on Milliman's GASB 67/68 Taskforce, which was established as a resource center and tool development to assist Milliman offices in the implementation of the new accounting standards.

Client projects have included ongoing plan valuation and administration, expense projections, asset/liability studies, development of simulation models for the redesign of benefit plans, and plan termination administration. He also performs replication audits, both externally for clients who have hired Milliman to audit their current actuary, and internally as part of Milliman's stringent peer review process.

Presentations and Publications

Joel has presented continuing education on various pension topics at Milliman's annual Employee Benefits Consultant's Forum.

Professional Designations

- Associate, Society of Actuaries
- Enrolled Actuary under ERISA
- Member, American Academy of Actuaries

Education

- BS, Mathematics with Actuarial Option, Pennsylvania State University

Bret Linton, FSA, FCA, EA, MAAA

Bret will serve as a Consulting Actuary. He will play a key role in the execution of UTA's actuarial consultations. Bret is a Principal and Consulting Actuary with the Boise, Idaho office of Milliman. He joined the firm in 2009. Bret works with a variety of public employers specializing in retirement plan and healthcare consulting. His consulting assignments have included actuarial valuations, assumption studies, asset/liability studies, plan design consulting, budgeting and cost projections, and plan amendments.

Prior to joining Milliman, Bret performed human resources (HR) operational due diligence for private equity investors and strategic buyers. His experience includes cost analysis of HR programs, benefit integration analysis, assessing financial risk exposures, transition services agreements, and negotiation of benefit programs.

Presentations and Publications

Bret has spoken before professional and client groups and has authored articles on employee benefits for Milliman.

Affiliations

- Program Chair and Board Member, Western Pension and Benefits Conference, Boise Chapter
- Member, Western Pension and Benefits Conference, Boise Chapter

Professional Designations

- Fellow, Society of Actuaries
- Fellow, Conference of Consulting Actuaries
- Enrolled Actuary under ERISA
- Member, American Academy of Actuaries
- Member, Western Pension and Benefits Conference

Education

- BS, Statistics, Brigham Young University

William Clark-Shim, FSA, EA, MAAA, CFA

Will is our Peer Review Actuary for UTA. Will is a Principal and Consulting Actuary in the Portland, Oregon office of Milliman. He joined the firm in 1998.

Will is currently the Consulting Actuary for the Lane Transit District and will lend his expertise to the UTA team. He also serves a variety of corporate, public sector, and union clients. His assignments include actuarial valuations, financial reporting, cost and liability projections, plan design studies, and plan drafting and administration.

Will has particular expertise relating the liabilities created by retirement programs to the funding and investment policies that finance those benefits.

Milliman has a formalized peer review process that has been in place for more than 30 years to assure that the highest quality standards are being maintained. Policies are continually reviewed to assure they are appropriate for each consulting assignment.

Each major assignment goes through a pre-release peer review within a practice prior to the issuance of a report to the client. The detailed process of checks and balances can only be satisfied by an actuary who has met the firm's stringent qualification requirements, and who is not the professional primarily responsible for the work.

Francine Moyer, ASA, MAAA

Francine will serve as a Supporting Actuary for UTA. She is an Associate Actuary in the Denver office of Milliman and joined the firm in 1996.

Francine's area of expertise is in defined benefit pension plans. She specializes in valuations and administration, including benefit calculations, special studies for benefit changes, funding valuations, and FASB and GASB valuations.

Katie Antoline, ASA, MAAA

Katie will serve as a Supporting Actuary for UTA. She is an Associate Actuary in the Denver office of Milliman. She joined the firm in 2013 with four and a half years of prior experience.

Katie's area of expertise is in defined benefit pension plans. She has provided actuarial services for corporate, public, and multiemployer plans. Katie has experience in actuarial valuations, financial reporting, benefit calculations, and cost and liability projections.

Elizabeth Weckstein, JD, CPC

Liz will serve as Compliance Consultant on the Milliman team. She is a Senior Pension Administrator with the Portland, Oregon office of Milliman and joined the firm in 1993.

Liz is experienced with all aspects of defined benefit administration, including benefit calculations, qualified domestic relations orders, benefit election forms, and lends her expertise to assist clients on applicable legal requirements.

Pricing and Fees

a. Please indicate pricing for the services requested. If some services are billed at an hourly rate, indicate which services those are and provide the hourly rate.

For ease of understanding, pricing for the requested services are broken down in the tables below. Services which are billed at an hourly rate are identified in the *Fees* column of the tables below. The hourly rates in the first year of the contract for these services are:

- Lead Actuary $320
- Consulting Actuaries $250-$300
- Compliance Consultant $220
- Peer Review Actuaries $320
- Support Actuaries $150-$200

These rates may be adjusted annually through the normal course of business operations at a maximum of 3% per year for up to five years to reflect the anticipated effects of inflation.

b. Provide annual fee for the scope of services listed in Sections 3.1-3.3

Service	RFP Reference	First Year Fee
Actuarial Consulting and Valuation Services	**Sections 3.1 and 3.2**	**$40,000**
Administrative, Plan Design & Compliance Consulting	Section 3.3	Client preference for hourly rate basis or pre-agreed fixed fee based on project scope

Fees quoted in this proposal sections 3.1 and 3.2 are for the first year of a five year contract. Fees for subsequent years would be increased at 3% per year (rounded to the nearest $100) to reflect the anticipated effects of inflation.

c. If you propose additional services, such services should be outlined and separately priced in your proposal.

We do not anticipate a significant amount of work for services not already outlined in this proposal. Should miscellaneous projects be requested, they will be billed based on client preference between the hourly billing rates stated above and pre-agreed fixed fees based on project scope.

d. Provide fees for additional services listed in Section 3.4

Service	RFP Reference	Fee
Experience Analysis Services	Section 3.41	$30,000
Disability Benefit Calculations	Section 3.42	Hourly rate basis
Special Benefit Calculations	Section 3.43	Hourly rate basis
Online Interactive Benefit Calculator	Section 3.44	Pre-agreed fixed fee based on project scope. Milliman has online calculators for a wide variety of sponsor functionality requirements, so quoting a single fee is not appropriate.
Consultation on Pricing Proposed Benefit Changes in Collective Bargaining Agreement	Section 3.45	Client preference for hourly rate basis or pre-agreed fixed fee based on project scope
Development of New Retirement Plans	Section 3.46	Client preference for hourly rate basis or pre-agreed fixed fee based on project scope

Unless otherwise specified, additional services will be billed at the hourly rates listed above in *Response a*.

References

a. Provide a list of public employee retirement systems for which the personnel you propose to perform consulting services currently provide consulting services and an indication of the type of consulting services provided and type of plan covered. Include system name, approximate number of participants and number of years firm has been retained. For three (3) public employee retirement systems (of comparable size to UTA's) included on the list, provide the address, telephone number, name and title of person(s) responsible for the administration of the system so UTA may contact them for a reference.

System Name	Services Provided	Plan Type	Number of Participants	# of Years of Service
Florida Retirement System	Valuation, consulting, administrative assistance	Pension & OPEB	900,000	25+
Oregon Public Employees Retirement System	Valuation, consulting, administrative assistance	Pension & OPEB	300,000	25+
Public Retirement System of Idaho	Valuation	Pension	100,000	25+
Employees' Retirement Fund of the City of Dallas	Valuation, health consulting, audit support	Pension & OPEB	13,000	7
Roman Catholic Diocese of Phoenix Lay Employees Retirement Plan	Valuation, consulting, administrative assistance	Pension	4,600	1
Portland TriMet	Valuation, consulting, administrative assistance	Pension & OPEB	4,000	10

System Name	Services Provided	Plan Type	Number of Participants	# of Years of Service
Portland Bureau of Fire and Police Disability & Retirement (FPDR)*	Valuation, consulting, administrative assistance	Pension	3,500	2
Employees' Retirement Plan of the Denver Board of Water Commissioners*	Valuation, consulting, administrative assistance	Pension & OPEB	1,600	4
Lane (OR) Transit District	Valuation, consulting, administrative assistance	Pension & OPEB	600	14
The Judges' Retirement Fund of the State of Idaho*	Valuation, Consulting	Pension	140	5

* As requested in the RFP, client contact information for these three public employee retirement systems of comparable size to UTA is provided below.

Additional relevant client contact information is included in the *Appendix*. We encourage UTA to do outreach to our references. Additional references are available upon request.

Portland Bureau of Fire & Police Disability & Retirement

Milliman UTA Team Member: Matt Larrabee

Client Contact:
Ms. Nancy Hartline, FPDR Financial Manager
1800 SW First Ave, Room 450
Portland, OR 97201
Email: Nancy.Hartline@portlandoregon.gov
Tel: +1 503 823 5501

Employees' Retirement Plan of the Denver Board of Water Commissioners

Milliman UTA Team Member: Joel Stewart

Client Contact:
Ms. Usha Sharma, Treasurer
1600 West 12th Avenue
Denver, CO 80204
Email: Usha.Sharma@denverwater.org
Tel: +1 303 628 6410

The Judges' Retirement Fund of the State of Idaho

Milliman UTA Team Member: Bret Linton

Client Contact:
Ms. Andrea Patterson, Human Resources Director
Idaho Supreme Court
P.O. Box 83720
Boise, ID 83720
Email: apatterson@idcourts.net
Tel: +1 208 947 7437

Forms

a. **Joint Venture**
b. **Subconsultants**
c. **Addenda**
d. **Signature**

Proposal forms are supplied for the purpose of listing the Proposer's team or individual data. The Proposer shall supply the data in the appropriate form. A Proposer's failure to follow the format specified may be considered non-responsive.

Please find the completed Forms in the following pages.

UTA

REQUEST FOR PROPOSALS

Part 5 – Forms

BID FORMS AND DECLARATIONS

TO: Janalee Hansen, Procurement Manager
Utah Transit Authority
669 West 200 South
Salt Lake City, Utah 84101

Having examined all the documents, general conditions and instructions, and work scope entitled **"Pension Actuarial Consulting Services"**, dated July 28, 2014 the undersigned requests consideration to furnish the services required by said documents exclusive of all Federal excise taxes, local sales and use taxes for the sum as mutually agreed to in the final contract documents.

A. JOINT VENTURE

The undersigned bidder/proposer is a joint venture which is comprised of the following persons, firms, or corporations. Enclosed is a copy of the Joint Venture Agreement entered into between the parties. Disadvantaged owned companies must be indicated in the column marked by a "D" below:

% of Contract	"D"	Firm Address
_____	___	_____
_____	___	_____
_____	___	_____
_____	___	_____
_____	___	_____

If there are no such persons, firms, or corporations, please so state in the following space:

There are no such persons, firms or corporations.

B. SUBCONTRACTORS:

The undersigned bidder/proposer proposes to have the following work performed by subcontractors. Disadvantaged-owned companies must be indicated in the column marked by a "D".

LIST OF SUBCONTRACTORS

Item of Work	% of Contract	"D"	Proposed Subcontractor	Address

If there are no such persons, firms, or corporations, please so state in the following space:
There are no such persons, firms or corporations.

The participation of disadvantaged-owned companies as shown above will be incorporated into any contract awarded as a result of this invitation or request.

The undersigned bidder/proposer does hereby certify that the above listed subcontractors have full knowledge that their names have been offered as subcontractors for the work, and the bidder/proposer further certifies that these subcontractors have consented to listing their names herein.

C. ADDENDA

The undersigned bidder/proposer acknowledges receipt of the following addenda:

Addendum No. 1 Date August 14, 2014

Addendum No.____ Date_____

Addendum No.____ Date_____

Addendum No.____ Date_____

Failure to acknowledge receipt of all addenda may cause the bid/proposal to be rejected as non-responsive.

D. SIGNATURE

The undersigned bidder/proposer certifies that it and each of its subcontractors possess an adequate supply of workers qualified to perform the work specified herein; that there is no existing or impending dispute between it and any labor organization; and that it is prepared to comply fully with prevailing wage requirements, minimum wages, maximum hours of work, and equal opportunity provisions contained in the general conditions of the contract.

This bid/proposal is submitted upon the declaration that neither I (we) nor, to the best of my (our) knowledge, none of the members of my (our) firm or company have either directly or indirectly entered into any agreement, participated in any collusion or otherwise taken any action in restraint of free competitive bidding/proposing in connection with this bid/proposal.

Dated at 10:25AM, this 25th day of August, 2014.

Signature of Bidder/Proposer:

If an individual:

doing business as_____.

By_____

If a partnership:

By_____, General Partner

If a corporation: _____.

a private corporation,

By Matt Lavrabec, ~~President~~ principal

Attest:_____
Secretary *

* please refer to attached "certification of corporate secretary"

If a joint venture:

joint venture comprised of:

_____

Name

_____

By

and

_____

Name

_____

By

Business Address of Bidder/Proposer:

111 SW Fifth Avenue, Suite 3700

Address

Portland, OR 97204

City, State, Zip Code (or Province and Country)

+1 503 227 0634

Area Code and Telephone Number of Bidder/Proposer

Milliman

Certification of Corporate Secretary

State of Washington)
ss.
County of King)

Brian S. Pollack, being first duly sworn upon oath, deposes and says:

1. I am the duly qualified and acting Corporate Secretary of Milliman, Inc.

2. On December 3, 2002, the following resolution was duly adopted by the Board of Directors of the corporation and remains in effect.

BE IT HEREBY RESOLVED, that each Principal of the firm and any consultant meeting requirements established by the Board of Directors are hereby granted the authority to individually negotiate and enter into proposals, engagement letters, contracts, letters of intent, and other documents on behalf of the corporation for the purpose of providing consulting, actuarial, and other professional services.

3. Matt R. Larrabee

☒ is a duly elected and acting Principal of the firm

☐ is a consultant of the firm who meets the requirements established by the Board of Directors

DATED this 22nd day of August 2014

Brian S. Pollack
Corporate Secretary

SUBSCRIBED AND SWORN to before me this 22nd day of August 2014

CAROLYN G. CROSSEN NOTARY PUBLIC STATE OF WASHINGTON COMMISSION EXPIRES 2-09-15

Notary Public in and for the State of Washington,
residing at Shoreline, Washington.
My commission expires 9 February 2015.

Appendix: Additional References

Oregon Public Employees Retirement System (OPERS)

Milliman UTA Team Member: Matt Larrabee

Client Contact:
Paul Cleary, Executive Director
Email: paul.cleary@state.or.us
Tel: +1 503 603 7701

Reason for inclusion as an additional UTA reference:
Skillful communication in a demanding environment

Roman Catholic Diocese of Phoenix Lay Employees Retirement Plan

Milliman UTA Team Members: Joel Stewart, Matt Larrabee

Client Contact:
Mark Krysiak, Director, Parish Administrative Services
Email: mkryisiak@diocesephoenix.org
Tel: +1 602 354 2189

Reason for inclusion as an additional UTA reference:
Demonstration of ease of transition, improvement in the depth and quality of consulting while holding the line on service fees

Employees' Retirement Fund of the City of Dallas

Milliman UTA Team Member: Bret Linton

Client Contact:
David Etheridge, Deputy Director of Benefits
Email: detheridge@dallaserf.org
Tel: +1 214 580 7708

Reason for inclusion as an additional UTA reference:
Good client perspective, strong overall consulting capabilities and client-consultant relationship.

Lane (Eugene, OR) Transit District

Milliman UTA Team Member: Will Clark-Shim

Client Contact:
Mary Adams, Director of HR & Risk Management
Email: mary.adams@ltd.org
Tel: +1 541 682 6100

Reason for inclusion as an additional UTA reference:
Demonstration of ability to work productively with all stakeholders of a transit district in a benefit design review study.

MEMORANDUM TO THE BOARD

TO: Utah Transit Authority Board of Trustees
THROUGH: Carolyn Gonot, Executive Director
FROM: Kimberly S. Ulibarri, Chief People Officer
PRESENTER(S): Kimberly S. Ulibarri, Chief People Officer

BOARD MEETING DATE: May 06, 2020

SUBJECT:	**Employer Health Insurance Agreement – Administrative Employees (Public Employers Health Plan)**
AGENDA ITEM TYPE:	**Expense Contract Change Order**
RECOMMENDATION:	Approve contract extension and authorize the Executive Director to execute the contract amendment and associated disbursements.
BACKGROUND:	The contract represents medical insurance coverage for Administrative employees through Public Employers Health Plan (PEHP) for Utah Transit Authority (UTA).
DISCUSSION:	Public Employers Health Plan (PEHP) has been utilized by UTA since 2017 as a medical insurance provider. UTA would like to renew their services for the 2020 Benefit Plan Year. The renewal rate for this contract is listed below. **Admin: 0% increase (hold on rates)** The renewal rate is well below the industry standard of between 8% & 9% per UTA's Benefits Consultant (GBS). Experience with PEHP has been positive overall from a customer service standpoint, and their network of providers allows employees a greater selection when seeking care.
CONTRACT SUMMARY:	Contractor Name: Employer Health Insurance Agreement with PEHP (UTA)
	Contract Number: 16-2070TP — Existing Contract Value: $ 7,938,635.89
	Base Contract Effective Dates: 05/01/2017 – 04/30/2018 — Extended Contract Dates: 05/01/2020 – 04/30/2021
	Amendment Amount: $3,000,000 — New/Total Amount Contract Value: $ 10,938,635.89
	Procurement Method: RFP (Competitive BID) — Funding Sources: Local

ALTERNATIVES:	Not approving this contract would require UTA to exercise the competitive bid process (RFP) and locate a new medical insurance provider immediately. This could delay medical insurance coverage for enrolled employees and require employees to switch providers mid-year once a new provider is selected.
FISCAL IMPACT:	Funding for this contract is included in UTA's 2020 budget.
ATTACHMENTS:	• Public Employers Health Plan Contract (Admin)

Employer Health Insurance Agreement

Between ___Utah Transit Authority___
and
Utah Retirement Systems Public Employees' Health Program
May 1, 2020 through April 30, 2021

Table of Contents

SECTION 1 – INTRODUCTION

1.1 Contract

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

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

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

1.2 Scope of Agreement

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

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

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

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

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

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

SECTION 2 – ELIGIBILITY AND ENROLLMENT

2.1 Eligibility

2.1.1 PEHP shall provide coverage to those Eligible Employees and their Eligible Dependents in accordance with the terms of the PEHP Master Policy attached as Appendix A.

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

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

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

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

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

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

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

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

2.2 Enrollment Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 3 – RESPONSIBILITIES OF EMPLOYER

3.1 In General

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

3.2 Rate Payments

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

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

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

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

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

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

3.3 Employment Verification and Status

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

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

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

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

3.4 Compliance

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

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

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

3.5 Miscellaneous

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

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

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

SECTION 4 – RESPONSIBILITIES OF PEHP

4.1 Plan Services

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

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

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

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

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

4.2 Reporting

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

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

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

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

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

4.3 Record Retention and Review

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

4.4 Claims Payment, Customer Service and Appeals

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

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

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

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

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

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

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

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

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

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

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

4.5 Information for Members

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

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

SECTION 5 – FUNDING

5.1 Self-Funded Status

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

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

5.2 Establishment of Rates

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

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

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

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

5.3 Reserves

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

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

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

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

5.4 Claims Reinsurance

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

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

5.5 Administrative Costs

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

SECTION 6 – CONFIDENTIALITY

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

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

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

SECTION 7 – TERM AND TERMINATION

7.1 Term of Agreement

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

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

7.2 Termination

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

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

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

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

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

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

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

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

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

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

SECTION 8 – GENERAL TERMS

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

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

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

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

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

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

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

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

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

8.9Notice.

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

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

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

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

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

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

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

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

SECTION 9 – DEFINITIONS

9.0 In General. This Agreement contains certain defined terms that are capitalized in the text and described in this Section. Words that are not defined have their usual meaning in everyday language.

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

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

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

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

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

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

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

9.8 Employee. An individual employed by Employer.

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

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

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

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

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

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

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

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

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

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

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

SECTION 10 – SIGNATURE PAGE

EXECUTED this 3rd day of March 2020.

UTAH RETIREMENT SYSTEMS
PUBLIC EMPLOYEES HEALTH PROGRAM

By_____
Chet Loftis
Director, Public Employees Health Program

EXECUTED this _____day of _____, 20__.

Utah Transit Authority

By _____Date_____
Kimberly S. Ulibarri
Chief People Officer

By _____Date_____
Carolyn Gonot
Executive Director

APPENDIX A

Plan Year: May 1, 2020 to April 30, 2021

A-1 Benefits

A Employer Plans/Programs

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

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

By participating in PEHP's Healthy Utah wellness program, Employer understands that PEHP will provide incentives and rebates to Member in conjunction with that program. PEHP will withhold taxes from those rebates in accordance with federal law requirements. These Member incentives are paid as claims from the Local Governments Risk Pool.

In addition to Member incentives, PEHP Healthy Utah may also incentivize Employers to encourage worksite wellness programs and activities through mini-grants and work well-being awards. These employer incentives are provided by PEHP through PEHP's administrative costs, and not funded through the Local Governments Risk Pool reserves. While PEHP makes every effort to ensure these Employer incentives comply with Utah and federal law, Employer maintains sole responsibility regarding the appropriation and disbursement of these funds, and PEHP shall maintain no liability regarding these funds once provided to the Employer.

Legal Guardianship
Employer has elected to allow children under guardianship to remain covered by PEHP between ages 19-26 like natural born children. In order to continue enrollment, the

guardian child must have been enrolled on the Employer's coverage prior to being 18 years of age and otherwise have met the qualifications for coverage as a guardian child. PEHP shall inform the Employer if a guardian child over the age of 19 has enrolled with PEHP on the monthly bill to Employer. The Employer understands that it may need to impute income to the employee if the guardian child does not qualify as a tax dependent under federal law. Employer acknowledges that it shall be solely liable for any tax consequences related to coverage of a guardian child over the age of 19, and that PEHP maintains no responsibility of any kind for any taxes which may be owed as a result of this coverage.

LTD Premium Waiver or Stipend

Employer has elected not to provide this benefit.

B Vesting Standards for LGRP

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

2. Employer IS deemed vested by PEHP.

C Reinsurance

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

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

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

4. PEHP shall evaluate claims and pay reinsurance amounts on a monthly basis. PEHP shall pay claims which are paid under the Employer's plan year in accordance with the PEHP Master Policy.

D. IRS Reporting

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

A-2 Rates

Summit Exclusive Traditional	**SINGLE**	**DOUBLE**	**FAMILY**
	$611.06	$1,353.87	$1,930.50

A-3 Additional Terms

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

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

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

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

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

A-4 Employer Portal –

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

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

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

(a) means

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

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

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

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

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

MEMORANDUM TO THE BOARD

TO: Utah Transit Authority Board of Trustees
THROUGH: Carolyn Gonot, Executive Director
FROM: Kimberly S. Ulibarri, Chief People Officer
PRESENTER(S): Kimberly S. Ulibarri, Chief People Officer

BOARD MEETING DATE: May 06, 2020

SUBJECT:	**Employer Health Insurance Agreement – Bargaining Employees (Public Employers Health Plan)**	
AGENDA ITEM TYPE:	**Expense Contract Change Order**	
RECOMMENDATION:	Approve contract extension and authorize the Executive Director to execute the contract amendment and associated disbursements.	
BACKGROUND:	The contract represents medical insurance coverage through Public Employers Health Plan (PEHP) for Amalgamated Transit Union (ATU) Local 382 represented employees. The contract is paid from the Joint Insurance Trust managed by UTA and ATU.	
DISCUSSION:	Public Employers Health Plan (PEHP) has been utilized by UTA since 2017 as a medical insurance provider. Both UTA & ATU wish to renew their services for the 2020 Benefit Plan Year. The renewal rate for this contract is listed below. **Bargaining: 3.9% increase in rates** The renewal rate is well below the industry standard of between 8% & 9% per UTA's Benefits Consultant (GBS). Experience with PEHP has been positive overall from a customer service standpoint, and their network of providers allows employees a greater selection when seeking care.	
CONTRACT SUMMARY:	Contractor Name: Employer Health Insurance Agreement with PEHP (UTA) & (ATU)	
	Contract Number: 16-2067TP	Existing Contract Value: $21,000,000
	Base Contract Effective Dates: 05/01/2017 – 04/30/2018	Extended Contract Dates: 05/01/2020 – 04/30/2021
	Amendment Amount: $7,000,000	New/Total Amount Contract Value: $28,000,000
	Procurement Method: RFP (Competitive BID)	Funding Sources: Local

ALTERNATIVES:	Not approving this contract would require both UTA/ATU to exercise the Competitive BID Process (RFP) and locate a new medical insurance provider immediately. This could delay medical insurance coverage for enrolled employees and require employees to switch providers mid-year once a new provider is selected.
FISCAL IMPACT:	Funding for the Joint Insurance Trust is already included in UTAs 2020 budget and is not impacted by this contract.
ATTACHMENTS:	• Public Employers Health Plan Contract (ATU)

Employer Health Insurance Agreement

Between UTA/ATU Joint Insurance Trust
and
Utah Retirement Systems Public Employees' Health Program
May 1, 2020 through April 30, 2021

Table of Contents

SECTION 1 – INTRODUCTION

1.1 Contract

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

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

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

1.2 Scope of Agreement

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

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

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

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

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

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

SECTION 2 – ELIGIBILITY AND ENROLLMENT

2.1 Eligibility

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

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

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

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

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

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

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

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

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

2.2 Enrollment Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 3 – RESPONSIBILITIES OF EMPLOYER

3.1 In General

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

3.2 Rate Payments

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

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

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

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

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

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

3.3 Employment Verification and Status

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

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

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

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

3.4 Compliance

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

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

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

3.5 Miscellaneous

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

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

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

SECTION 4 – RESPONSIBILITIES OF PEHP

4.1 Plan Services

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

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

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

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

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

4.2 Reporting

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

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

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

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

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

4.3 Record Retention and Review

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

4.4 Claims Payment, Customer Service and Appeals

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

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

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

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

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

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

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

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

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

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

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

4.5 Information for Members

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

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

SECTION 5 – FUNDING

5.1 Self-Funded Status

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

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

5.2 Establishment of Rates

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

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

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

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

5.3 Reserves

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

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

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

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

5.4 Claims Reinsurance

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

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

5.5 Administrative Costs

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

SECTION 6 – CONFIDENTIALITY

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

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

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

SECTION 7 – TERM AND TERMINATION

7.1 Term of Agreement

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

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

7.2 Termination

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

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

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

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

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

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

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

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

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

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

SECTION 8 – GENERAL TERMS

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

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

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

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

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

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

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

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

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

8.9 Notice.

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

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

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

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

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

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

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

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

SECTION 9 – DEFINITIONS

9.0 In General. This Agreement contains certain defined terms that are capitalized in the text and described in this Section. Words that are not defined have their usual meaning in everyday language.

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

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

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

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

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

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

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

9.8 Employee. An individual employed by Employer.

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

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

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

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

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

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

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

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

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

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

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

SECTION 10 – SIGNATURE PAGE

EXECUTED this 3rd day of March 2020.

UTAH RETIREMENT SYSTEMS
PUBLIC EMPLOYEES HEALTH PROGRAM

By_____
Chet Loftis
Director, Public Employees Health Program

EXECUTED this _____day of _____, 20__.

Utah Transit Authority

By _____Date_____
Kimberly S. Ulibarri
Chief People Officer

By _____Date_____
Carolyn Gonot
Executive Director

APPENDIX A

Plan Year: May 1, 2020 to April 30, 2021

A-1 Benefits

A Employer Plans/Programs

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

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

By participating in PEHP's Healthy Utah wellness program, Employer understands that PEHP will provide incentives and rebates to Member in conjunction with that program. PEHP will withhold taxes from those rebates in accordance with federal law requirements. These Member incentives are paid as claims from the Local Governments Risk Pool.

In addition to Member incentives, PEHP Healthy Utah may also incentivize Employers to encourage worksite wellness programs and activities through mini-grants and work well-being awards. These employer incentives are provided by PEHP through PEHP's administrative costs, and not funded through the Local Governments Risk Pool reserves. While PEHP makes every effort to ensure these Employer incentives comply with Utah and federal law, Employer maintains sole responsibility regarding the appropriation and disbursement of these funds, and PEHP shall maintain no liability regarding these funds once provided to the Employer.

Legal Guardianship
Employer has elected to allow children under guardianship to remain covered by PEHP between ages 19-26 like natural born children. In order to continue enrollment, the guardian child must have been enrolled on the Employer's coverage prior to being 18 years of age and otherwise have met the qualifications for coverage as a guardian

child. PEHP shall inform the Employer if a guardian child over the age of 19 has enrolled with PEHP on the monthly bill to Employer. The Employer understands that it may need to impute income to the employee if the guardian child does not qualify as a tax dependent under federal law. Employer acknowledges that it shall be solely liable for any tax consequences related to coverage of a guardian child over the age of 19, and that PEHP maintains no responsibility of any kind for any taxes which may be owed as a result of this coverage.

LTD Premium Waiver or Stipend

Employer has elected not to provide this benefit.

B Vesting Standards for LGRP

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

2. Employer IS deemed vested by PEHP.

C Reinsurance

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

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

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

4. PEHP shall evaluate claims and pay reinsurance amounts on a monthly basis. PEHP shall pay claims which are paid under the Employer's plan year in accordance with the PEHP Master Policy.

D. IRS Reporting

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

A-2 Rates

Summit Exclusive Traditional	**SINGLE**	**DOUBLE**	**FAMILY**
	$583.98	$1,440.22	$2,044.12

A-3 Additional Terms

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

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

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

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

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

A-4 Employer Portal

The PEHP Employer Portal through the website pehp.org if available for Employers 24 hours per day, seven days a week at no additional administrative charge to Employer. PEHP may

temporarily suspend PEHP Employer Portal access and services at its discretion for maintenance or other quality control issues.

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

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

(a) means

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

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

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

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

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

Appendix B

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

MEMORANDUM TO THE BOARD

TO: Utah Transit Authority Board of Trustees
THROUGH: Carolyn Gonot, Executive Director
FROM: Kimberly S. Ulibarri, Chief People Officer
PRESENTER(S): Kimberly S. Ulibarri, Chief People Officer

BOARD MEETING DATE: May 06, 2020

SUBJECT:	**Employer Health Insurance Agreement – Administrative Employees (Select Health)**	
AGENDA ITEM TYPE:	**Expense Contract Change Order**	
RECOMMENDATION:	Approve contract extension and authorize the Executive Director to execute the contract amendment and associated disbursements.	
BACKGROUND:	The contract represents medical insurance coverage for Administrative employees through Select Health for Utah Transit Authority (UTA) employees.	
DISCUSSION:	Select Health has been a medical insurance provider for UTA for some time and the current contract began in 2017. UTA would like to renew their services for the 2020 Benefit Plan Year. The contract renewal rate is listed below. **Admin: 1.4% rate increase** The renewal rate is well below the industry standard of between 8% & 9% per UTA's Benefits Consultant (GBS). Experience with Select Health has been very positive overall from a customer service standpoint, and their broad network of providers allows employees a greater selection when seeking care.	
CONTRACT SUMMARY:	Contractor Name: Employer Health Insurance Agreement with Select Health (UTA)	
	Contract Number: 16-2070TP-1	Existing Contract Value: $26,132,884.16
	Base Contract Effective Dates: 05/01/2017 – 04/30/2018	Extended Contract Dates: 05/01/2020 – 04/30/2021
	Amendment Amount: $9,300,000	New/Total Amount Contract Value: $35,432,884.16
	Procurement Method: RFP (Competitive BID)	Funding Sources: Local (Employee & Employer)
ALTERNATIVES:	Not approving this contract would require UTA to exercise the competitive bid process (RFP) and locate a new medical insurance provider immediately. This could delay	

	medical insurance coverage for enrolled employees and require employees to switch providers mid-year once a new provider is selected.
FISCAL IMPACT:	Funding for this contract is included in UTA's 2020 budget.
ATTACHMENTS:	• Select Health Medical Contract (Administrative)

2020

Medical Contract

UTA - Administrative Employees

selecthealth®

GROUP APPLICATION

Product	SelectHealth Med
Employer	UTA - Administrative Employees
Employer Contact	Jacob Gomez
Employer Address	669 W 200 S
	SALT LAKE CITY, UT 84101

Affiliated Businesses/Subsidiaries Covered by this Application

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

1. Monthly Premiums.

On or before the first day of each month, the following designated Premiums shall be paid to SelectHealth:

$ 615.90	for each single party enrollment
$ 1297.90	for each Subscriber plus spouse enrollment
$ 1297.90	for each Subscriber plus child enrollment
$ 1880.50	for each Subscriber plus children enrollment
$ 1880.50	for each family enrollment

2. Eligibility, Prepayment and Enrollment Criteria.

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

2.1 Scheduled hours of work per week.

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

2.2 Portion of Premium Subscriber must contribute.

Wellness program	**No Wellness**	
$ 91.38	$ 152.31	for each single party enrollment
$ 210.70	$ 342.39	for each two party enrollment
$ 302.80	$ 485.01	for each family enrollment

2.3 Limiting Age.

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

2.4 Retirees.

Retirees are not covered.

2.5 Domestic Partners.

Domestic partners are not covered.

2.6 Leave of Absence.

Eligible employees may be granted up to a 60 day leave of absence by employer or up to the time allowed for a qualifying leave under the Family Medical Leave Act.

2.7 Initial Eligibility Period.

The Initial Eligibility Period is 31 days.

2.8 Waiting Period.

The Employer Waiting Period is 30 days and the Effective Date for these employees is the first day of the next calendar month following the Employer Waiting Period.

2.9 Other employees.

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

2.10 Termination.

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

3. Duration of Contract.

This Contract is effective on May 1, 2020 to April 30, 2021, for a term of 12 months.

4. Additional Terms.

4.1 Additional Eligibility.

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

In Section 2.3 "Grace Period" of the contract LE-CONTRACT 01/01/20, the grace period has been extended from thirty (30) days to forty five (45) days.

Product: SelectHealth Med

Effective Date: May 1, 2020

Acknowledged and agreed:

Employer: UTA - Administrative Employees

By: _____

Printed Name: _____

Title: _____

Date: _____

By: _____

Printed Name: _____

Title: _____

Date: _____

SelectHealth:

By: _____

Printed Name: Patricia R. Richards

Title: President / Chief Executive Officer

Date: 3/23/2020

medical
contract

selecthealth®

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SECTION 1 INTRODUCTION

1.1 Contract

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

1.2 SelectHealth

SelectHealth is an HMO licensed by the State of Utah located at 5381 Green Street, Murray, Utah 84123. We are affiliated with Intermountain Healthcare, but are a separate company. The Contract does not involve Intermountain Healthcare or any other affiliated Intermountain companies, or their officers or employees. Such companies are not responsible for our obligations or actions.

1.3 Agency

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

1.4 Administration of Contract

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

1.5 ERISA and SelectHealth's Authority

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

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

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

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

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

SECTION 2 PREMIUM

2.1 Employer Responsibility

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

2.2 Premium Rates

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

2.3 Grace Period

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

2.4 Refund of Premium

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

SECTION 3 COVERAGE

3.1 Certificate of Coverage

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

3.2 Administrative Processes

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

3.3 No Vested Rights

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

SECTION 4 ELIGIBILITY AND ENROLLMENT

4.1 Eligibility

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

4.2 Changes in Member Information or Eligibility

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

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

b. Child loses Dependent status;

c. Death;

d. Divorce;

e. Marriage;

f. Involuntary loss of other coverage;

g. Member called to active military duty;

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

i. Reduction in employment hours;

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

k. Termination of employment; and

l. Other events as required by federal law.

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

4.3 Enrollment

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

4.4 Enrolling a Dependent Because of a Court Order

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

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

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

4.5.1 Minimum Extent

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

4.5.2 Documentation

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

4.6 Right to Decline Enrollment

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

SECTION 5 RESPONSIBILITIES OF THE PARTIES

5.1 Compliance

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

5.2 Indemnification

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

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

5.3 Reports

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

5.4 Internal Revenue Code (IRC) Section 6055 Reporting

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

5.5 Summary of Benefits and Coverage (SBC)

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

SECTION 6 TERMINATION

6.1 Reasons for Termination

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

6.1.1 Termination by Employer

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

6.1.2 Termination of Employer Group by SelectHealth

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

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

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

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

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

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

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

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

6.1.3 Employer Notice of Termination to Subscribers

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

6.2 Rescission

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

6.3 Liability for Services After Termination

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

SECTION 7 GENERAL

7.1 Binding Effect

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

7.2 Partial Invalidity

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

7.3 Non-Assignability

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

7.4 Choice of Law

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

7.5 Right to Audit Employer Records

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

7.6 Term

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

7.7 Circumstances Beyond Control

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

7.8 Workers' Compensation Insurance

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

7.9 No Waiver

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

7.10 Notices

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

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

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

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

d. We do not provide COBRA notification services.

SECTION 8 DEFINITIONS

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

8.1 Affordable Care Act (ACA)

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

8.2 Benefit(s)

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

8.3 Certificate of Coverage (Certificate)

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

8.4 COBRA Coverage

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

8.5 Continuation Coverage

COBRA Coverage and/or Utah mini-COBRA coverage.

8.6 Contract

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

8.7 Covered Services

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

8.8 Dependents

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

8.9 Effective Date

The date on which coverage for a Member begins.

8.10 Eligible, Eligibility

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

8.11 Employer Waiting Period

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

8.12 Employer Plan

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

8.13 ERISA

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

8.14 Exclusion(s)

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

8.15 Facility

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

8.16 Group Application

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

8.17 Grace Period

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

8.18 Limitation(s)

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

8.19 Member

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

8.20 Member Payment Summary

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

8.21 Optional Benefit

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

8.22 Plan

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

8.23 Plan Sponsor

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

8.24 Premium(s)

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

8.25 Provider

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

8.26 Qualified Medical Child Support Order

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

8.27 Rescission

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

8.28 Service Area

As defined in the Certificate(s) of Coverage.

8.29 Service(s)

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

8.30 Subscriber

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

8.31 Utah mini-COBRA

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

selecthealth

MED NETWORK

MEMBER PAYMENT SUMMARY	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.
CONDITIONS AND LIMITATIONS		
Lifetime Maximum Plan Payment - *Per Person*	None	
Pre-Existing Conditions (PEC)	None	
Benefit Accumulator Period	plan year	
Maximum Annual Out-of-Network Payment - (per plan year)	None	None
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5]	**IN-NETWORK**	**OUT-OF-NETWORK**
Self Only Coverage, 1 person enrolled - per plan year		
Deductible	$750	$1,500
Out-of-Pocket Maximum	$2,000	$4,000
Family Coverage, 2 or more enrolled - per plan year		
Deductible - per person/family	$750/$1500	$1500/$3000
Out-of-Pocket Maximum - per person/family	$2000/$4000	$4000/$8000
(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	40% after deductible
Skilled Nursing Facility[4] - Up to 60 days per plan year	20% after deductible	40% after deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	20% after deductible	40% after deductible
Up to 40 days per plan year for all therapy types combined		
PROFESSIONAL SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP)[1]	$25	40% after deductible
Secondary Care Provider (SCP)[1]	$35	40% after deductible
Allergy Tests	See Office Visits Above	Not Covered
Allergy Treatment and Serum	20%	Not Covered
Major Surgery	20%	40% after deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after deductible	40% after deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Provider (PCP)[1]	Covered 100%	Not Covered
Secondary Care Provider (SCP)[1]	Covered 100%	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Not Covered
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	Not Covered
Diagnostic Tests: Minor	Covered 100%	Not Covered
Other Preventive Services	Covered 100%	Not Covered
VISION SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Preventive Eye Exams	Covered 100%	Not Covered
All Other Eye Exams	$35	40% after deductible
OUTPATIENT SERVICES[4]	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Facility and Ambulatory Surgical	20% after deductible	40% after deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after deductible	See In-Network Benefit
Emergency Room - *(In-Network facility)*	$200	See In-Network Benefit
Emergency Room - *(Out-of-Network facility)*	$200	See In-Network Benefit
Intermountain InstaCare® Facilities, Urgent Care Facilities	$35	40% after deductible
Intermountain KidsCare® Facilities	$25	Not Available
Intermountain Connect Care®	Covered 100%	Not Available
Chemotherapy, Radiation and Dialysis	20% after deductible	40% after deductible
Diagnostic Tests: Minor[2]	Covered 100%	40% after deductible
Diagnostic Tests: Major[2]	20% after deductible	40% after deductible
Home Health, Hospice, Outpatient Private Nurse	20% after deductible	40% after deductible
Outpatient Cardiac Rehab	Covered 100%	40% after deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	$35 after deductible	40% after deductible

See other side for additional benefits

selecthealth

MED NETWORK

MEMBER PAYMENT SUMMARY	
IN-NETWORK	**OUT-OF-NETWORK**

MISCELLANEOUS SERVICES	IN-NETWORK	OUT-OF-NETWORK
Durable Medical Equipment (DME)[4]	20% after deductible	40% after deductible
Miscellaneous Medical Supplies (MMS)[3]	20% after deductible	40% 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[4,6]	See Professional, Inpatient or Outpatient	40% after deductible
Cochlear Implants[4]	See Professional, Inpatient or Outpatient	Not Covered
Infertility - *Select Services* *(Max Plan Payment $1,500/ plan year; $5,000 lifetime)*	*50% after deductible	Not Covered
Donor Fees for Covered Organ Transplants[4]	20% after deductible	Not Covered
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient	Not Covered

OPTIONAL BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Mental Health and Chemical Dependency[4]		
Office Visits	$25	40% after deductible
Inpatient	20% after deductible	40% after deductible
Outpatient	20%	40% after deductible
Residential Treatment[2]	20% after deductible	40% after deductible
Chiropractic - American Specialty Health (ASH) - 800-678-9133	$20 (up to 15 visits per plan year)	Not Covered
Injectable Drugs and Specialty Medications[4]	20% after deductible	40% after deductible
Bariatric Surgery *(Up to one surgery/lifetime)*[4]	See Professional, Inpatient or Outpatient	Not Covered

PRESCRIPTION DRUGS	
Pharmacy Deductible - Per Person per plan year	$50
Prescription Drug List (formulary)	RxSelect®
Prescription Drugs - *Up to 30 Day Supply of Covered Medications*[4]	
Tier 1	$7
Tier 2	$30 after pharmacy deductible
Tier 3	$60 after pharmacy deductible
Tier 4	$100 after pharmacy deductible
Maintenance Drugs - *90 Day Supply (Mail-Order, Retail90®)-selected drugs*[4]	
Tier 1	$7
Tier 2	$60 after pharmacy deductible
Tier 3	$180 after pharmacy deductible
Generic Substitution Required	Generic required or must pay copay plus cost difference between name brand and generic

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

2 Refer to your Certificate of Coverage for more information.

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

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

5 All deductible/copay/coinsurance amounts are based on the allowed amounts and not on the providers billed charges. 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 SelectHealth pays for Covered Services. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

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

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

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

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

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

medical
certificate of coverage

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Fair Treatment Notice

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

We provide free:

- Aid to those with disabilities to help them communicate with us, such as sign language interpreters and written information in other formats (large print, audio, electronic formats, other).
- Language help for those whose first language is not English, such as Interpreters and member materials written in other languages.

For help, call SelectHealth Member Services at **1-800-538-5038** or SelectHealth Advantage Member Services at **1-855-442-9900** (TTY Users: 711).

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

Language Access Services

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

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

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

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. SelectHealth. 번으로 전화해 주십시오.

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę'', t'áá jiik'eh, éí ná hóló', kojį' hódíílnih SelectHealth.

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

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

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

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

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

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎቶች ያለክፍያ ለእርስዎ ይገኛሉ። SelectHealth **ን ያናግሩ።**

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

تنبيه: إذا كنت تتحدث عربي، فستتوفر لك خدمات المساعدة اللغوية مجاناً. اتصل بـ SelectHealth.

توجه: اگر به زبان ار او در کنی صحبت می‌کنید، خدمات کمک زبانی، بصورت رایگان در اختیار شما ست. با SelectHealth تماس بگیرید.

หมายเหตุ: หากคุณพูด ใส่ภาษา, การบริการภาษา โดยไม่มีค่าใช้จ่าย มีพร้อมบริการให้กับคุณ ติดต่อ SelectHealth

SelectHealth: 1-800-538-5038
SelectHealth Advantage: 1-855-442-9900

selecthealth

SECTION 1 INTRODUCTION

1.1 This Certificate

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

1.2 SelectHealth, Inc.

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

1.3 Managed Care

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

1.4 Your Agreement

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

1.5 No Vested Rights

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

1.6 Administration

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

1.7 Non-Assignment

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

1.8 Notices

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

1.9 Nondiscrimination

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

1.10 Questions

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

1.11 Benefit Changes

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

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

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

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

SECTION 2 ELIGIBILITY

2.1 General

Your employer decides, in consultation with SelectHealth, which categories of its employees, retirees, and their Dependents are Eligible for Benefits, and establishes the other Eligibility requirements of the Plan. These Eligibility requirements are described in this section and in the Group Application of the Contract. In order to become and remain a Member, you and your Dependents must continuously satisfy these requirements. No one, including your employer, may change, extend, expand, or waive the Eligibility requirements without first obtaining the advance, written approval of an officer of SelectHealth.

2.2 Subscriber Eligibility

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

2.3 Dependent Eligibility

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

2.3.1 Spouse

Your lawful spouse. Eligibility may not be established retroactively.

2.3.2 Children

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

2.3.3 Disabled Children

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

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

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

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

SelectHealth may require you to provide proof of incapacity and dependency within 30 days of the Effective Date or the date the child reaches age 26 and annually after the two-year period following the child's 26th birthday.

2.3.4 Incarcerated Dependents

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

2.4 Court-Ordered Dependent Coverage

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

2.4.1 Qualified Medical Child Support Order (QMCSO)

A QMCSO can be issued by a court of law or by a state or local child welfare agency. In order for the medical child support order to be qualified, the order must specify the following:

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

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

c. The period to which the order applies.

2.4.2 National Medical Support Notice (NMSN)

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

2.4.3 Eligibility and Enrollment

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

2.4.4 Duration of Coverage

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

SECTION 3 ENROLLMENT

3.1 General

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

You and your Dependents will not be considered enrolled until:

a. All enrollment information is provided to SelectHealth; and

b. The Premium has been paid to SelectHealth by your employer.

3.2 Enrollment Process

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

3.3 Effective Date of Coverage

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

3.3.1 Annual Open Enrollment

Coverage elected during an Annual Open Enrollment will take effect on the day the Contract is effective.

3.3.2 Newly Eligible Employees

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

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

3.3.3 Court or Administrative Order

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

a. The start date indicated in the order;

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

c. The date SelectHealth receives the order.

3.4 Special Enrollment Rights

SelectHealth provides Special Enrollment Rights in the following circumstances:

3.4.1 Loss of Other Coverage

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

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

b. The loss of the other health plan coverage occurred because of a loss of eligibility (this Special Enrollment Right will not apply if the other coverage is lost due to nonpayment of Premiums). One exception to this rule exists: if a Dependent is enrolled on another group health plan and the Annual Open Enrollment periods of the two plans do not coincide, the Dependent may voluntarily drop coverage under their health plan's open enrollment and a special enrollment period will be permitted under the Plan in order to avoid a gap in coverage; and

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

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

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

3.4.2 New Dependents

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

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

a. As of the date of marriage;

b. As of the date of birth;

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

d. As of the later of:

   i. The effective date of the guardianship court order or testamentary appointment; or

   ii. The date the guardianship court order or testamentary appointment is received by SelectHealth.

3.4.3 Qualification for a Subsidy Through Utah's Premium Partnership

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

3.4.4 Loss of Medicaid or CHIP Coverage

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

3.4.5 As Required by State or Federal Law

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

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

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

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

b. If enrolling the child does not change the Premium, you must enroll the child within 31 days from the date SelectHealth mails notification that a claim for Services was received for the child.

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

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

3.6 Leave of Absence

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

3.7 Family Medical Leave Act

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

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

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

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

SECTION 4 TERMINATION

4.1 Group Termination

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

4.1.1 Termination by Employer

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

4.1.2 Termination of Employer Group by SelectHealth

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

a. Nonpayment of applicable Premiums;

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

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

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

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

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

g. SelectHealth withdraws from the market and discontinues all of its health benefit plans. If that happens, you will be given at least 180 days advance notice.

4.2 Individual Termination

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

4.2.1 Termination Date

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

4.2.2 Fraud or Misrepresentation

a. Made During Enrollment:

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

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

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

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

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

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

4.2.3 Leaving the Service Area

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

4.2.4 Annual Open Enrollment

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

4.2.5 Nonpayment of Premium or Contributions

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

4.2.6 Court or Administrative Order

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

4.3 Member Receiving Treatment at Termination

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

4.4 Reinstatement

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

SECTION 5 CONTINUATION COVERAGE

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

5.1 COBRA or Utah mini-COBRA (Continuation Coverage)

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

5.1.1 Employer's Obligation

Continuation Coverage is an employer obligation. SelectHealth is not the administrator of Continuation Coverage procedures and requirements. SelectHealth has contractually agreed to assist your employer in providing Continuation Coverage in certain circumstances. It is your employer's responsibility to do the following in a timely manner:

a. Notify persons entitled to Continuation Coverage;

b. Notify SelectHealth of such individuals; and

c. Collect and submit to SelectHealth all applicable Premiums.

If the Contract is terminated, your Continuation Coverage with SelectHealth will terminate. Your employer is responsible for obtaining substitute coverage.

5.2 Minimum Extent

Continuation Coverage will only be provided for the minimum time and only to the minimum extent required by applicable federal law or pursuant to Utah Code Annotated 31A-22-722. SelectHealth will not provide Continuation Coverage if you, your Dependents, or your employer fails to strictly comply with all applicable notices and other requirements and deadlines.

SECTION 6 PROVIDERS/NETWORKS

6.1 Providers and Facilities

SelectHealth contracts with certain Providers and Facilities (known as 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 SelectHealth.

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 a In-Network Provider or Facility. Refer to your Member Payment Summary 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 a Out-of-Network Provider or Facility. Refer to your Member Payment Summary for details.

6.1.3 Other Networks

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

6.2 Access to Healthcare Providers

You may be entitled to coverage for healthcare Services from the following

Out-of-Network Providers if you live or reside within 30 paved road miles of the listed Providers, or if you live or reside in closer proximity to the listed Providers than to your In-Network Providers:

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

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

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

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

6.3 Providers and Facilities not Agents/Employees of SelectHealth

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

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

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

6.4 Payment

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

6.4.1 Incentives

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

6.4.2 Payments to Members

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

6.5 Provider/Patient Relationship

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

6.6 Continuity of Care

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

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

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

a. Accept the Allowed Amount as payment in full;

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

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

d. Share information with SelectHealth regarding the treatment plan.

SECTION 7 ABOUT YOUR BENEFITS

7.1 General

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

7.2 Member Payment Summary

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

7.3 Identification (ID) Cards

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

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

7.4 Medical Necessity

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

7.5 Benefit Changes

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

7.6 Calendar-Year or Plan-Year Basis

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

7.7 Lifetime Maximums

Your Member Payment Summary will specify any applicable Lifetime Maximums.

7.8 Two Benefit Levels

7.8.1 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 SelectHealth pays for Covered Services. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

7.9 Emergency Conditions

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 SelectHealth 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 more than 40 miles away from any In-Network Provider or Facility.

7.11 Out-of-Area Benefits and Services

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

7.12 Third Party Payments

To the extent permissible under federal or state law, third-party payments (including discounts and coupons) may not apply towards your Deductible and Out-of-Pocket Maximum.

SECTION 8 COVERED SERVICES

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

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

a. Log in to My Health at selecthealth.org/myhealth;
b. Visit selecthealth.org;
c. Refer to your Provider & Facility Directory; or
d. Call Member Services at 800-538-5038.

8.1 Facility Services

8.1.1 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 SelectHealth-approved treatment Facility for alcohol/drug dependency.
f. Maternity/obstetrical Services.
g. Services in connection with an otherwise covered inpatient Hospital stay.

8.1.3 Nutritional Therapy

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

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

8.1.4 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.

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

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

8.2.3 Dental Services

Only:

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

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

   i. Maxillary and/or mandibular procedures;

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

   iii. Orthognathic Services; or

   iv. Services for Congenital Oligodontia/Anodontia.

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

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

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

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

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

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

8.2.4 Dietary Products

Only in the following limited circumstances:

a. For hereditary metabolic disorders when:

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

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

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

b. Certain enteral formulas according to SelectHealth policy.

8.2.5 Genetic Counseling

Only when rendered by an In-Network Provider.

8.2.6 Genetic Testing

Only when ordered or recommended by a medical geneticist, a genetic counselor, or a provider with

recognized expertise in the area being assessed and only when all of the following criteria are met:

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

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

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

8.2.7 Home Visits

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

8.2.8 Infertility

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

8.2.9 Major Surgery

8.2.10 Mastectomy/Reconstructive Services

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

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

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

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

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

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

8.2.11 Medical/Surgical

In an inpatient, outpatient, or Ambulatory Surgical Facility.

8.2.12 Maternity Services

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

8.2.13 Office Visits

For consultation, diagnosis, and treatment.

8.2.14 Preventive Services

8.2.15 Sleep Studies

Only when provided by an In-Network provider who is a board-certified sleep specialist and:

a. The Service is performed at an In-Network Facility certified as a sleep center/lab by the American Board of Sleep Medicine; or

b. For home studies if the Member receiving Services is 18 or older.

8.2.16 Sterilization Procedures

8.3 Miscellaneous Services

8.3.1 Adoption Indemnity Benefit

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

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

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

8.3.2 Ambulance/Transportation Services

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

8.3.3 Approved Clinical Trials

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

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

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

c. Either:

   i. The referring health care professional is 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 Chemotherapy, Radiation Therapy, and Dialysis

8.3.5 Cochlear Implants

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

8.3.6 Durable Medical Equipment (DME)

Only:

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

   i. Prescribed by a Provider;

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

   iii. Required for Activities of Daily Living;

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

   v. Not attached to a home or vehicle.

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

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

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

8.3.7 Home Healthcare

a. When you:

   i. Have a condition that requires the services of a licensed Provider;

   ii. Are home bound for medical reasons;

   iii. Are physically unable to obtain necessary medical care on an outpatient basis; and

   iv. Are under the care of a Physician.

b. In order to be considered home bound, you must either:

   i. Have a medical condition that restricts your ability to leave the home without the assistance of another individual or supportive device or because absences from the home are medically contraindicated; or

   ii. Leave the home only to receive medical treatment that cannot be provided in your home or other treatments that require equipment that cannot be made available in your home or infrequently and for short periods of time for nonmedical purposes.

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

8.3.8 Hospice Care

8.3.9 Injectable Drugs and Specialty Medications

Up to a 30-day supply, though exceptions can be made for travel purposes. Injectable drugs and specialty medications must be provided by an In-Network Provider unless otherwise approved in writing in advance by SelectHealth. You may be required to receive the drug or medication in your Provider's office. Some Injectable Drugs and Specialty Medications may only be obtained from certain drug distributors. Call Member Services to determine if this is the case and to obtain information on In-Network drug vendors.

8.3.10 Miscellaneous Medical Supplies (MMS)

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

8.3.11 Neuropsychological Testing (Medical)

As a medical Benefit, only as follows:

a. Testing performed as part of the preoperative evaluation for patients undergoing:

   i. Seizure surgery;

   ii. Solid organ transplantation; or

   iii. Central nervous system malignancy.

b. Patients being evaluated for dementia/Alzheimer's disease;

c. Patients with Parkinson's Disease;

d. Stroke patients undergoing formal rehabilitation; and

e. Post-traumatic-brain-injury patients.

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

8.3.12 Organ Transplants

a. Only if:

   i. Provided by In-Network Providers in an In-Network Facility unless otherwise approved in writing in advance by SelectHealth.

b. And only the following:

   i. Bone marrow as outlined in SelectHealth criteria;

   ii. Combined heart/lung;

   iii. Combined pancreas/kidney;

   iv. Cornea;

   v. Heart;

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

   vii. Liver;

   viii. Pancreas after kidney;

   ix. Single or double lung and

   x. Small bowel.

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

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

8.3.13 Orthotics and Other Corrective Appliances for the Foot

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

8.3.14 Osteoporosis Screening

Only central bone density testing (DEXA scan)

8.3.15 Private Duty Nursing

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

8.3.16 Rehabilitation Therapy

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

8.3.17 TeleHealth

Otherwise covered evaluation and management, genetic counseling and mental health Services when rendered by an In-Network Provider, and as otherwise indicated in medical policy.

8.3.18 Temporomandibular Joint (TMJ)

8.3.19 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 a Participating Provider

8.3.20 Vision Aids

Only:

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

b. Monofocal intraocular lenses after cataract surgery.

8.4 Prescription Drug Services

Refer to Section 9 Prescription Drug Benefits for details.

SECTION 9 PRESCRIPTION DRUG BENEFITS

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

9.1 Prescription Drug Benefit Resources

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

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

b. Visit selecthealth.org/pharmacy;

c. Refer to your Provider & Facility Directory; or

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

9.2 Use In-Network Pharmacies

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

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

9.3 Tiered Benefits

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

Drugs on each tier are selected by an expert panel of Physicians and pharmacists and may change periodically. To determine which tier a drug is assigned to, call Member Services or log in to My Health.

9.4 Filling Your Prescription

9.4.1 Copay/Coinsurance

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

9.4.2 Quantity and Day Supply

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

9.4.3 Refills

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

9.5 Generic Drug Substitution Required

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

9.6 Maintenance Drugs

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

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

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

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

Maintenance drugs are identified by the letter (M) on the Prescription Drug List. You have two options when filling prescriptions under the maintenance drug Benefit: (1) Retail90SM, which is available at certain retail pharmacies; and (2) mail order. Please refer to your Member Payment Summary or contact Member Services to verify if the 90-day maintenance drug Benefit is available on your Plan.

9.7 Preauthorization of Prescription Drugs

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

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

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

9.8 Step Therapy

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

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

9.9 Coordination of Benefits (COB)

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

9.10 Inappropriate Prescription Practices

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

a. These drugs include:
    i. Narcotic analgesics;
    ii. Other addictive or potentially addictive drugs; and
    iii. Drugs prescribed in quantities, dosages, or usages that are outside the usual standard of care for the medication in question.
b. These drugs are not covered when they are prescribed:
    i. Outside the usual standard of care for the practitioner prescribing the drug;
    ii. In a manner inconsistent with accepted medical practice; or
    iii. For indications that are Experimental and/or Investigational.

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

9.11 Prescription Drug Benefit Abuse

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

a. Obtain prescriptions in limited dosages and supplies;

b. Obtain prescriptions only from a specified Provider;

c. Fill your prescriptions at a specified pharmacy;

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

e. Complete a drug treatment program; or

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

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

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

9.12 Pharmacy Injectable Drugs and Specialty Medications

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

9.13 Prescription Drug List (PDL)

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

9.14 Exceptions Process

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

9.15 Prescriptions Dispensed in a Provider's Office

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

9.16 Disclaimer

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

SECTION 10 LIMITATIONS AND EXCLUSIONS

Unless otherwise noted in your Member Payment Summary or Appendix A Optional Benefits, the following Limitations and Exclusions apply.

10.1 Abortions/Termination of Pregnancy

Abortions are not covered except:

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

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

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

10.2 Acupuncture/Acupressure

Acupuncture and acupressure Services are not covered.

10.3 Administrative Services/Charges

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

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

10.4 Allergy Tests/Treatments

a. The following allergy tests are not covered:
   i. Cytotoxic Test (Bryan's Test);
   ii. Leukocyte Histamine Release Test;
   iii. Mediator Release Test (MRT);
   iv. Passive Cutaneous Transfer Test (P-K Test);
   v. Provocative Conjunctival Test;
   vi. Provocative Nasal Test;
   vii. Rebuck Skin Window Test;
   viii. Rinkel Test;
   ix. Subcutaneous Provocative Food and Chemical Test; and
   x. Sublingual Provocative Food and Chemical Test.

b. The following allergy treatments are not covered:
   i. Allergoids;
   ii. Autogenous urine immunization;
   iii. LEAP therapy;
   iv. Medical devices (filtering air cleaner, electrostatic air cleaner, air conditioners etc.);
   v. Neutralization therapy;
   vi. Photo-inactivated extracts; and
   vii. Polymerized extracts.

10.5 Anesthesia

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

10.6 Biofeedback/Neurofeedback

Biofeedback/neurofeedback is not covered.

10.7 Birthing Centers and Home Childbirth

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

10.8 Certain Cancer Therapies

Neutron beam therapy is not covered.

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

a. Chordomas or chondrosarcomas arising at the base of the skull or along the axial skeleton without distant metastases;

b. Other central nervous system tumors located near vital structures;

c. Pituitary neoplasms;

d. Uveal melanomas confined to the globe (not distant metastases); or

e. In accordance with SelectHealth medical policy.

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

10.9 Certain Illegal Activities

Subject to the nondiscrimination provisions of the Health Insurance Portability and Accountability Act (HIPAA), Services for an illness, condition, accident, or injury related directly to voluntary participation in an illegal activity are not covered. This exclusion does not apply for any injuries sustained from an act of domestic violence or a medical condition.

10.10 Chiropractic Services

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

10.11 Claims After One Year

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

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

10.12 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.

10.13 Custodial Care

Custodial Care is not covered.

10.14 Debarred Providers

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

10.15 Dental Anesthesia

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

a. You or your Dependent is developmentally delayed, regardless of his or her chronological age;

b. You or your Dependent, regardless of age, has a congenital cardiac or neurological condition and documentation is provided that the dental anesthesia is needed to closely monitor the condition; or

c. You or your Dependent is younger than five years of age and:

   i. The proposed dental work involves three or more teeth;

ii. The diagnosis is nursing bottle-mouth syndrome or extreme enamel hypoplasia; and

iii. The proposed procedures are restoration or extraction for rampant decay.

10.16 Dry Needling

Dry needling procedures are not covered.

10.17 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.

10.18 Exercise Equipment or Fitness Training

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

10.19 Experimental and/or Investigational Services

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

10.20 Eye Surgery, Refractive

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

10.21 Food Supplements

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

10.22 Hearing Aids

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

10.23 Home Health Aides

Services provided by a home health aide are not covered.

10.24 Immunizations

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

10.25 Mental Health

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

10.26 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.

10.27 Pain Management Services

The following Services are not covered:

a. Prolotherapy;

b. Radiofrequency ablation of dorsal root ganglion; and

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

10.28 Prescription Drugs/Injectable Drugs and Specialty Medications

The following are not covered:

a. Appetite suppressants and weight loss drugs;

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

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

d. Compound drugs when alternative products are available commercially;

e. Cosmetic health and beauty aids;

f. Drugs not on your Formulary;

g. Drugs purchased from Out-of-Network Providers over the Internet;

h. Drugs purchased through a foreign pharmacy. However, please call Member Services if you have a special need for medications from a foreign pharmacy (for example, for an emergency while traveling out of the country);

i. Flu symptom drugs, except when approved by an expert panel of Physicians and SelectHealth;

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

k. Infertility drugs;

l. Medical foods;

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

   i. Food and Drug Administration (FDA) approval;

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

   iii. Nationally recognized compendium sources currently utilized by SelectHealth;

   iv. National Comprehensive Cancer Network (NCCN); or

   v. As defined within SelectHealth's Preauthorization criteria or medical policy.

n. Drugs used for infertility purposes;

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

p. Non-Sedating Antihistamines;

q. Over-the-counter (OTC) drugs, except as required by the Patient Protection and Affordable Care Act (ACA), or when all of the following conditions are met:

   i. The OTC drug is listed on a SelectHealth Formulary as a covered drug;

   ii. The SelectHealth Pharmacy & Therapeutics Committee has approved the OTC medication as a medically appropriate substitution of a Prescription Drug; and

iii. You or your Dependent has obtained a prescription for the OTC drug from a licensed Provider and filled the prescription at an In-Network Pharmacy.

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

s. Prescription Drugs used for cosmetic purposes;

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

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

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

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

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

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

10.29 Reconstructive, Corrective, and Cosmetic Services

a. Services provided for the following reasons are not covered:

i. To improve form or appearance;

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

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

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

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

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

i. Congenital cleft lip except for treatment rendered within 12 months of birth, or a planned, staged series of Services (as specifically documented in you or your Dependent's medical record) is initiated, or when congenital cleft lip surgery is performed as part of a cleft palate repair; or

ii. Treatment for venous telangiectasias (spider veins).

10.30 Related Provider Services

Services provided, ordered, and/or directed for you or your Dependent by a Provider who ordinarily resides in the same household are not covered.

10.31 Respite Care

Respite Care is not covered.

10.32 Robot-Assisted Surgery

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

10.33 Sexual Dysfunction

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

10.34 Specialty Services

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

10.35 Specific Services

The following Services are not covered:

a. Anodyne infrared device for any indication;

b. Auditory brain implantation;

c. Automated home blood pressure monitoring equipment;

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

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

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

g. Computer-assisted navigation for orthopedic procedures;

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

i. Extracorporeal shock wave therapy for musculoskeletal indications;

j. Freestanding/home cervical traction;

k. Infrared light coagulation for the treatment of hemorrhoids;

l. Interferential/neuromuscular stimulators;

m. Intimal Media Thickness (IMT) testing to assess risk of coronary disease;

n. Magnetic Source Imaging (MSI);

o. Manipulation under anesthesia for treatment of back and pelvic pain;

p. Mole mapping;

q. Nonsurgical spinal decompression therapy (e.g., VAX-D or DRS therapy);

r. Nucleoplasty or other forms of percutaneous disc decompression;

s. Oncofertility;

t. Pediatric/infant scales;

u. Peripheral nerve stimulation for occipital neuralgia and chronic headaches;

v. Platelet Rich Plasma or other blood derived therapies for orthopedic procedures;

w. Pressure Specified Sensory Device (PSSD) for neuropathy testing;

x. Prolotherapy;

y. Radiofrequency ablation for lateral epicondylitis;

z. Radiofrequency ablation of the dorsal root ganglion;

aa. Virtual colonoscopy as a screening for colon cancer; and

bb. Whole body scanning.

10.36 Telephone/E-mail Consultations

Except for TeleHealth Services, as described in Section 8 Covered Services, charges for Provider telephone, e-mail, or other electronic consultations are not covered.

10.37 Terrorism or Nuclear Release

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

10.38 Travel-related Expenses

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

10.39 War

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

SECTION 11 HEALTHCARE MANAGEMENT

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

11.1 Preauthorization

Preauthorization is prior approval from SelectHealth for certain Services and is considered a Preservice Claim (refer to Section 12 Claims and Appeals). Preauthorization is not required when SelectHealth is your secondary plan. Obtaining Preauthorization does not guarantee coverage. Your Benefits for the Preauthorized Services are subject to the Eligibility requirements, Limitations, Exclusions and all other provisions of the Plan. Preauthorization requirements for Prescription Drugs are also found in Section 9 – Prescription Drug Benefits.

11.1.1 Services Requiring Preauthorization

Preauthorization is required for the following Services:

a. Advanced imaging including Magnetic Resonance Imaging (MRI), Computerized Tomography (CT) scans, Positron Emission Tomography (PET) scans, and cardiac imaging;

b. All admissions to facilities, including rehabilitation, transitional care, skilled nursing, and all hospitalizations that are not for Urgent or Emergency Conditions;

c. All nonroutine obstetrics admissions, maternity stays longer than two days for a normal delivery or longer than four days for a cesarean section, and deliveries outside of the Service Area;

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

e. Bariatric surgery;

f. Home Healthcare, Hospice Care, and Private Duty Nursing;

g. Joint replacement;

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

i. Pain management/pain clinic Services;

j. Certain genetic testing;

k. Certain ultrasounds;

l. Certain radiation therapies;

m. Certain sleep studies;

n. Certain medical oncology drugs;

o. Cochlear Implants;

p. Continuous glucose monitors;

q. Hysterectomy;

r. Tonsillectomy;

s. Adenoidectomy;

t. Outpatient Rehabilitative, Habilitative, and Chiropractic-therapy Services after 10 visits per therapy type, per calendar Year;

u. Organ Transplants;

v. The following Durable Medical Equipment:

   i. Insulin pumps;

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

   iii. Prosthetics (except eye prosthetics);

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

   v. Motorized or customized wheelchairs; and

vi. DME with a purchase price over $5,000;

w. The medications listed on selecthealth.org/pharmacy/pharmacy-benefits. You may also request this list by calling Pharmacy Services at 800-538-5038.

In addition to these Services, In-Network Providers must Preauthorize other Services as specified in SelectHealth 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 a Out-of-Network Provider or Facility.

11.1.3 How to request Preauthorization

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

You should call SelectHealth as soon as you know you will be using 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 percent and Benefits will apply to what remains according to regular Plan guidelines. You will be responsible for the 50 percent penalty, your Copay, Coinsurance, and Deductible, and you may be responsible for any amount that exceeds the Allowed Amount.

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

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

11.2 Case Management

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

11.3 Benefit Exceptions

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

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

11.4 Second Opinions/Physical Examinations

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

11.5 Medical Policies

SelectHealth has developed medical policies to serve as guidelines for coverage decisions. These guidelines detail when certain Services are considered Medically Necessary or Experimental and/or Investigational by SelectHealth. Medical policies do not supersede the express provisions of this Certificate. Coverage decisions are subject to all terms and conditions of the applicable Plan, including specific Exclusions and Limitations. Because medical policies are based on constantly changing science, they are periodically reviewed and updated by SelectHealth. For questions about SelectHealth's medical policies, call Member Services at 800-538-5038.

SECTION 12 CLAIMS AND APPEALS

12.1 Administrative Consistency

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

12.2 Claims and Appeals Definitions

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

12.2.1 Adverse Benefit Determination

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

12.2.2 Appeal(s)

Review by SelectHealth of an Adverse Benefit Determination.

12.2.3 Authorized Representative

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

12.2.4 Benefit Determination

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

12.2.5 Claimant

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

12.2.6 Concurrent Care Decisions

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

12.2.7 External Review

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

12.2.8 Final Internal Adverse Benefit Determination

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

12.2.9 Independent Review Organization (IRO)

An entity that conducts independent External Reviews.

12.2.10 Postservice Appeal

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

12.2.11 Postservice Claim

Any claim related to Services you have already received.

12.2.12 Preservice Appeal

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

12.2.13 Preservice Claim

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

12.2.14 Urgent Preservice Claim

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

12.3 How to File a Claim for Benefits

12.3.1 Urgent Preservice Claims

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

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

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

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

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

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

12.3.2 Other Preservice Claims

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

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

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

12.3.3 Postservice Claims

a. In-Network Providers and Facilities. In-Network Providers and Facilities file Postservice Claims with SelectHealth and SelectHealth 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 SelectHealth. If an Out-of-Network Provider or Facility does not submit a Postservice Claim to SelectHealth or you pay the Out-of-Network Provider or Facility, you must submit the claim in writing in a form approved by SelectHealth. Call Member Services or your employer to find out what information is needed to submit a Postservice Claim. All claims must be received by SelectHealth within a 12-month period from the date of the expense or as soon as reasonably possible. Claims received outside of this timeframe will be denied. Failure to file a claim does not bar recovery under the policy if SelectHealth fails to show it was prejudiced by the failure.

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

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

12.4 Problem Solving

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

12.5 Formal Appeals

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

12.5.1 General Rules and Procedures

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

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

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

12.5.2 Form and Timing

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

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

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

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

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

12.5.3 Appeals Process

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

After a mandatory review process, you may choose to pursue civil action, including, if applicable, under ERISA Section 502(a). Failure to properly pursue the mandatory Appeals process may result in a waiver of the right to challenge the original decision of SelectHealth.

12.5.4 Preservice Appeals

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

Mandatory Review

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

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

Voluntary Review

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

Voluntary External Review

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, or a Rescission of coverage. To request an External Review, you must complete the Independent Review Request Form. For a copy of this form, or for other questions, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City, UT 84114; by phone at 801-538-3077; or electronically at healthappeals.uid@utah.gov. An External Review request must be made within 180 days from the date the Appeals Department notifies you of the Final Internal Adverse Benefit Determination. An authorization to obtain medical records may be required. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. The IRO will provide written notice of its decision within 45 days after receipt of the request.

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

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

Voluntary Internal Review

If you choose to pursue the voluntary internal review process, you may request a review of your Appeal. Depending on the nature of the Appeal, it will be considered by the Administrative and Clinical Appeal Review Committee. Such a request must be made in writing to the Appeals Department within 60 days of the date the Appeals Department notifies you of the Final Internal Adverse Benefit Determination. SelectHealth will notify you of the result of the review in writing within 30 days of the date you requested the review. However, SelectHealth may extend this period if SelectHealth: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which SelectHealth expects to render a decision. If you are not satisfied with the decision made by the reviewing committee, you may request a review by the SelectHealth Appeals Committee. Such a request must be made in writing to the Appeals Department within 60 days of the date the reviewing committee notifies you of its decision.

12.5.5 Postservice Appeals

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

Mandatory Review

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

Voluntary Review

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

Voluntary External Review

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, or a Rescission of coverage. To request an External Review you must complete the Independent Review Request Form. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. For a copy of this form, or for other questions, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City, UT 84114; by phone at 801-538-3077; or electronically at healthappeals.uid@utah.gov. An External Review request must be made within 180 days from the date SelectHealth sends the Final Internal Adverse Benefit Determination. An authorization to obtain medical records may be required. The IRO will provide written notice of its decision within 45 days after receipt of the request.

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

Voluntary Internal Review

If you choose to pursue the voluntary internal review process, you may request a review of your Appeal. Depending on the nature of the Appeal, it will be considered by the Administrative and Clinical Appeal Review Committee. Such a request must be made in writing to the Appeals Department within 60 days of the date the Appeals Department notifies you of the Final Internal Adverse Benefit Determination. SelectHealth will notify you of the result of the review in writing within 30 days of the date you requested the review. However, SelectHealth may extend this period if SelectHealth: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which SelectHealth expects to render a decision. If you are not satisfied with the decision made by the reviewing committee, you may request a review by the SelectHealth Appeals Committee. Such a request must be made in writing to the Appeals Department within 60 days of the date the reviewing committee notifies you of its decision.

SECTION 13 OTHER PROVISIONS AFFECTING YOUR BENEFITS

13.1 Coordination of Benefits (COB)

When you or your Dependents have healthcare coverage under more than one health benefit plan, SelectHealth will coordinate Benefits with the other healthcare coverage according to the COB rules set forth in Utah Administrative Code R590-131.

13.1.1 Required Cooperation

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

13.1.2 Direct Payments

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

13.2 Subrogation, Reimbursement and Recovery

13.2.1 Payment of Claims When a Third Party is Liable

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

13.2.2 SelectHealth's Recovery Rights

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

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

13.2.3 Agreement by Members

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

If requested to do so by SelectHealth, you and your Dependents must execute a written recovery agreement as a condition of payment on claims arising from injuries or illnesses caused by third parties. If your Dependent is so injured or has such an illness, both you and your Dependent are required to execute the written recovery agreement. If the injured or ill person is a minor or legally incompetent, the written recovery agreement must be executed by the person's parent(s), managing conservator and/or guardian. If you or your Dependent has died, your or your Dependent's legal representative must execute the agreement. Any Plan benefits paid must be returned to SelectHealth immediately in the event that SelectHealth requests that a written recovery agreement be signed and there is a failure or refusal to execute the recovery agreement. SelectHealth's rights, however, are not waived if SelectHealth does not request a written recovery agreement under this section 13.2.

13.2.4 Constructive Trust and First Lien

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

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

13.2.5 Rights to Intervene and Sue

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

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

The amount that SelectHealth is entitled to recover from you and your Dependents under this section 13.2 is specifically unreduced by any attorney, legal or other fees and costs incurred by you or your Dependents in seeking recovery from a third party (whether the third party is the responsible party or is an insurer), except if SelectHealth specifically agrees in writing to participate in these fees.

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

13.2.6 Special Subrogation Rules for Utah

Notwithstanding anything else in this Section 13.2 to the contrary, SelectHealth's rights under this section 13.2, when SelectHealth is asserting rights against underinsured/uninsured motorist coverage subject to Utah Code Annotated sections 31A-22-305 or 31A-22-305.3 shall be limited to situations in which you or your Dependents have been made whole.

13.3 Excess Payment

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

SECTION 14 SUBSCRIBER RESPONSIBILITIES

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

14.1 Payment

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

14.2 Changes in Eligibility or Contact Information

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

14.3 Other Coverage

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

14.4 Information/Records

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

14.5 Notification of Members

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

SECTION 15 EMPLOYER RESPONSIBILITIES

15.1 Enrollment

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

15.2 Payment

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

15.3 Contract

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

15.4 Compliance

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

SECTION 16 DEFINITIONS

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

16.1 Activities of Daily Living

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

16.2 Affordable Care Act (ACA)

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

16.3 Allowed Amount

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

16.4 Ambulatory Surgical Facility

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

16.5 Annual Open Enrollment

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

16.6 Anodontia

The condition of congenitally missing all teeth, either primary or permanent.

16.7 Application

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

16.8 Approved Clinical Trials

A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease (any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted) and is described in any of the following:

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

   i. The National Institutes of Health.

   ii. The Centers for Disease Control and Prevention.

   iii. The Agency for Health Care Research and Quality.

   iv. The Centers for Medicare & Medicaid Services.

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

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

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

      1) The Department of Veterans Affairs.

      2) The Department of Defense.

      3) The Department of Energy.

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

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

16.9 Autism Spectrum Disorder

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

a. Asperger's Syndrome;

b. Autistic Disorder;

c. Childhood Disintegrative Disorder; and

d. Pervasive developmental disorder not otherwise specified.

16.10 Benefit(s)

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

16.11 Certificate of Coverage (Certificate)

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

16.12 COBRA Coverage

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

16.13 Coinsurance

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

16.14 Continuation Coverage

COBRA Coverage and/or Utah mini-COBRA coverage.

16.15 Contraceptive

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

16.16 Contract

The Group Health Insurance Contract between SelectHealth and your employer.

16.17 Copay (Copayment)

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

16.18 Covered Services

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

16.19 Custodial Care

Services provided primarily to maintain rather than improve a Member's condition or for the purpose of controlling or changing the Member's environment. Services requested for the convenience of the Member or the Member's family that do not require the training and technical skills of a licensed Nurse or other licensed Provider, such as convalescent care, rest cures, nursing home services, etc. Services that are provided principally for personal hygiene or for assistance in daily activities.

16.20 Deductible(s)

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

16.21 Dental Services

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

16.22 Dependents

Your Eligible dependents as set forth in Section 2 Eligibility.

16.23 Durable Medical Equipment (DME)

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

16.24 Effective Date

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

16.25 Eligible, Eligibility

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

16.26 Emergency Condition(s)

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

a. Placing a Member's health in serious jeopardy;

b. Placing the health of a pregnant woman or her unborn child in serious jeopardy;

c. Serious impairment to bodily functions; or

d. Serious dysfunction of any bodily organ or part.

16.27 Employer Waiting Period

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

16.28 Employer's Plan

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

16.29 Endorsement

A document that amends the Contract.

16.30 ERISA

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

16.31 Excess Charges

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

16.32 Exclusion(s)

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

16.33 Experimental and/or Investigational

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

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

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

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

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

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

16.34 Facility

An institution that provides certain healthcare Services within specific licensure requirements.

16.35 Formulary

The Prescription Drugs covered by your Plan.

16.36 Generic Drug(s)

A medication that has the same active ingredients, safety, dosage, quality, and strength as its brand-name counterpart. Both the brand-name drug and the Generic Drug must get approval from the FDA before they can be sold.

16.37 Group Application

A form used by SelectHealth both as an application for coverage by your employer and to specify group-specific details of coverage. The Group Application may contain modifications to the language of the Contract. It also demonstrates your employer's acceptance of the Contract. Other documents, such as Endorsements, may be incorporated by reference into the Group Application.

16.38 Group Health Insurance Contract

The agreement between your employer and SelectHealth that contains the terms and conditions under which SelectHealth provides group insurance coverage to you and your Dependents. The Group Application and this Certificate are part of the Group Health Insurance Contract. If your employer is not directly sponsoring the Plan, references to employer throughout the Certificate of Coverage can also include the party contracting with SelectHealth for Benefits provided to you.

16.39 Healthcare Management Program

A program designed to help you obtain quality, cost-effective, and medically appropriate care, as described in Section 11 Healthcare Management.

16.40 Home Healthcare

Services provided to Members at their home by a licensed Provider who works for an organization that is licensed by the state where Services are provided.

16.41 Hospice Care

Supportive care provided on an inpatient or outpatient basis to a terminally ill Member not expected to live more than six months.

16.42 Hospital

A Facility that is licensed by the state in which Services are provided that is legally operated for the medical care and treatment of sick or injured individuals.

A Facility that is licensed and operating within the scope of such license, which:

a. Operates primarily for the admission, acute care, and treatment of injured or sick persons as inpatients;

b. Has a 24-hour-a-day nursing service by or under the supervision of a graduate registered Nurse (R.N.) or a licensed practical Nurse (L.P.N.);

c. Has a staff of one or more licensed Physicians available at all times; and

d. Provides organized facilities for diagnosis and surgery either on its premises or in facilities available to the Hospital on a contractual prearranged basis.

16.43 Infertility

A condition resulting from a disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the male or female reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery.

16.44 Injectable Drugs and Specialty Medications

A class of drugs that may be administered orally, as a single injection, intravenous infusion or in an inhaled/nebulized solution. Injectable drugs and specialty medications include all or some of the following:

a. Are often products of a living organism or produced by a living organism through genetic manipulation of the organism's natural function;

b. Are generally used to treat an ongoing chronic illness;

c. Require special training to administer;

d. Have special storage and handling requirements;

e. Are typically limited in their supply and distribution to patients or Providers; and

f. Often have additional monitoring requirements.

Certain drugs used in a Provider's office to treat common medical conditions (such as intramuscular penicillin) are not considered Injectable Drugs and specialty medications, because they are widely available, distributed without limitation, and are not the product of bioengineering.

16.45 Initial Eligibility Period

The period determined by SelectHealth and your employer during which you may enroll yourself and your Dependents in the Plan. The Initial Eligibility Period is identified in the Group Application.

16.46 In-Network Benefits

The higher level of Benefits available to you when you obtain Covered Services from an In-Network Provider or Facility.

16.47 In-Network Facility

Facilities under contract with SelectHealth to accept Allowed Amounts as payment in full for Covered Services.

16.48 In-Network Pharmacies

Pharmacies under contract with SelectHealth to accept Allowed Amounts as payment in full for Covered Services.

16.49 In-Network Providers

Providers under contract with SelectHealth to accept Allowed Amounts as payment in full for Covered Services.

16.50 Lifetime Maximum

The maximum accumulated amount that SelectHealth will pay for certain Covered Services (as allowed by the Affordable Care Act) during a Member's lifetime. This includes all amounts paid on behalf of the Member under any prior health benefit plans insured by SelectHealth (including those sponsored by former employers) or any of its affiliated or subsidiary companies. In addition, some categories of Benefits are subject to a separate lifetime maximum amount. If applicable, lifetime maximums are specified in your Member Payment Summary.

16.51 Limitation(s)

Situations and Services in which coverage is limited by SelectHealth under the Plan. Most Limitations are set forth in Section 10 Limitations and Exclusions, but other provisions throughout this Certificate and the Contract may have the effect of limiting coverage in particular situations.

16.52 Major Diagnostic Tests

Diagnostic tests categorized as major by SelectHealth. SelectHealth categorizes tests based on several considerations such as the invasiveness and complexity of the test, the level of expertise required to interpret or perform the test, and where the test is commonly performed. Examples of common major diagnostic tests are:

a. Cardiac nuclear studies or cardiovascular procedures such as coronary angiograms;

b. Gene-based testing and genetic testing;

c. Imaging studies such as MRIs, CT scans, and PET scans; and

d. Neurologic studies such as EMGs and nerve conduction studies.

If you have a question about the category of a particular test, please contact Member Services.

16.53 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.

16.54 Maximum Annual Out-of-Network Payment

The maximum accumulated amount SelectHealth will pay each Year for Covered Services applied to the Out-of-Network Benefit.

The limit includes all amounts paid on behalf of the Member under any prior Plans provided by SelectHealth or any of its affiliated or subsidiary companies for any one Year. The Maximum Annual Out-of-Network Payment amount is specified in your Member Payment Summary.

16.55 Medical Director

The Physician(s) designated as such by SelectHealth.

16.56 Medical Necessity/Medically Necessary

Services that a prudent healthcare professional would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

a. In accordance with generally accepted standards of medical practice in the United States;

b. Clinically appropriate in terms of type, frequency, extent, site, and duration; and

c. Not primarily for the convenience of the patient, Physician, or other Provider.

When a medical question-of-fact exists, Medical Necessity shall include the most appropriate available supply or level of service for the Member in question, considering potential benefit and harm to the Member.

Medical Necessity is determined by the treating Physician and by SelectHealth's Medical Director or his or her designee. The fact that a Provider or Facility, even a 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.

16.57 Member

You and your Dependents, when properly enrolled in the Plan and accepted by SelectHealth.

16.58 Member Payment Summary

A summary of your Benefits by category of service, attached to and considered part of this Certificate.

16.59 Minor Diagnostic Tests

Tests not categorized as Major Diagnostic Tests. Examples of common minor diagnostic tests are:

a. Bone density tests;

b. Certain EKGs;

c. Echocardiograms;

d. Common blood and urine tests;

e. Simple X-rays such as chest and long bone X-rays; and

f. Spirometry/pulmonary function testing.

16.60 Miscellaneous Medical Supplies (MMS)

Supplies that are disposable or designed for temporary use.

16.61 Nurse

A graduate Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who is licensed by the state where Services are provided to provide medical care and treatment under the supervision of a Physician.

16.62 Oligodontia

The condition of congenitally missing more than six teeth, not including third molars or wisdom teeth.

16.63 Optional Benefit

Additional coverage purchased by your employer as noted in your Member Payment Summary that modifies Limitations and/or Exclusions.

16.64 Out-of-Network Benefits

A lower level of Benefits available for Covered Services obtained from a Out-of-Network Provider or Facility, even when such Services are not available through In-Network Providers or Facilities.

16.65 Out-of-Network Facility

Healthcare Facilities that are not under contract with SelectHealth.

16.66 Out-of-Network Pharmacies

Pharmacies that are not under contract with SelectHealth.

16.67 Out-of-Network Provider

Providers that are not under contract with SelectHealth.

16.68 Out-of-Pocket Maximum

The maximum amount specified in your Member Payment Summary that you must pay each Year to Providers and/or Facilities as Deductibles, Copays, and Coinsurance. Except when otherwise noted in your Member Payment Summary, SelectHealth will pay 100 percent of Allowed Amounts during the remainder of the Year once the Out-of-Pocket Maximum is satisfied. Some categories of Benefits may be subject to separate Out-of-Pocket Maximum amounts. Payments you make for Excess Charges, non-Covered Services, and certain categories of Services specified in your Member Payment Summary are not applied to the Out-of-Pocket Maximum.

16.69 Physician

A doctor of medicine or osteopathy who is licensed by the state in which he or she provides Services and who practices within the scope of his or her license.

16.70 Plan

The specific combination of Covered Services, Limitations, Exclusions, and other requirements agreed upon between SelectHealth and your employer as set forth in this Certificate and the Contract.

16.71 Plan Sponsor

As defined in ERISA. The Plan Sponsor is typically your employer.

16.72 Preauthorization (Preauthorize)

Prior approval from SelectHealth for certain Services. Refer to Section 11 Healthcare Management and your Member Payment Summary.

16.73 Premium(s)

The amount your Employer periodically pays to SelectHealth as consideration for providing Benefits under the Plan. The Premium is specified in the Group Application.

16.74 Prescription Drugs

Drugs and medications, including insulin, that by law must be dispensed by a licensed pharmacist and that require a Provider's written prescription.

16.75 Preventive Services

Periodic healthcare that includes screenings, checkups, and patient counseling to prevent illness, disease, or other health problems not previously known to exist in the individual, and as defined by the Affordable Care Act and/or SelectHealth. Some examples of these services are well-child exams, immunizations, pediatric vision screenings, and Contraceptives as required by the ACA. Preventive services also include a Contraceptive that is medically necessary for you as determined by your Provider and evidenced through written documentation submitted to SelectHealth.

16.76 Primary Care Physician or Primary Care Provider (PCP)

A general practitioner who attends to common medical problems, provides Preventive Services, and health maintenance. The following types of Physicians and Providers, and their associated physician assistants and nurse practitioners, are PCPs:

a. Certified Nurse Midwives;

b. Family Practice;

c. Geriatrics;

d. Internal Medicine;

e. Obstetrics and Gynecology (OB/GYN); and

f. Pediatrics.

16.77 Private Duty Nursing

Services rendered by a Nurse to prepare and educate family members and other caregivers on proper procedures for care during the transition from an acute Hospital setting to the home setting.

16.78 Provider

A vendor of healthcare Services licensed by the state where Services are provided and that provides Services within the scope of its license.

16.79 Qualified Medical Child Support Order (QMCSO)

A court order for the medical support of a child as defined in ERISA.

16.80 Rescission (Rescind)

A cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required Premiums or contributions towards the cost of coverage.

16.81 Residential Treatment Center

A licensed psychiatric facility which provides 24-hour continuous, individually-planned programs of therapeutic treatment and supervision.

16.82 Respite Care

Care provided primarily for relief or rest from caretaking responsibilities.

16.83 Routine Care

Care that is intended to monitor identified health conditions or assess new symptoms or signs of possible health conditions in a non-urgent or non-emergency setting.

16.84 Secondary Care Physician or Secondary Care Provider (SCP)

Physicians and other Providers who are not a Primary Care Physician or Primary Care Provider. Examples of an SCP include:

a. Cardiologists;

b. Dermatologists;

c. Neurologists;

d. Ophthalmologists;

e. Orthopedic Surgeons; and

f. Otolaryngologists (ENTs).

16.85 Service Area

The geographical area in which SelectHealth arranges for Covered Services for Members from In-Network Providers and Facilities. Contact SelectHealth for Service Area information if the U.S. Postal Service changes or adds ZIP codes after the beginning of the Year.

The SelectHealth Med® Service Area is the State of Utah.

16.86 Service(s)

Services, care, tests, treatments, drugs, medications, supplies, or equipment.

16.87 Skilled Nursing Facility

A Facility that provides Services that improve, rather than maintain, your health condition, that requires the skills of a Nurse in order to be provided safely and effectively, and that:

a. Is being operated as required by law;

b. Is primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a Physician;

c. Provides 24 hours a day, seven days a week nursing service by or under the supervision of a Registered Nurse (R.N.); and

d. Maintains a daily medical record of each patient.

A Skilled Nursing Facility is not a place that is primarily used for rest or for the care and treatment of mental diseases or disorders, chemical dependency, alcoholism, Custodial Care, nursing home care, or educational care.

16.88 Special Enrollment Right

An opportunity to enroll in the Plan outside of your employer's Annual Open Enrollment period under defined circumstances described in Section 3 Enrollment.

16.89 Subscriber

You, the individual with an employment or another defined relationship to the Plan Sponsor, through whom Dependents may be enrolled with SelectHealth.

16.90 TeleHealth

Services provided via interactive (synchronous) video and audio telecommunications systems.

16.91 Urgent Condition(s)

An acute health condition with a sudden, unexpected onset that is not life threatening but that poses a danger to a person's health if not attended by a Physician within 24 hours, e.g., high fevers, possible fractures.

16.92 Utah mini-COBRA

Continuation coverage required by Utah law for employers with fewer than 20 employees.

16.93 Year

Benefits are calculated on either a calendar-year or plan-year basis, as indicated on your Member Payment Summary.

a. The calendar year begins on January 1 at 12:00 a.m. Mountain Standard Time and ends on December 31, at 11:59 p.m. Mountain Standard Time.

b. The plan year, if applicable, is indicated in the Group Application.

appendix A
optional benefits

selecthealth℠

MENTAL HEALTH/CHEMICAL DEPENDENCY OPTIONAL BENEFIT

1. Your Mental Health Benefits

This Optional Benefit provides mental health and chemical dependency Benefits for the treatment of emotional conditions or chemical dependency listed as a mental disorder in the Diagnostic and Statistical Manual, as periodically revised, and which require professional intervention for as long as Services are considered Medically Necessary. These Benefits are subject to all the provisions, limitations, and exclusions of your medical Benefits that are listed in the Certificate.

If you have any questions regarding any aspect of the Benefits described in this Optional Benefit, please call the Behavioral Health Advocates[SM] weekdays, from 8:00 a.m. to 6:00 p.m. at 800-876-1989.

2. Using In-Network Mental Health Providers

Mental health Services will be covered only when rendered by a In-Network Provider unless otherwise noted on your Member Payment Summary.

3. Services requiring Preauthorization

Preauthorization is required for the following mental health services that are not for Emergency Conditions:

a. Inpatient psychiatric/detoxification admissions;
b. Residential treatment (when indicated as a covered Benefit on your Member Payment Summary);
c. Day treatment;
d. Partial hospitalization; and
e. Intensive outpatient treatment.

If you need to request Preauthorization, call the Behavioral Health Advocates. Refer to Section 11 – "Healthcare Management" of your Certificate of Coverage for additional information.

4. Exclusions

4.1 The following Services are not covered:

a. Behavior modification;
b. Counseling with a patient's family, friend(s), employer, school authorities, or others, except for approved Medically Necessary collateral visits, with or without the patient present, in connection with otherwise covered treatment of the patient's mental illness;
c. Education or training;
d. Long-term care;
e. Milieu therapy;
f. Rest cures;
g. Self-care or self-help training (nonmedical); and
h. Surgical procedures to remedy a condition diagnosed as psychological, emotional, or mental.

4.2 In addition, Services for conduct disorder are not covered.

SelectHealth, Inc. (domiciled in Utah)

ASH CHIROPRACTIC OPTIONAL BENEFIT

Your Chiropractic Benefits are administered by American Specialty Health Group, Inc ("ASH"). If you have any questions, concerns, or complaints about your chiropractic Benefits, please call ASH Member Services Department at 800-678-9133, or write to the following address:

American Specialty Health Group Incorporated
Attn: ASH Member Services Department
P.O. Box 509002
San Diego, CA 92150-9002

1. Definitions

This Optional Benefit uses the following capitalized defined terms in addition to Section 16Ð"Definitions" of the Contract. If there is a conflict between these terms and those in Section 16, these terms prevail.

1.1 Administrative Appeals

Administrative Appeals may result from Adverse Benefit Determinations that are based on issues that arise from administrative procedures.

Examples of Administrative Appeals may include the following scenarios:

a. Treatment plan was denied for not meeting authorization and/or claim timeframe requirements.
b. Necessary information was not received from Practitioner according to ASH timelines.

1.2 ASH Quality Management and Improvement ("QI") Program

Those standards, protocols, policies, and procedures adopted by ASH to monitor and improve the quality of clinical care and quality of Services provided to you.

1.3 ASH Service Area

The geographic area in which ASH arranges Chiropractic Services in Utah.

1.4 ASH Utilization Management Program

Those standards, protocols, policies, and procedures adopted by ASH regarding the management, review, and approval of the provision of Covered Chiropractic Services to you.

1.5 Chiropractic Appliances

Chiropractic appliances are support-type devices prescribed by a In-Network Chiropractor. Following are the only items that could be covered: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces/supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units (cervical or lumbar), ankle braces, knee braces, rib supports, and wrist braces.

1.6 Chiropractic Services

The Services rendered or made available to you by a chiropractor for treatment or diagnosis of Musculoskeletal and Related Disorders.

1.7 Clinical Appeals

Clinical Appeals may result from Adverse Benefit Determinations that are based on Medical Necessity, Experimental and/or Investigational treatment, or similar Exclusions or Limitations. Examples of Clinical Appeals may include the following scenarios:

a. Treatment plan was denied or modified due to lack of Medical Necessity.
b. The number of visits requested by the Practitioner did not meet clinical criteria.

1.8 Covered Chiropractic Services

The Chiropractic Services that ASH determines to be Medically Necessary, as limited by this Optional Benefit.

1.9 Emergency Chiropractic Services

Services provided to manage an injury or condition with a sudden and unexpected onset, which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate clinical attention to result in:

a. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
b. Serious impairment to bodily functions;
c. Serious dysfunction of any bodily organ or part; or
d. Decreasing the likelihood of maximum recovery.

1.10 Medical Necessity/Medically Necessary

Chiropractic Services that are:

a. Necessary, appropriate, safe, effective, and rendered in accordance with professionally recognized, valid, evidence-based standards and guidelines that have been adopted by ASH for its use in determining whether Chiropractic Services are appropriate for reimbursement;
b. Directly applicable to the diagnosis and treatment of a covered condition;
c. Verified by ASH as being rendered for the purpose of reaching a defined and appropriate functional outcome or maximum therapeutic benefit (defined as your return to your pre-illness/pre-injury daily functional status and activity);
d. Rendered in a manner that appropriately assesses and manages your response to the clinical intervention;
e. Rendered for the diagnosis and treatment of a covered condition;
f. Rendered in accordance with the Clinical Services Management Program and Clinical Performance Management Program standards as published in the ASH Chiropractic Provider Operations Manual;
g. Appropriate for the severity and complexity of symptoms and consistent with the covered condition (diagnosis) and appropriate for your response to care; and
h. Not considered to be an elective Chiropractic Service or a Chiropractic Service for any condition that is not a covered condition. Examples of elective services are:
    i. Preventive maintenance services;
    ii. Wellness services;
    iii. Services not necessary to return you to pre-illness/pre-injury functional status
    iv. and activity; and
    v. Services provided after you have reached maximum therapeutic benefit.

1.11 Musculoskeletal and Related Disorders

Musculoskeletal and Related Disorders are conditions with associated signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or biomechanical dysfunction of the joints of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs, and synovial structures), and related neurological manifestations or conditions.

1.12 Out-of-Area Services

Those Emergency Chiropractic Services provided while you are outside the ASH Service Area that would have been the financial responsibility of ASH had the Services been provided within the ASH Service Area. Covered Chiropractic Services that are to be provided outside the ASH Service Area, and are arranged by ASH for assigned Members, are not considered Out-of-Area Services.

1.13 In-Network Chiropractor

A chiropractor who is duly licensed to practice chiropractic in the state in which they provide the Service and who has entered into an agreement with ASH to provide covered Chiropractic Services to you.

1.14 Out-of-Network Chiropractor

A chiropractor not under contract with ASH to provide covered Chiropractic Services to you.

2. Using Your Chiropractic Benefits

Using your chiropractic Benefits is easy. Simply use an In-Network Chiropractor listed in the Chiropractic Provider Directory.

You may receive Covered Chiropractic Services from any In-Network Chiropractor without a referral. Except for Medically Necessary Emergency Chiropractic Services, ASH will not pay for Services received from any Out-of-Network Chiropractor.

3. Preauthorization/Utilization Management and Quality Improvement

After the initial examination, the In-Network Chiropractor must obtain Preauthorization for any additional Covered Chiropractic Services that you receive. The In-Network Chiropractor will be responsible for filing all claims with ASH. You must cooperate with ASH in the operation of its Utilization Management and Quality Improvement Programs.

4. Emergency Chiropractic Services

You may receive Emergency Chiropractic Services from any chiropractor, including an Out-of-Network Chiropractic if the delay caused by seeking immediate chiropractic attention from an In-Network Chiropractor could decrease the likelihood of maximum recovery. ASH will pay the out-of-network chiropractic Provider for the Emergency Chiropractic Service to the extent they are Covered Chiropractic Services.

5. Types of Covered Chiropractic Services

Each office visit to an In-Network Chiropractor, as described below, requires a Copay by you at the time Covered Chiropractic Services are provided. A maximum number of visits per calendar Year will apply to each Member as specified in your Member Payment Summary.

a. A new patient examination is performed by an In-Network Chiropractor to determine the nature of your problem, and if Covered Chiropractic Services appear warranted, a Medical Necessity Review Form (MNR Form) is prepared by the In-Network Chiropractor. A new patient examination will be provided for each new patient. A Copay will be required.
b. An established patient examination may be performed by the In-Network Chiropractor to assess the need to continue, extend or change an MNR Form approved by ASH. A reevaluation may be performed during a subsequent office visit or separately. If performed separately, a Copay is required.
c. Subsequent office visits, as set forth in an MNR Form approved by ASH, may involve an adjustment, a brief re-examination, and other Services in various combinations. A Copay will be required for each visit to the office.
d. Adjunctive therapy, as set forth in an MNR Form approved by ASH, may involve modalities such as ultrasound, hot packs, cold packs, electrical muscle stimulation, and other therapies.
e. X-rays and lab tests are payable in full when prescribed by an In-Network Chiropractor and authorized by ASH. Radiological consultations are a covered Benefit when authorized by ASH as Medically Necessary and provided by a licensed chiropractic radiologist, medical radiologist, radiology group, or Hospital that has contracted with ASH to provide those services.
f. Chiropractic appliances are payable up to a maximum of $50.00 per year when

prescribed by an In-Network Chiropractor and approved by ASH.

6. Chiropractic Exclusions and Limitations

ASH will not pay for or otherwise cover the following:

a. Any Services or treatments not authorized by ASH, except for a new patient examination and Emergency Chiropractic Services;
b. Any Services or treatments not delivered by an In-Network Chiropractor for the delivery of chiropractic care to you, except for Emergency Chiropractic Services; services that are provided pursuant to a continuity of care plan approved by ASH Networks; or services that are provided upon referral by ASH Networks in situations where such services are not available and accessible to a Member from a Contracted Practitioner within the Service Area;
c. Services for examinations (other than an initial examination to determine the appropriateness of Chiropractic Services) and/or treatments for conditions other than those related to Musculoskeletal and Related Disorders;
d. Hypnotherapy, behavior training, sleep therapy, and weight programs;
e. Thermography;
f. Services, lab tests, x-rays, and other treatments not documented as Medically Necessary, as appropriate, or classified as Experimental and/or Investigational, or as being in the research stage, as determined in accordance with professionally recognized standards of practice;
g. Services that are not documented as Medically Necessary;
h. Services for children 12 and younger;
i. Magnetic resonance imaging (MRI), CAT scans, and any types of diagnostic radiology;
j. Transportation costs including local ambulance charges;
k. Education programs, nonmedical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing;
l. Services or treatments for pre-employment physicals or vocational rehabilitation;
m. Any services or treatments caused by or arising out of the course of employment or covered under any public liability insurance;
n. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices or appliances, all chiropractic appliances, or Durable Medical Equipment, except as specified herein;
o. All chiropractic appliances or Durable Medical Equipment, except as specified herein;
p. Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order;
q. Services provided by a chiropractor practicing outside of the Service Area, except for Emergency Chiropractic Services.
r. Hospitalization, anesthesia, manipulation under anesthesia, or other related services;
s. All auxiliary aids and services, including interpreters, transcription services, written materials, telecommunication devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids;
t. Adjunctive therapy not associated with spinal, muscle, or joint manipulation;
u. Vitamins, minerals, nutritional supplements, injectable supplements and injection services,or other similar products;
v. Any services or treatments that are furnished before the date the Member becomes eligible or after the date the member ceases to be eligible under the Member's plan;
w. Massage Therapy, venipuncture, or Natural childbirth services;
x. Services rendered in excess of visits or benefit maximums;
y. Any service or supply that is not permitted by state law with respect to the provider's scope of practice;
z. Any services provided by a person who is a Family Member. Family Member means a person who is related to the covered person in any of the following ways: spouse, domestic partner, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-

law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child). A Family Member also includes individuals who normally live in the covered person's household; or

aa. Any services rendered for elective or maintenance care (e.g., services provided to a Member whose treatment records indicate he or she has reached Maximum Therapeutic Benefit).

7. This Optional Benefit

This Optional Benefit is subject to all provisions, Limitations, Exclusions, and agreements of the Certificate of Coverage and the Contract (available from your employer).

8. Claims and Appeals

ASH will follow administrative processes and safeguards designed to ensure and to verify that Benefit claim determinations are made in accordance with the provisions of this Optional Benefit administered by ASH and that the provisions have been applied consistently with respect to similarly situated Claimants.

8.1 Defined Terms

This section uses the following additional (capitalized) defined terms:

8.1.1 Adverse Benefit Determination

Any of the following: a Rescission of coverage or a denial, reduction, or termination of a claim for Benefits, or a failure to provide or make payment for such a claim in whole or in part, including determinations related to a Claimant's Eligibility, the application of a review under ASH Utilization Management Program, and determinations that particular Services are Experimental and/or Investigational or not Medically Necessary or appropriate.

8.1.2 Appeal(s)

Review by ASH of an Adverse Benefit Determination.

8.1.3 Authorized Representative

Someone you have designated to represent you in the claims or Appeals process. To designate an Authorized Representative, you must provide written authorization on a form provided by the ASH Appeals Department or ASH Member Services. However, where an Urgent Preservice Claim is involved, a healthcare professional with knowledge of the medical condition will be permitted to act as your Authorized Representative without a prior written authorization. In this section, the words you and your include your Authorized Representative.

8.1.4 Benefit Determination

The decision by ASH regarding the acceptance or denial of a claim for Benefits.

8.1.5 Claimant

Any Subscriber or Member making a claim for Benefits. Claimants may file claims themselves or may act through an Authorized Representative. In this section, the words you and your are used interchangeably with Claimant.

8.1.6 Concurrent Care Decisions

Decisions by ASH regarding coverage of an ongoing course of treatment that has been approved in advance.

8.1.7 External Review

A review by an outside entity, at no cost to the Member, of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination).

8.1.8 Final Internal Adverse Benefit Determination

An Adverse Benefit Determination that has been upheld by ASH at the completion of the mandatory Appeals process.

8.1.9 Independent Review Organization (IRO)

An entity that conducts independent External Reviews.

8.1.10 Postservice Appeal

A request to change an Adverse Benefit Determination for Services you have already received.

8.1.11 Postservice Claim

Any claim related to care or treatment that has already been received by the Member.

8.1.12 Preservice Appeal

A request to change an Adverse Benefit Determination on a Preservice Claim.

8.1.13 Preservice Claim

Any claim related to care or treatment that has not been received by the Member.

8.1.14 Urgent Preservice Claim

Any Preservice Claim that if subject to the normal timeframes for determination could seriously jeopardize your life, health, or ability to regain maximum function or that, in the opinion of your treating Physician, would subject you to severe pain that could not adequately be managed without the requested Services. Whether a claim is an Urgent Preservice Claim will be determined by an individual acting on behalf of ASH applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that your treating Physician determines is an Urgent Preservice Claim will be treated as such.

8.2 How to File a Claim for Benefits

8.2.1 Urgent Preservice Claims

In order to file an Urgent Preservice Claim, you must provide ASH with:

a. Information sufficient to determine to what extent Benefits are covered by the Plan; and
b. A description of the medical circumstances that give rise to the need for expedited review.

Under certain circumstances provided by federal law, if you fail to follow the proper procedures for filing an Urgent Preservice Claim, ASH will notify you of the failure and the proper procedures to be followed. ASH will notify you as soon as reasonably possible, but no later than 24 hours after receiving the claim. This notice may be verbal unless you specifically request otherwise in writing.

Notice of a Benefit Determination will be provided as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receipt of the claim. However, if ASH gives you notice of an incomplete claim, the notice will give you at least 48 hours to provide the requested information. ASH will then provide a notice of Benefit Determination within 48 hours after receiving the specified information or the end of the period of time given you to provide the information, whichever occurs first. If the Benefit Determination is provided verbally, it will be followed in writing no later than three days after the verbal notice.

If the Urgent Preservice Claim involves a Concurrent Care Decision, notice of the Benefit Determination will be provided as soon as possible but no later than 24 hours after receipt of your claim for extension of treatment or care, as long as the claim is made at least 24 hours before the prescribed period of time expires or the prescribed number of treatments ends.

8.2.2 Other Preservice Claims

The procedure for filing most Preservice Claims (Preauthorization) is set forth in Section 11Ð"Healthcare Management." If there is any other Benefit that would be subject to a Preservice Claim, you may file a claim for that Benefit by contacting ASH Member Services. Under certain circumstances provided by federal law, if you fail to follow the proper procedures for filing a Preservice Claim, ASH will provide notice of the failure and the proper procedures to be followed. This notification will be provided as soon as reasonably possible, but no later than five days after receipt of the claim, and may be verbal unless you specifically request it in writing.

Notice of a Benefit Determination will be provided in writing within a reasonable period appropriate to the medical circumstances, but no later than 15 days after receipt of the claim. However, ASH may extend this period for up to an additional 15 days if ASH: (1) determines that such an extension is necessary due to matters beyond its control; and (2) provides you written notice, prior to the end of the original 15-day period, of the circumstances requiring the extension and the date by which ASH expects to render a decision. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information, and you will be given 60 days from your receipt of the notice to provide the requested information.

Notice of an Adverse Benefit Determination regarding a Concurrent Care Decision will be provided sufficiently in advance of any termination or reduction of Benefits to allow you to Appeal and obtain a determination before the Benefit is reduced or terminates.

8.2.3 Postservice Claims

a. In-Network Chiropractors file Postservice Claims with ASH and ASH makes payment to the Providers and Facilities.
b. Out-of-Network Chiropractors are not required to file claims with ASH. If an Out-of-Network Chiropractor does not submit a Postservice Claim to ASH or you pay the Out-of-Network Chiropractor, you must submit the claim in writing in a form approved by ASH. Call ASH Member Services or your employer to find out what information is needed to submit a Postservice Claim. All claims must be received by ASH within a 12-month period from the date of the expense or as soon as reasonably possible. Claims received outside of this timeframe will be denied.

Notice of Adverse Benefit Determinations will be provided in writing within a reasonable period of time, but no later than 30 days after receipt of the claim. However, ASH may extend this period if ASH: (1) determines that such an extension is necessary due to matters beyond its control; and (2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which ASH expects to render a decision.

The applicable time period for the Benefit Determination begins when your claim is filed in accordance with ASH's procedures, even if you have not submitted all the information necessary to make a Benefit Determination.

8.3 Problem Solving

ASH is committed to making sure that any concerns or problems regarding your claims are investigated and resolved as soon as possible. Many situations can be resolved informally by contacting ASH Member Services at 800-678-9133.

8.4 Formal Appeals

If you are not satisfied with the result of working with ASH Member Services, you may file a written formal Appeal of any Adverse Benefit Determination. Written formal Appeals should be sent to the ASH Appeals Department. As the delegated claims review fiduciary under your Employer's Plan, ASH will conduct a full and fair review of your Appeal and has final discretionary authority and responsibility for deciding all matters regarding Eligibility and coverage.

8.4.1 General Rules and Procedures

You will have the opportunity to submit written comments, documents, records, and other information relating to your Appeal. ASH will consider this information regardless of whether it was considered in the Adverse Benefit Determination.

During an Appeal, no deference will be afforded to the Adverse Benefit Determination, and decisions will be made by fiduciaries who did not make the Adverse Benefit Determination and who do not report to anyone who did. If the Adverse Benefit Determination was based on medical judgment, including determinations that Services are Experimental and/or Investigational or not Medically Necessary, the fiduciaries during any Appeal will consult with a medical professional with appropriate training and experience in the appropriate field of medicine and who was neither consulted in connection with the Adverse Benefit Determination nor is the subordinate of such an individual. Upon request, you will be provided the identification of any medical expert(s) whose advice was obtained on behalf of ASH in connection with the Adverse Benefit Determination, whether or not the advice was relied upon in making the Adverse Benefit Determination.

Before ASH can issue a Final Internal Adverse Benefit Determination, you will be provided with any new or additional evidence or rationale considered, relied upon, or generated by us in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of a Final Internal Benefit Determination is required to be provided to give you a reasonable opportunity to respond prior to the date.

8.4.2 Form and Timing

All requests for an Appeal of an Adverse Benefit Determination (other than those involving an Urgent Preservice Claim) must be in writing and should include a copy of the Adverse Benefit Determination and any other pertinent information that you want ASH to review in conjunction with your Appeal. Send all information to the ASH Appeals Department at the following address:

ASH Appeals Coordinator
P.O. Box 509001
San Diego, CA 92150-9002

You may Appeal an Adverse Benefit Determination of an Urgent Preservice Claim on an expedited basis either verbally or in writing. You may Appeal verbally by calling the ASH Appeals Department at 800-678-9133.

If the request is made verbally, the ASH Appeals Department will within 24 hours send written confirmation acknowledging the receipt of your request.

You must file a formal Appeal within 180 days from the date you received notification of the Adverse Benefit Determination.

Appeals that do not comply with the above requirements are not subject to review by ASH or legal challenge.

8.4.3 Appeals Process

The Appeals process includes both mandatory and voluntary reviews. You must exhaust all mandatory reviews before you may pursue civil action under ERISA Section 502(a). It is your choice, however, whether or not to seek voluntary review, and you are not required to do so before pursuing civil action. ASH agrees that any statute of limitations or other legal defense based on timeliness is suspended during the time that any voluntary Appeal is pending. Your decision whether or not to seek voluntary review will have no effect on your rights to any other Benefits. ASH will provide you, upon request, sufficient information to enable you to make an informed decision about whether or not to engage in a voluntary review.

After a mandatory review process, you may choose to pursue civil action under ERISA Section 502(a). Failure to properly pursue the mandatory Appeals process may result in a waiver of the right to challenge ASH's original decision.

8.4.4 Preservice Appeals

The process for appealing a Preservice Claim provides one mandatory review, possible voluntary reviews, and the right to pursue civil action under ERISA Section 502(a).

Mandatory Review

Your Appeal will be investigated by the ASH Appeals Department. All relevant, available information will be reviewed. The ASH Appeals Department will notify you in writing of the Appeal decision within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after the receipt of your Appeal. However, ASH may extend this period if ASH: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which ASH expects to render a decision.

If your Appeal involves an Urgent Preservice Claim, you may request an expedited review. You will be notified of the Appeal decision on an expedited review as soon as possible, taking into account the medical circumstances, but no later than 72 hours after the receipt of your Appeal. A decision communicated verbally will be followed up in writing.

Voluntary Review

After completing the mandatory review process described above, you may pursue a voluntary External Review or a voluntary internal review. However, External Review is only available in the circumstances described below. If you choose to pursue a voluntary External Review, you may not pursue the voluntary internal review process.

Voluntary External Review

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, or a Rescission of coverage. To request an External Review, you must complete the Independent Review Request Form. For a copy of this form, or for other questions, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City, UT 84114; by phone at 801-538-3077; or electronically at healthappeals.uid@utah.gov. An External Review request must be made within 180 days from the date the ASH Appeals Department notifies you of the Final Internal Adverse Benefit Determination.

An authorization to obtain medical records may be required. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. The IRO will provide written notice of its decision within 45 days after receipt of the request.

If your Appeal involves an Urgent Preservice Claim, you may request an expedited review. You will be notified by the IRO of the Appeal decision on an expedited review as soon as possible, taking into account the medical circumstances, but no later than 72 hours after the receipt of your Appeal. A decision communicated verbally will be followed up in writing.

If you pursue a voluntary External Review, it will be your last level of Appeal.

Voluntary Internal Review

If you choose to pursue the voluntary internal review process, you may first request a review of your Appeal by the ASH Grievance Committee. Such a request must be made in writing to the ASH Appeals Department within 60 days of the date the ASH Appeals Department notifies you the Final Internal Adverse Benefit Determination. ASH will notify you of the result of the review in writing within 30 days of the date you requested the review. However, ASH may extend this period if ASH: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which ASH expects to render a decision. If you are not satisfied with the decision made by the ASH Grievance Committee, you may request a review by the ASH Appeals Committee. Such a request must be made in writing to the ASH Appeals Department within 60 days of the date the ASH Grievance Committee notifies you of its decision.

8.4.5 Postservice Appeals

The process for appealing a Postservice Claim provides two mandatory reviews, possible voluntary reviews, and the right to pursue civil action under ERISA Section 502(a).

Mandatory Review

Your Appeal will be investigated by the ASH Appeals Department. All relevant information will be reviewed and the ASH Appeals Department will notify you in writing of the Appeal decision within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after the receipt of your Appeal. However, ASH may extend this period if ASH: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which ASH expects to render a decision.

Voluntary Review

After completing the mandatory review process described above, you may pursue either a voluntary External Review or a voluntary internal review. However, External Review is only available in the circumstances described below. If you choose to pursue the voluntary External Review process, you may not pursue the voluntary internal review process.

Voluntary External Review

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, or a Rescission of coverage. To request an External Review you must complete the Independent Review Request Form. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. For a copy of this form, or for other questions, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City, UT 84114; by phone at 801-538-3077; or electronically at healthappeals.uid@utah.gov. An External Review request must be made within 180 days from the date of ASH's Final Internal Adverse Benefit Determination. An authorization to obtain medical records may be required. The IRO will provide written notice of its decision within 45 days after receipt of the request.

If you pursue a voluntary External Review, it will be your last level of Appeal.

Voluntary Internal Review

If you choose to pursue the voluntary internal review process, you may request a review of your Appeal. Such a request must be made in writing to the ASH Appeals Department within 60 days of the date the ASH Appeals Department notifies you of the Final Internal Adverse Benefit Determination. ASH will notify you of the result of the review in writing within 30 days of the date you requested the review. If you are not satisfied with the decision made by the reviewing committee, you may request a review by the Appeals Committee. Such a request must be made in writing to the ASH Appeals Department within 60 days of the date the reviewing committee notifies you of its decision.

MEMORANDUM TO THE BOARD

TO: Utah Transit Authority Board of Trustees
THROUGH: Carolyn Gonot, Executive Director
FROM: Kimberly S. Ulibarri, Chief People Officer
PRESENTER(S): Kimberly S. Ulibarri, Chief People Officer

BOARD MEETING DATE: May 06, 2020

SUBJECT:	**Employer Health Insurance Agreement – Bargaining Employees (Select Health)**
AGENDA ITEM TYPE:	**Expense Contract Change Order**
RECOMMENDATION:	Approve contract extension and authorize the Executive Director to execute the contract amendment and associated disbursements.
BACKGROUND:	The contract represents medical insurance coverage through SelectHealth for Amalgamated Transit Union (ATU) Local 382 represented employees. The contract is paid from the Joint Insurance Trust managed by UTA and ATU.
DISCUSSION:	Select Health has been a medical insurance provider for UTA for some time and the current contract began in 2017. Both UTA & ATU wish to renew their services for the 2020 Benefit Plan Year. The renewal rates for each contract are listed below. **Bargaining: 1.0% rate increase** The renewal rate is well below the industry standard of between 8% & 9% per UTA's Benefits Consultant (GBS). Experience with Select Health has been very positive overall from a customer service standpoint, and their broad network of providers allows employees a greater selection when seeking care.
CONTRACT SUMMARY:	Contractor Name: Employer Health Insurance Agreement with Select Health (ATU)
	Contract Number: 16-2067TP-1 / Existing Contract Value: $37,500,000.00
	Base Contract Effective Dates: 05/01/2017 – 04/30/2018 / Extended Contract Dates: 05/01/2020 – 04/30/2021
	Amendment Amount: $12,500,00 / New/Total Amount Contract Value: $50,000,000
	Procurement Method: RFP (Competitive BID) / Funding Sources: Local (Employee, Employer, JIT)

ALTERNATIVES:	Not approving this contract would require UTA/ATU to exercise the competitive bid process (RFP) and locate a new medical insurance provider immediately. This could delay medical insurance coverage for enrolled employees and require employees to switch providers mid-year once a new provider is selected.
FISCAL IMPACT:	Funding for the Joint Insurance Trust is already included in UTAs 2020 budget and is not impacted by this contract.
ATTACHMENTS:	• Select Health Medical Contract (Bargaining)

2020

Medical Contract

UTA-ATU/Joint Insurance Trust

selecthealth®

GROUP APPLICATION

Product	SelectHealth Med
Employer	UTA-ATU/Joint Insurance Trust
Employer Contact	Jacob Gomez
Employer Address	669 W 200 S
	SALT LAKE CITY, UT 84101

Affiliated Businesses/Subsidiaries Covered by this Application

Employer is hereby applying for, and agreeing to, the terms of the attached Group Health Insurance Contract with SelectHealth, 5381 Green Street, Murray, Utah 84123. SelectHealth is entering into this Contract in reliance upon the underwriting information supplied by the employer, which shall be considered to be material representations of fact by employer to SelectHealth. SelectHealth and employer agree upon the following:

1. Monthly Premiums.

On or before the first day of each month, the following designated Premiums shall be paid to SelectHealth:

$ 522.30	for each single party enrollment
$ 1305.30	for each Subscriber plus spouse enrollment
$ 1305.30	for each Subscriber plus child enrollment
$ 1827.60	for each Subscriber plus children enrollment
$ 1827.60	for each family enrollment

2. Eligibility, Prepayment and Enrollment Criteria.

In order to be Eligible, your employees and their Dependents must meet the criteria for participation and enrollment specified in this Group Application and elsewhere in the Contract. A person may only be considered an employee if the employer withholds and pays to the government Social Security and Medicare taxes and income tax withholding on the employee's wages.

2.1 Scheduled hours of work per week.

Employees must be scheduled to work 30 hours per week to be Eligible for coverage under the Plan, unless the employer is required to offer them coverage under the Affordable Care Act. During the Employer Waiting Period, the employee must work the minimum required hours except for paid time off or time the employee does not work due to health status, a medical condition, the receipt of health care, or disability. SelectHealth may require documentation to verify the number of hours an employee has worked.

2.2 Portion of Premium Subscriber must contribute.

Wellness program	**No Wellness**	
$ 102.01	$ 127.09	for each single party enrollment
$ 237.56	$ 300.69	for each two party enrollment
$ 331.48	$ 420.80	for each family enrollment

2.3 Limiting Age.

Children are eligible to the age of 26 except where the child meets the criteria for disabled children specified in Section 2- "Eligibility" of the Certificate.

2.4 Retirees.

Retirees are not covered.

2.5 Domestic Partners.

Domestic partners are not covered.

2.6 Leave of Absence.

Eligible employees may be granted up to a 60 day leave of absence by employer or up to the time allowed for a qualifying leave under the Family Medical Leave Act. Leave time can only be accrued and used by the employee using the leave time. Leave banks beyond what is required by the FMLA, i.e. where employees share or purchase leave time from other employees, are not allowed.

2.7 Initial Eligibility Period.

The Initial Eligibility Period is 31 days.

2.8 Waiting Period.

The Employer Waiting Period for employees classified as Operator is 60 days and the Effective Date is the first day of the next calendar month following the Employer Waiting Period. The Employer Waiting Period for all other employees is 30 days and the Effective Date is the first day of the next calendar month following the Employer Waiting Period.

2.9 Other employees.

Leased employees and independent contractors are not Eligible for coverage by SelectHealth.

2.10 Termination.

Coverage will terminate on the end of the calendar month in which Subscriber and/or Dependents lose Eligibility. When a loss of Eligibility is not reported in a timely fashion as required by the Contract and federal or state law prevents SelectHealth from retroactively terminating coverage, SelectHealth has the discretion to determine the prospective date of termination. SelectHealth also has the discretion to determine the date of termination for Rescissions.

3. Duration of Contract.

This Contract is effective on May 1, 2020 to April 30, 2021, for a term of 12 months.

4. Additional Terms.

4.1 Additional Eligibility.

Eligible participants shall also include full time officials of the Amalgamated Transit Union, Local 382 ("Union"), who are on leave of absence for the Authority in order to serve as elected officials of the Union.

An eligible employee who waives COBRA continuation coverage or enrolls on COBRA at any time while on a medical leave of absence of up to one year will remain eligible for reinstatement upon return to work on a full-time basis within the one-year period.

In Section 2.3 "Grace Period" of the contract LE-CONTRACT 01/01/20, the grace period has been extended from thirty (30) days to forty five (45) days.

Product: SelectHealth Med

Effective Date: May 1, 2020

Acknowledged and agreed:

Employer: UTA-ATU/Joint Insurance Trust

By: _____

Printed Name: _____

Title: _____

Date: _____

By: _____

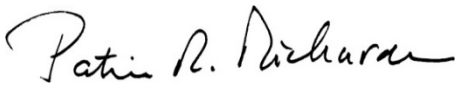
Printed Name: _____

Title: _____

Date: _____

SelectHealth:

By: _____



Printed Name: Patricia R. Richards

Title: President / Chief Executive Officer

Date: 3/23/2020

medical
contract

selecthealth®

TABLE OF CONTENTS

SECTION 1 INTRODUCTION

1.1 Contract

This group health insurance contract (Contract) is made between **SelectHealth, Inc.** (we or us) and the employer indicated in the Group Application (you). In exchange for your payment of Premium, we provide defined healthcare Benefits to Members. Any payment of Premium will constitute your agreement to the terms of the Contract, regardless of whether you have actually signed the Group Application.

1.2 SelectHealth

SelectHealth is an HMO licensed by the State of Utah located at 5381 Green Street, Murray, Utah 84123. We are affiliated with Intermountain Healthcare, but are a separate company. The Contract does not involve Intermountain Healthcare or any other affiliated Intermountain companies, or their officers or employees. Such companies are not responsible for our obligations or actions.

1.3 Agency

You do not have the authority to act as our agent. We are not your agent for any purpose. You agree to act in a timely and diligent manner as the agent of your Subscribers for certain purposes, such as enrollment and termination procedures, providing consent to release information, and agreeing to the conditions in the Contract.

1.4 Administration of Contract

We may adopt reasonable policies, rules, and procedures to help in the administration of the Contract. You agree to abide by all such reasonable policies, rules, and procedures that are not inconsistent with the Contract.

1.5 ERISA and SelectHealth's Authority

If the Contract is part of an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), you or your designated employee(s) will be the plan administrator and in that capacity hereby delegate to us the following discretionary authority:

Benefits under the Contract will be paid only if we decide in our discretion that the Claimant is entitled to them. We also have discretion to determine Eligibility for Benefits and to interpret the terms and conditions of the benefit plan. Our determinations under this reservation of discretion do not prohibit or prevent a Claimant from seeking judicial review in federal court.

The reservation of discretion made under this provision only establishes the scope of review that a federal court will apply when a Claimant seeks judicial review of our determination of Eligibility for Benefits, the payment of Benefits, or interpretation of the terms and conditions applicable to the health benefit plan.

We are an insurance company that insures the Employer Plan and the federal court will determine the level of discretion that it will accord our determinations.

If the Contract is not part of an employee benefit plan subject to ERISA, this Provision 1.5 does not apply and is not considered part of the Contract.

SECTION 2 PREMIUM

2.1 Employer Responsibility

Coverage under the Contract is contingent upon your timely payment of Premium. The monthly Premium amount and due date are set forth in the Group Application. Your obligation to make Premium payments is not contingent upon your ability to collect any Subscriber contributions.

2.2 Premium Rates

The Premium rates specified in the Group Application will remain the same until the end of the Contract term. However, we may reasonably modify the Premium if federal or state laws or regulations mandate that we adjust Benefits under the Contract.

2.3 Grace Period

There is a 30-day Grace Period for the payment of Premium. We will continue to pay Benefits during the Grace Period, but you will be responsible for reimbursing us for the amount of any Benefits paid if you fail to pay Premium.

2.4 Refund of Premium

We are entitled to offset from any refund the amount of any claims paid for such individuals before you notified us that they were not Eligible.

SECTION 3 COVERAGE

3.1 Certificate of Coverage

We will provide you with a copy of each applicable Certificate of Coverage, which describes the Benefits offered under the Contract in exchange for your payment of Premium.

3.2 Administrative Processes

We establish reasonable administrative processes for claims adjudication, Member Services, Healthcare Management, and other functions. Members and Participating Providers and Facilities are required to cooperate with these processes when obtaining and providing Covered Services.

3.3 No Vested Rights

No Member has a vested right to any Covered Services. Changes to the Contract may be made without consulting with, or obtaining the consent of, Members. The rights and interest of Members at any particular time depend on the Contract terms in effect at that time.

SECTION 4 ELIGIBILITY AND ENROLLMENT

4.1 Eligibility

In consultation with us, you decide which categories of employees, retirees and Dependents are Eligible to become Members and establish related Eligibility requirements. The Eligibility criteria are specified in the Certificate of Coverage and the Group Application. You may not change, extend, expand, or waive the Eligibility criteria without first obtaining the advance, written approval of an officer of SelectHealth. Only individuals who continuously satisfy the Eligibility criteria of the Contract may be enrolled and continue as Members. You, your Subscribers, and their Dependents are responsible for obtaining and submitting to us evidence of Eligibility.

4.2 Changes in Member Information or Eligibility

You must notify us within 31 days whenever there is a change in a Member's situation that may affect Eligibility or enrollment. This includes the following events:

a. Adoption of a child, birth of a child, or gaining legal guardianship of a child;

b. Child loses Dependent status;

c. Death;

d. Divorce;

e. Marriage;

f. Involuntary loss of other coverage;

g. Member called to active military duty;

h. You receive a Qualified Medical Child Support Order (QMCSO);

i. Reduction in employment hours;

j. Subscriber takes, returns from, or does not return from a leave of absence;

k. Termination of employment; and

l. Other events as required by federal law.

If you fail to notify us within 31 days of a Member's termination from employment or other event that results in the loss of a Member's Eligibility, you agree to promptly pay us any amounts paid as Benefits for such Member before we were notified.

4.3 Enrollment

In order for an Eligible individual to receive Benefits, you must enroll the individual, we must accept the individual as a Member, and you must pay the applicable Premiums. You agree to limit enrollment to Subscribers and their Dependents. You are responsible for submitting the enrollment materials we require.

4.4 Enrolling a Dependent Because of a Court Order

We will enroll Dependents as the result of a valid court order. Compliance with, and administration of, court orders, including Qualified Medical Child Support Orders (QMCSO's), is your responsibility. When you direct us to enroll an individual on the basis of a QMCSO, we reserve the right to review and confirm that the order is qualified.

4.5 COBRA or Utah mini-COBRA Coverage (Continuation Coverage)

Continuation Coverage is your obligation. We are not the administrator of Continuation Coverage procedures and requirements. We agree to assist you in providing Continuation Coverage in certain circumstances. It is your responsibility to timely: notify persons entitled to Continuation Coverage, notify us of such individuals, and collect and submit to us all applicable Premiums. If the Contract is terminated, Continuation Coverage with us will terminate. You are responsible for obtaining substitute coverage. You may engage the services of a third-party contractor to assist with the administration of Continuation Coverage.

4.5.1 Minimum Extent

Continuation Coverage will only be provided for the minimum time and only to the minimum extent required by applicable state and federal law. We will not provide Continuation Coverage if you or the Member fails to strictly comply with all applicable notice and other requirements and deadlines.

4.5.2 Documentation

You are required to provide sufficient documentation of a Member's eligibility for Continuation Coverage. We determine whether the documentation is sufficient.

4.6 Right to Decline Enrollment

We may decline to enroll individuals who do not satisfy the Eligibility criteria of the Contract.

SECTION 5 RESPONSIBILITIES OF THE PARTIES

5.1 Compliance

Each party is responsible for its own compliance with applicable laws, rules, and regulations. For you, this includes the reporting and disclosure requirements of ERISA, all applicable requirements under Titles I and II of HIPAA, and any other state and federal requirements that apply to the Employer Plan. You must notify us when you receive Medicare secondary payer information.

5.2 Indemnification

We agree to defend and indemnify you from and against any claims or other liability based upon our failure to comply with our obligations under the Contract.

You agree to defend and indemnify us from and against any claims or other liability based upon your failure to comply with your obligations under the Contract.

5.3 Reports

We will help you comply with applicable federal reporting requirements by providing you with necessary Benefits information in our possession.

5.4 Internal Revenue Code (IRC) Section 6055 Reporting

You agree to request the Social Security Numbers of your Employees and their Dependents, and provide this information to us, in the time and manner required by IRC Section 6055.

5.5 Summary of Benefits and Coverage (SBC)

We agree to provide you with an SBC as defined by the Affordable Care Act (ACA). You agree to distribute the SBC to eligible individuals in the time and manner required by applicable law. We agree to provide the Uniform Glossary of Terms, as defined by the ACA, on our website. We also agree to distribute the SBC and Uniform Glossary of Terms created by us to those Members who contact us directly. You agree to indemnify and hold us harmless in the event that you fail to make any required distributions of the SBC, make any modifications to the SBC, or decide to use your own SBC.

SECTION 6 TERMINATION

6.1 Reasons for Termination

The Contract, and coverage for all Members under the Contract, can terminate for the reasons listed below.

6.1.1 Termination by Employer

You may terminate the Contract by providing us with written notice prior to the date you wish coverage to end. If you properly notify us, coverage will terminate on the last day of the month for which Premium has been paid. We will not accept retroactive termination dates.

6.1.2 Termination of Employer Group by SelectHealth

Your coverage under the Contract may be terminated for any of the following reasons:

a. You fail to pay Premiums in accordance with the Contract. Partial payment will be treated as nonpayment unless we, at our sole discretion, indicate otherwise in writing;

b. You perform an act or practice that constitutes fraud or make an intentional misrepresentation of material fact under the terms of the coverage;

c. No Members live, reside, or work in the Service Area;

d. Your membership in an association, through which the Contract was made available, ceases;

e. We cease to offer this particular health benefit product in accordance with applicable state and federal law. In such instance, we will give you at least 90 days advance notice;

f. We withdraw from the market in accordance with applicable state and federal law. In such instance, we will give you at least 180 days advance notice; or

g. You fail to satisfy our minimum participation requirements, if applicable.

6.1.3 Employer Notice of Termination to Subscribers

It is your responsibility to provide Subscribers a 30-day written notice of the Contract's termination. We will provide you a sample notice upon request.

6.2 Rescission

Rescission may only occur for fraud or intentional misrepresentation of material fact. You agree to only request a Member's Rescission in these limited circumstances and to hold SelectHealth harmless for any improper Rescission that you request.

6.3 Liability for Services After Termination

We do not cover Services obtained after the date of termination, regardless of when a condition arose and despite care or treatment anticipated or already in progress.

SECTION 7 GENERAL

7.1 Binding Effect

The Contract contains the entire agreement between the parties. In the event you have received a written proposal, your compliance with the minimum enrollment and underwriting factors set forth in the proposal is a condition to the effectiveness of the Contract. The Contract is binding upon you, us, Members and their heirs, personal representatives and assignees.

7.2 Partial Invalidity

If any provision of the Contract is held to be unenforceable, it will be deemed to be omitted and the remaining provisions shall continue in full force and effect.

7.3 Non-Assignability

The parties to the Contract agree that they may not transfer or assign their rights or obligations without the advance written approval of the other party.

7.4 Choice of Law

The Contract will be interpreted and enforced according to the laws and regulations of the State of Utah and any applicable federal laws or regulations. If an inconsistency exists between the Contract and any applicable law, the Contract will be construed to include the minimum requirements of the applicable law.

7.5 Right to Audit Employer Records

We reserve the right to audit your personnel and/or payroll records to verify the status and Eligibility of Members.

7.6 Term

The term of the Contract is specified in the Group Application.

7.7 Circumstances Beyond Control

Neither party will be responsible for a delay in performing its obligations under the Contract due to circumstances reasonably beyond its control, such as natural disaster, epidemic, riot, war, terrorism, or nuclear release.

7.8 Workers' Compensation Insurance

The Contract does not provide or replace workers' compensation coverage for your employees.

7.9 No Waiver

Failure by either party to insist upon strict compliance with any part of the Contract or with any procedure or requirement will not result in a waiver of its right to insist upon strict compliance in any other situation.

7.10 Notices

All required notices shall be sent by at least first-class mail.

a. Any notice we are required to send will be sufficient if mailed to the address we have on record.

b. Any notice we are required to send to a Dependent will be sufficient if given to the Subscriber.

c. Any notice you are required to send to us will be sufficient if mailed to the principal office of SelectHealth in Murray, Utah.

d. We do not provide COBRA notification services.

SECTION 8 DEFINITIONS

The Contract contains certain defined terms that are capitalized in the text and described in this section. Words that are not defined have their usual meaning in everyday language.

8.1 Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 and associated regulations.

8.2 Benefit(s)

The payments and privileges to which Members are entitled by the Contract.

8.3 Certificate of Coverage (Certificate)

The document(s), considered part of the Contract, which describe(s) the terms and conditions of the health insurance Benefits with us. The Member Payment Summary and any endorsements are attached to, and considered part of, the Certificate.

8.4 COBRA Coverage

Coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

8.5 Continuation Coverage

COBRA Coverage and/or Utah mini-COBRA coverage.

8.6 Contract

The group health insurance contract, including the Group Application, the Certificate of Coverage and all other documents expressly referred to and incorporated by reference.

8.7 Covered Services

The Services listed in the Certificate in Section 8 Covered Services and applicable Optional Benefits and not excluded in the Certificate in Section 10 Limitations and Exclusions.

8.8 Dependents

A Subscriber's lawful spouse and any child who meets the Eligibility criteria set forth in the Certificate in Section 2 Eligibility, and the Group Application.

8.9 Effective Date

The date on which coverage for a Member begins.

8.10 Eligible, Eligibility

In order to be Eligible, a Subscriber and his/her dependents must meet the criteria for participation specified in the Group Application and in the Certificate in Section 2 Eligibility.

8.11 Employer Waiting Period

The time period that a Subscriber and any Dependents must wait after becoming Eligible for coverage before the Effective Date. Subject to approval by us, you specify the length of this period in the Group Application.

8.12 Employer Plan

The group health plan sponsored by you and insured under the Contract.

8.13 ERISA

The Employee Retirement Income Security Act (ERISA), a federal law governing employee benefit plans.

8.14 Exclusion(s)

Situations and Services that are not covered by us under the Plan. Most Exclusions are set forth in the Certificate in Section 10 Limitations and Exclusions, but other provisions throughout the Certificate and the Contract may have the effect of excluding coverage in particular situations.

8.15 Facility

An institution that provides certain healthcare Services within specific licensure requirements.

8.16 Group Application

A form we use both as your application for coverage and to specify group-specific details of coverage. The Group Application may contain modifications to the language of the Contract. It also demonstrates your acceptance of the Contract. Other documents, such as Endorsements, may be incorporated by reference into the Group Application.

8.17 Grace Period

A specified period of time after a Premium is due during which coverage under the Contract continues and you may pay the Premium.

8.18 Limitation(s)

Situations and Services in which coverage is limited by us under the Plan. Most Limitations are set forth in the Certificate in Section 10 Limitations and Exclusions, but other provisions throughout the Certificate and the Contract may have the effect of limiting coverage in particular situations.

8.19 Member

A Subscriber and any Dependents, when properly enrolled in the Plan and accepted by us.

8.20 Member Payment Summary

A summary of Benefits by category of service, attached to and considered part of the Certificate.

8.21 Optional Benefit

Additional coverage purchased by you as noted in the Certificate that modifies Limitations and/or Exclusions.

8.22 Plan

The specific combination of Covered Services, Limitations, Exclusions, and other requirements agreed upon between you and us as set forth in the Certificate and the Contract.

8.23 Plan Sponsor

As defined in ERISA. The Plan Sponsor is typically the employer.

8.24 Premium(s)

The amount you periodically pay to us as consideration for providing Benefits under the Plan. The Premium is specified in the Group Application.

8.25 Provider

A vendor of healthcare Services licensed by the state where Services are provided and that provides Services within the scope of its license.

8.26 Qualified Medical Child Support Order

A court order for the medical support of a child as defined in ERISA.

8.27 Rescission

A cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required Premiums or contributions towards the cost of coverage.

8.28 Service Area

As defined in the Certificate(s) of Coverage.

8.29 Service(s)

Services, care, tests, treatments, drugs, medications, supplies, or equipment.

8.30 Subscriber

The individual with an employment or other defined relationship to the Plan Sponsor, through whom Dependents may be enrolled. Subscribers are also Members.

8.31 Utah mini-COBRA

Continuation coverage required by Utah law for employers with fewer than 20 employees.

selecthealth

MED NETWORK

MEMBER PAYMENT SUMMARY	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.
CONDITIONS AND LIMITATIONS		
Lifetime Maximum Plan Payment - *Per Person*	None	
Pre-Existing Conditions (PEC)	None	
Benefit Accumulator Period	plan year	
Maximum Annual Out-of-Network Payment - (per plan year)	None	None
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5]	**IN-NETWORK**	**OUT-OF-NETWORK**
Self Only Coverage, 1 person enrolled - per plan year		
Deductible	$1,000	$2,000
Out-of-Pocket Maximum	$3,000	$6,000
Family Coverage, 2 or more enrolled - per plan year		
Deductible - per person/family	$1000/$3000	$2000/$6000
Out-of-Pocket Maximum - per person/family	$3000/$6000	$6000/$12000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)		
INPATIENT SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Medical, Surgical and Hospice[4]	20% after deductible	40% after deductible
Skilled Nursing Facility[4] - Up to 60 days per plan year	20% after deductible	40% after deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	20% after deductible	40% after deductible
Up to 40 days per plan year for all therapy types combined		
PROFESSIONAL SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP)[1]	$25	40% after deductible
Secondary Care Provider (SCP)[1]	$35	40% after deductible
Allergy Tests	See Office Visits Above	Not Covered
Allergy Treatment and Serum	20%	Not Covered
Major Surgery	20%	40% after deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after deductible	40% after deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Provider (PCP)[1]	Covered 100%	Not Covered
Secondary Care Provider (SCP)[1]	Covered 100%	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Not Covered
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	Not Covered
Diagnostic Tests: Minor	Covered 100%	Not Covered
Other Preventive Services	Covered 100%	Not Covered
VISION SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Preventive Eye Exams	Covered 100%	Not Covered
All Other Eye Exams	$35	40% after deductible
OUTPATIENT SERVICES[4]	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Facility and Ambulatory Surgical	20% after deductible	40% after deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after deductible	See In-Network Benefit
Emergency Room - *(In-Network facility)*	$300 after deductible	See In-Network Benefit
Emergency Room - *(Out-of-Network facility)*	$300 after deductible	See In-Network Benefit
Intermountain InstaCare® Facilities, Urgent Care Facilities	$40	40% after deductible
Intermountain KidsCare® Facilities	$25	Not Available
Intermountain Connect Care®	Covered 100%	Not Available
Chemotherapy, Radiation and Dialysis	20% after deductible	40% after deductible
Diagnostic Tests: Minor[2]	Covered 100%	40% after deductible
Diagnostic Tests: Major[2]	20% after deductible	40% after deductible
Home Health, Hospice, Outpatient Private Nurse	20% after deductible	40% after deductible
Outpatient Cardiac Rehab	Covered 100%	40% after deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	$35 after deductible	40% after deductible

See other side for additional benefits

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MED NETWORK

	MEMBER PAYMENT SUMMARY	
	IN-NETWORK	**OUT-OF-NETWORK**
MISCELLANEOUS SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Durable Medical Equipment (DME)[4]	20% after deductible	40% after deductible
Miscellaneous Medical Supplies (MMS)[3]	20% after deductible	40% 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[4,6]	See Professional, Inpatient or Outpatient	40% after deductible
Cochlear Implants[4]	See Professional, Inpatient or Outpatient	Not Covered
Infertility - *Select Services* *(Max Plan Payment $1,500/ plan year; $5,000 lifetime)*	*50% after deductible	Not Covered
Donor Fees for Covered Organ Transplants[4]	20% after deductible	Not Covered
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient	Not Covered
OPTIONAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Mental Health and Chemical Dependency[4]		
Office Visits	$25	40% after deductible
Inpatient	20% after deductible	40% after deductible
Outpatient	20%	40% after deductible
Residential Treatment[2]	20% after deductible	40% after deductible
Chiropractic - American Specialty Health (ASH) - 800-678-9133	$20 (up to 15 visits per plan year)	Not Covered
Injectable Drugs and Specialty Medications[4]	20% after deductible	40% after deductible
Bariatric Surgery *(Up to one surgery/lifetime)*[4]	See Professional, Inpatient or Outpatient	Not Covered
PRESCRIPTION DRUGS		
Pharmacy Deductible - Per Person per plan year	$100	
Prescription Drug List (formulary)	RxSelect®	
Prescription Drugs - *Up to 30 Day Supply of Covered Medications*[4]		
Tier 1	$10	
Tier 2	25% after pharmacy deductible (minimum $25/maximum $75)	
Tier 3	50% after pharmacy deductible (minimum $50/maximum $150)	
Tier 4	20% after pharmacy deductible	
Maintenance Drugs - *90 Day Supply (Mail-Order, Retail90®)-selected drugs*[4]		
Tier 1	$10	
Tier 2	25% after pharmacy deductible (minimum $50/maximum $150)	
Tier 3	50% after pharmacy deductible (minimum $100/maximum $300)	
Generic Substitution Required	Generic required or must pay copay plus cost difference between name brand and generic	

1 Refer to **selecthealth.org/findadoctor** to identify whether a provider is a primary or secondary care provider.

2 Refer to your Certificate of Coverage for more information.

3 Frequency and/or quantity limitations apply to some preventive care and MMS services.

4 Preauthorization is required for certain services. Benefits may be reduced or denied if you do not preauthorize certain services with out-of-network providers. Please refer to Section 11--" Healthcare Management", in your Certificate of Coverage, for details.

5 All deductible/copay/coinsurance amounts are based on the allowed amounts and not on the providers billed charges. 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 SelectHealth pays for Covered Services. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

6 SelectHealth provides a $4000 adoption indemnity as outlined by the state of Utah. Medical deductible, copay, or coinsurance listed under the benefit applies and may exhaust the benefits prior to any plan payments.

* Not applied to Medical out-of-pocket maximum.

All covered services obtained outside the United States, except for routine, urgent, or emergency conditions require preauthorization.

To contact Member Services, call 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., Saturdays, from 9:00 a.m. to 2:00 p.m. TTY users should call 711.

Benefits are administered and underwritten by SelectHealth, Inc.℠ (domiciled in Utah).

medical
certificate of coverage

TABLE OF CONTENTS

Fair Treatment Notice

SelectHealth obeys Federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

We provide free:

- Aid to those with disabilities to help them communicate with us, such as sign language interpreters and written information in other formats (large print, audio, electronic formats, other).
- Language help for those whose first language is not English, such as Interpreters and member materials written in other languages.

For help, call SelectHealth Member Services at **1-800-538-5038** or SelectHealth Advantage Member Services at **1-855-442-9900** (TTY Users: 711).

If you feel you've been treated unfairly, call SelectHealth 504/Civil Rights Coordinator at **1-844-208-9012** (TTY Users: 711) or the Compliance Hotline at **1-800-442-4845** (TTY Users: 711). You may also call the Office for Civil Rights at **1-800-368-1019** (TTY Users: **1-800-537-7697**).

Language Access Services

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a SelectHealth.

注意：如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 SelectHealth。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số SelectHealth.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. SelectHealth. 번으로 전화해 주십시오.

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę́ę'', t'áá jiik'eh, éí ná hóló', kojį' hódíílnih SelectHealth.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa SelectHealth.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: SelectHealth.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните SelectHealth.

ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez SelectHealth.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。SelectHealth. まで、お電話にてご連絡ください。

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎቶች ያለክፍያ ለእርስዎ ይገኛሉ። SelectHealth **ን ያናግሩ።**

ПАЖЊА: Ако говорите Српски, бесплатне услуге пмоћи за језик, биће вам доступне. Контактирајте SelectHealth.

تنبيه: إذا كنت تتحدث عربي، فستتوفر لك خدمات المساعدة اللغوية مجاناً. اتصل بـ SelectHealth.

توجه: اگر به زبان ار او در کنی صحبت می‌کنید، خدمات کمک زبانی، بصورت رایگان در اختیار شما ست. با SelectHealth تماس بگیرید.

หมายเหตุ: หากคุณพูด ใส่ภาษา, การบริการภาษา โดยไม่มีค่าใช้จ่าย มีพร้อมบริการให้กับคุณ ติดต่อ SelectHealth

SelectHealth: 1-800-538-5038
SelectHealth Advantage: 1-855-442-9900

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SECTION 1 INTRODUCTION

1.1 This Certificate

This Certificate of Coverage describes the terms and conditions of the health insurance Benefits provided under the Group Health Insurance Contract. Please read it carefully and keep it for future reference. Technical terms are capitalized and described in Section 16 Definitions. Your Member Payment Summary, which contains a quick summary of the Benefits by category of service, is attached to and considered part of this Certificate.

1.2 SelectHealth, Inc.

SelectHealth is an HMO licensed by and **domiciled in the State of Utah and is located at 5381 Green Street, Murray, Utah 84123**. SelectHealth is affiliated with Intermountain Healthcare, but is a separate company. The Contract does not involve Intermountain Healthcare or any other affiliated Intermountain companies, or their officers or employees. Such companies are not responsible to you or any other Members for the obligations or actions of SelectHealth.

1.3 Managed Care

SelectHealth provides managed healthcare coverage. Such management necessarily limits some choices of Providers and Facilities. The management features and procedures are described by this Certificate. The Plan is intended to meet basic healthcare needs, but not necessarily to satisfy every healthcare need or every desire Members may have for Services.

1.4 Your Agreement

As a condition to enrollment and to receiving Benefits from SelectHealth, you (the Subscriber) and every other Member enrolled through your coverage (your Dependents) agree to the managed care features that are a part of the Plan in which you are enrolled and all of the other terms and conditions of this Certificate and the Contract.

1.5 No Vested Rights

You are only entitled to receive Benefits while the Contract is in effect and you, and your Dependents, if applicable, are properly enrolled and recognized by SelectHealth as Members. You do not have any permanent or vested interest in any Benefits under the Plan. Benefits may change as the Contract is renewed or modified from year to year. Unless otherwise expressly stated in this Certificate, all Benefits end when the Contract ends.

1.6 Administration

SelectHealth establishes reasonable rules, regulations, policies, procedures, and protocols to help it in the administration of your Benefits. You are subject to these administrative practices when receiving Benefits, but they do not change the express provisions of this Certificate or the Contract.

1.7 Non-Assignment

Benefits are not assignable or transferable. Any attempted assignment or transfer by any Member of the right to receive payment from SelectHealth will be invalid unless approved in advance in writing by SelectHealth.

1.8 Notices

Any notice required of SelectHealth under the Contract will be sufficient if mailed to you at the address appearing on the records of SelectHealth. Notice to your Dependents will be sufficient if given to you. Any notice to SelectHealth will be sufficient if mailed to the principal office of SelectHealth. All required notices must be sent by at least first class mail.

1.9 Nondiscrimination

SelectHealth will not discriminate against any Member based on race, sex, religion, national origin, or any other basis forbidden by law. SelectHealth will not terminate or refuse to enroll any Member because of the health status or the healthcare needs of the Member or because he or she exercised any right under the SelectHealth complaint resolution system.

1.10 Questions

If you have questions about your Benefits, call Member Services at 800-538-5038, or visit selecthealth.org. Member Services can also provide you with a provider directory and information about In-Network Providers, such as medical school attended, residency completed, and board certification status. SelectHealth offers foreign language assistance.

1.11 Benefit Changes

SelectHealth employees often respond to inquiries regarding coverage as part of their job responsibilities. These employees do not have the authority to extend or modify the Benefits provided by the Plan.

a. In the event of a discrepancy between information given by a SelectHealth employee and the written terms of the Contract, the terms of the Contract will control.

b. Any changes or modifications that would increase your Benefits must be provided in writing and signed by the president, vice president, or medical director of SelectHealth.

c. Administrative errors will not invalidate Benefits otherwise in force or give rise to rights or Benefits not otherwise provided for by the Plan.

SECTION 2 ELIGIBILITY

2.1 General

Your employer decides, in consultation with SelectHealth, which categories of its employees, retirees, and their Dependents are Eligible for Benefits, and establishes the other Eligibility requirements of the Plan. These Eligibility requirements are described in this section and in the Group Application of the Contract. In order to become and remain a Member, you and your Dependents must continuously satisfy these requirements. No one, including your employer, may change, extend, expand, or waive the Eligibility requirements without first obtaining the advance, written approval of an officer of SelectHealth.

2.2 Subscriber Eligibility

You are Eligible for Benefits as set forth in the Group Application. During the Employer Waiting Period, you must work the specified minimum required hours except for paid time off and hours you do not work due to a medical condition, the receipt of healthcare, your health status or disability. SelectHealth may require payroll reports from your employer to verify the number of hours you have worked as well as documentation from you to verify hours that you did not work due to paid time off, a medical condition, the receipt of healthcare, your health status or disability.

2.3 Dependent Eligibility

Unless stated otherwise in the Group Application, your Dependents are:

2.3.1 Spouse

Your lawful spouse. Eligibility may not be established retroactively.

2.3.2 Children

The children (by birth or adoption, and children placed for adoption or under legal guardianship through testamentary appointment or court order, but not under temporary guardianship or guardianship for school residency purposes) of you or your lawful spouse, who are younger than age 26.

2.3.3 Disabled Children

Unmarried Dependent children who meet the Eligibility requirements in Subsection 2.3.2 may enroll or remain enrolled as Dependents after reaching age 26 as long as they:

a. Are unable to engage in substantial gainful employment to the degree they can achieve economic independence due to medically determinable physical or mental impairment which can be expected to last for a continuous period of not less than 12 months or result in death;

b. Are chiefly dependent upon you or your lawful spouse for support and maintenance since they reached age 26; and

c. Have been continuously enrolled in some form of healthcare coverage, with no break in coverage of more than 63 days since the date they reached age 26.

SelectHealth may require you to provide proof of incapacity and dependency within 30 days of the Effective Date or the date the child reaches age 26 and annually after the two-year period following the child's 26th birthday.

2.3.4 Incarcerated Dependents

Despite otherwise qualifying as described above, a person incarcerated in a prison, jail, or other correctional facility is not a Dependent.

2.4 Court-Ordered Dependent Coverage

When you or your lawful spouse are required by a court or administrative order to provide health insurance coverage for a child, the child will be enrolled in your family coverage according to SelectHealth guidelines and only to the minimum extent required pursuant to Utah Code Annotated 31A-22-610 through 611, and 718. If you are not enrolled for coverage at the time the court or administrative order becomes effective, only you and the affected Dependent will be allowed to enroll for coverage. For more information about SelectHealth guidelines, please call Member Services.

2.4.1 Qualified Medical Child Support Order (QMCSO)

A QMCSO can be issued by a court of law or by a state or local child welfare agency. In order for the medical child support order to be qualified, the order must specify the following:

a. Your name and last known mailing address (if any) and the name and mailing address of each alternate recipient covered by the order;

b. A reasonable description of the type of coverage to be provided, or the manner in which the coverage will be determined; and

c. The period to which the order applies.

2.4.2 National Medical Support Notice (NMSN)

An NMSN is a QMCSO issued by a state or local child welfare agency to withhold from your income any contributions required by the Plan to provide health insurance coverage for an Eligible child.

2.4.3 Eligibility and Enrollment

You and the Dependent child must be Eligible for coverage, unless specifically required otherwise by applicable law. You and/or the Dependent child will be enrolled without regard to an Annual Open Enrollment restriction and will be subject to applicable Employer Waiting Period requirements. SelectHealth will not recognize Dependent Eligibility for a former spouse as the result of a court order.

2.4.4 Duration of Coverage

Court-ordered coverage for a Dependent child who is otherwise eligible for coverage will be provided until the court order is no longer in effect.

SECTION 3 ENROLLMENT

3.1 General

You may enroll yourself and your Dependents in the Plan during the Initial Eligibility Period, under a Special Enrollment Right, or, if offered by your employer, during an Annual Open Enrollment.

You and your Dependents will not be considered enrolled until:

a. All enrollment information is provided to SelectHealth; and

b. The Premium has been paid to SelectHealth by your employer.

3.2 Enrollment Process

Unless separately agreed to in writing by SelectHealth and your employer, you must enroll on an Application accepted by SelectHealth. You and your Dependents are responsible for obtaining and submitting to SelectHealth evidence of Eligibility and all other information required by SelectHealth in the enrollment process. You enroll yourself and any Dependents by completing, signing, and submitting an Application and any other required enrollment materials to SelectHealth.

3.3 Effective Date of Coverage

Coverage for you and your Dependents will take effect as follows:

3.3.1 Annual Open Enrollment

Coverage elected during an Annual Open Enrollment will take effect on the day the Contract is effective.

3.3.2 Newly Eligible Employees

Coverage you elect as a newly Eligible employee will take effect as specified in the Group Application if SelectHealth receives a properly completed Application.

If you do not enroll in the Plan for yourself and/or your Dependents during the Initial Eligibility Period, you may not enroll until an Annual Open Enrollment unless you experience an event that creates a Special Enrollment Right.

3.3.3 Court or Administrative Order

When you or your lawful spouse are required by a court or administrative order to provide health insurance coverage for a child, the Effective Date of coverage will be the later of:

a. The start date indicated in the order;

b. The date any applicable Employer Waiting Period is satisfied; or

c. The date SelectHealth receives the order.

3.4 Special Enrollment Rights

SelectHealth provides Special Enrollment Rights in the following circumstances:

3.4.1 Loss of Other Coverage

If you do not enroll in the Plan for yourself and/or your Dependents when initially Eligible, you may enroll at a time other than an Annual Open Enrollment if each of the following conditions are met:

a. You initially declined to enroll in the Plan due to the existence of other health plan coverage;

b. The loss of the other health plan coverage occurred because of a loss of eligibility (this Special Enrollment Right will not apply if the other coverage is lost due to nonpayment of Premiums). One exception to this rule exists: if a Dependent is enrolled on another group health plan and the Annual Open Enrollment periods of the two plans do not coincide, the Dependent may voluntarily drop coverage under their health plan's open enrollment and a special enrollment period will be permitted under the Plan in order to avoid a gap in coverage; and

c. You and/or your Dependents who lost the other coverage must enroll in the Plan within 31 days after the date the other coverage is lost.

Proof of loss of the other coverage must be submitted to SelectHealth as soon as reasonably possible. Proof of loss of other coverage must be submitted before any Benefits will be paid.

Coverage of any Members properly enrolled under this Special Enrollment Right will be effective on the date the other coverage was lost.

3.4.2 New Dependents

If you are enrolled in the Plan (or are Eligible to be covered but previously declined to enroll), and gain a Dependent through marriage, birth, adoption, placement for adoption or placement under legal guardianship with you or your lawful spouse, then you may enroll the Dependents (and yourself, if applicable) in the Plan. In the case of birth, adoption or placement for adoption of a child, you may also enroll your Eligible spouse, even if he or she is not newly Eligible as a Dependent. However, this Special Enrollment Right is only available by enrolling within 31 days of the marriage, birth, adoption, placement for adoption or placement under legal guardianship (there is an exception for enrolling a newborn, adopted child, or child placed for adoption or under legal guardianship if enrolling the child does not change the Premium, as explained in Section 3.5 Enrolling a Newborn, Adopted Child, or Child Placed for Adoption or Under Legal Guardianship).

Coverage of any Members properly enrolled under this Special Enrollment Right will be effective:

a. As of the date of marriage;

b. As of the date of birth;

c. If the child is less than 31 days old when adopted or placed for adoption, as of the date of birth; if the child is more than 31 days old when adopted or placed for adoption, as of the child's date of placement; or

d. As of the later of:

   i. The effective date of the guardianship court order or testamentary appointment; or

   ii. The date the guardianship court order or testamentary appointment is received by SelectHealth.

3.4.3 Qualification for a Subsidy Through Utah's Premium Partnership

You and/or your Eligible Dependents who qualify for a subsidy through the state Medicaid program to purchase health insurance may enroll in the Plan if application is made within 60 days of receiving written notification of eligibility for the subsidy. If you timely enroll, the Effective Date of coverage is the first of the month following date of enrollment.

3.4.4 Loss of Medicaid or CHIP Coverage

If you and/or your Eligible Dependents lose coverage under a Medicaid or CHIP plan due to loss of eligibility, you may enroll in the Plan if application is made within 60 days. If you enroll within 60 days, the Effective Date of coverage is the first day after your Medicaid or CHIP coverage ended.

3.4.5 As Required by State or Federal Law

SelectHealth will recognize other special enrollment rights as required by state or federal law.

3.5 Enrolling a Newborn, Adopted Child, or Child Placed for Adoption or Under Legal Guardianship

You must enroll your newborn, adopted child, child placed for adoption or child under legal guardianship according to the following requirements:

a. If enrolling the child requires additional Premium, you must enroll the child within 31 days of the child's birth, adoption, or placement for adoption or under legal guardianship.

b. If enrolling the child does not change the Premium, you must enroll the child within 31 days from the date SelectHealth mails notification that a claim for Services was received for the child.

If the child is not enrolled within these time frames, then you may not enroll the child until an Annual Open Enrollment or if you experience an event that creates a Special Enrollment Right.

If you lose Eligibility for coverage before the end of the applicable time frame listed in (a) or (b) above, you are still allowed to enroll the child within the applicable time frame. However, the child will only be covered from the moment of birth, adoption, placement for adoption or under legal guardianship until the date that you lost Eligibility for coverage.

3.6 Leave of Absence

If you are granted a temporary leave by your employer, you and any Dependents may continue to be enrolled with SelectHealth for up to the length of time specified in the Group Application, as long as the monthly Premiums for your coverage are paid to SelectHealth by your employer. Military personnel called into active duty will continue to be covered to the extent required by law. A leave of absence may not be treated retroactively as a termination of employment.

3.7 Family Medical Leave Act

If you are on a leave required by the Family Medical Leave Act (FMLA), SelectHealth will administer your coverage as follows:

a. You and your enrolled Dependents may continue your coverage with SelectHealth to the minimum extent required by the FMLA as long as applicable Premiums continue to be paid to SelectHealth by your employer.

b. If Premiums are not paid, your coverage will be terminated. Upon your return to work, you and any previously enrolled Dependents who are still Eligible will be prospectively reinstated if the applicable Premium for you is paid to SelectHealth by your employer within 30 days. SelectHealth will not be responsible for any claims incurred by you or your Dependents during this break in coverage.

Any non-FMLA leave of absence granted by your employer that could have been classified as FMLA leave will be considered by SelectHealth as an FMLA leave of absence.

SECTION 4 TERMINATION

4.1 Group Termination

Coverage under the Plan for you and your Dependents will terminate when the Contract terminates.

4.1.1 Termination by Employer

Your employer may terminate the Contract, with or without cause, by providing SelectHealth with written notice of termination not less than 30 days before the proposed termination date.

4.1.2 Termination of Employer Group by SelectHealth

SelectHealth may terminate the Contract for any of the following reasons:

a. Nonpayment of applicable Premiums;

b. Fraud or intentional misrepresentation of material fact to SelectHealth by your employer in any matter related to the Contract or the administration of the Plan;

c. Your employer's coverage under the Contract is through an association and your employer terminates membership in the association;

d. Your employer fails to satisfy the minimum group participation and/or employer contribution requirements of SelectHealth;

e. No employees live, reside, or work in the Service Area;

f. SelectHealth elects to discontinue offering a particular health benefit plan. If that happens, you will be given at least 90 days advance notice; or

g. SelectHealth withdraws from the market and discontinues all of its health benefit plans. If that happens, you will be given at least 180 days advance notice.

4.2 Individual Termination

Your coverage under the Plan may terminate even though the Contract with your employer remains in force.

4.2.1 Termination Date

If you and/or your enrolled Dependents lose Eligibility, then coverage will terminate either on the date Eligibility is lost or the end of the month in which Eligibility is lost, as specified in the Group Application. However, when a Dependent child ceases to be a Dependent, coverage will terminate at the end of the month in which Dependent status is lost. When a loss of Eligibility is not reported in a timely fashion as required by the Contract, and federal or state law prevents SelectHealth from retroactively terminating coverage, SelectHealth has the discretion to determine the prospective date of termination. SelectHealth also has the discretion to determine the date of termination for Rescissions.

4.2.2 Fraud or Misrepresentation

a. Made During Enrollment:

   i. Coverage for you and/or your Dependents may be terminated or Rescinded during the two-year period after you enroll if you or they make an intentional misrepresentation of material fact in connection with insurability.

   ii. Coverage for you and/or your Dependents may be terminated or Rescinded at any time if you or they make any fraudulent misrepresentation in connection with insurability.

   iii. Please Note: If coverage is Rescinded as described above, the termination is retroactive to the Effective Date of coverage.

b. Made After Enrollment: Coverage for you and/or your Dependents may be terminated or Rescinded if you or they commit fraud or make an intentional misrepresentation of material fact in connection with Benefits or Eligibility. At the discretion of SelectHealth, the Rescission may be effective retroactively to the date of the fraud or misrepresentation.

c. If coverage for you or your Dependent is terminated or Rescinded for fraud or intentional misrepresentation of material fact, you or they are allowed to reenroll 12 months after the date of the termination, provided the Contract is still in force. You will be given notice of this provision at the time of termination.

d. The termination from the Plan of a Dependent for cause does not necessarily affect your Eligibility or enrollment or the Eligibility or enrollment of your other Dependents.

4.2.3 Leaving the Service Area

Coverage for you and/or your Dependents terminates if you no longer live, work or reside in the Service Area.

4.2.4 Annual Open Enrollment

You can drop coverage for yourself and any Dependents during an Annual Open Enrollment.

4.2.5 Nonpayment of Premium or Contributions

SelectHealth may terminate coverage for you and/or your Dependents for nonpayment of applicable Premiums or contributions. Termination may be retroactive to the beginning of the period for which Premiums or contributions were not paid, and SelectHealth may recover from you and/or your Dependent(s) the amount of any Benefits you or they received during the period of lost coverage.

4.2.6 Court or Administrative Order

In cases of court or administrative orders that grant a divorce or annul/declare void a marriage, subject to SelectHealth policy, the effective date of the change will be the date the court or administrative order was signed by the court or administrative agency.

4.3 Member Receiving Treatment at Termination

All Benefits under the Plan terminate when the Contract terminates, including coverage for Members hospitalized or otherwise within a course of care or treatment. All Services received after the date of termination are the responsibility of the Member and not the responsibility of SelectHealth no matter when the condition arose and despite care or treatment anticipated or already in progress.

4.4 Reinstatement

Members terminated from coverage for cause may not be reinstated without the written approval of SelectHealth.

SECTION 5 CONTINUATION COVERAGE

If your coverage terminates, you or your enrolled Dependents may be entitled to continue and/or convert coverage. For detailed information about your rights and obligations under your Employer's Plan and under federal law, contact your employer.

5.1 COBRA or Utah mini-COBRA (Continuation Coverage)

You and/or your Dependents may have the right to temporarily continue your coverage under the Plan when coverage is lost due to certain events. The federal law that governs this right is called COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1986) and generally applies to employers with 20 or more employees. For employers with fewer than 20 employees, Utah law provides for mini-COBRA coverage.

5.1.1 Employer's Obligation

Continuation Coverage is an employer obligation. SelectHealth is not the administrator of Continuation Coverage procedures and requirements. SelectHealth has contractually agreed to assist your employer in providing Continuation Coverage in certain circumstances. It is your employer's responsibility to do the following in a timely manner:

a. Notify persons entitled to Continuation Coverage;

b. Notify SelectHealth of such individuals; and

c. Collect and submit to SelectHealth all applicable Premiums.

If the Contract is terminated, your Continuation Coverage with SelectHealth will terminate. Your employer is responsible for obtaining substitute coverage.

5.2 Minimum Extent

Continuation Coverage will only be provided for the minimum time and only to the minimum extent required by applicable federal law or pursuant to Utah Code Annotated 31A-22-722. SelectHealth will not provide Continuation Coverage if you, your Dependents, or your employer fails to strictly comply with all applicable notices and other requirements and deadlines.

SECTION 6 PROVIDERS/NETWORKS

6.1 Providers and Facilities

SelectHealth contracts with certain Providers and Facilities (known as 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 SelectHealth.

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 a In-Network Provider or Facility. Refer to your Member Payment Summary 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 a Out-of-Network Provider or Facility. Refer to your Member Payment Summary for details.

6.1.3 Other Networks

For Dependent children residing and receiving care outside of the Service Area, In-Network Benefits apply for Services received from Providers on the SelectHealth Med network in Utah, SelectHealth network in Idaho, and MultiPlan/PHCS Providers outside of Utah or Idaho. Contact Member Services for additional information.

6.2 Access to Healthcare Providers

You may be entitled to coverage for healthcare Services from the following

Out-of-Network Providers if you live or reside within 30 paved road miles of the listed Providers, or if you live or reside in closer proximity to the listed Providers than to your In-Network Providers:

Independent Hospital(s)
Brigham City Community Hospital, Brigham City, Box Elder County, Utah

Federally Qualified Health Centers
Beaver Medical Clinic, Beaver, Beaver County, Utah
Blanding Family Practice/Blanding Medical Center, Blanding, Utah
Bryce Valley Clinic, Cannonville, Utah
Carbon Medical Services, Carbon, Carbon County, Utah
Circleview Clinic, Circleview, Piute County, Utah
Duchesne Valley Medical Clinic, Duchesne, Duchesne County, Utah
Emery Medical Center, Castledale, Emery County, Utah
Enterprise Valley Medical Clinic, Enterprise, Washington County, Utah
Garfield Memorial Clinic, Panguitch, Garfield County, Utah
Green Valley/River Clinic, Green River, Emery/Grand Counties, Utah
Halchita Clinic, San Juan County, Utah
Hurricane Family Practice Clinic, Hurricane, Washington County, Utah
Kamas Health Center, Kamas, Summit County, Utah
Kazan Memorial Clinic, Escalante, Garfield County, Utah
Long Valley Medical, Kane County, Utah
Milford Valley Clinic, Milford, Beaver County, Utah
Montezuma Creek Health Center, Montezuma Creek, San Juan County, Utah
Monument Valley Health Center, Monument Valley, Utah
Navajo Mountain Health Center, San Juan County, Utah
Wayne County Medical Clinic, Bicknell, Wayne County, Utah

This list may change periodically, please check on our website or call for verification.

If you have questions concerning your rights to see a Provider on this list, call Member Services at 800-538-5038. If SelectHealth does not resolve your problem, you may contact the Office of Consumer Health Assistance in the Utah Insurance Department.

6.3 Providers and Facilities not Agents/Employees of SelectHealth

Providers contract independently with SelectHealth and are not agents or employees of SelectHealth. They are entitled and required to exercise independent professional medical judgment in providing Covered Services. SelectHealth makes a reasonable effort to credential In-Network Providers and Facilities, but it does not guarantee the quality of Services rendered by Providers and Facilities or the outcomes of medical care or health-related Services. Providers and Facilities, not SelectHealth, are solely responsible for their actions, or failures to act, in providing Services to you.

Providers and Facilities are not authorized to speak on behalf of SelectHealth or to cause SelectHealth to be legally bound by what they say. A recommendation, order, or referral from a Provider or Facility, including In-Network Providers and Facilities, does not guarantee coverage by SelectHealth.

Providers and Facilities do not have authority, either intentionally or unintentionally, to modify the terms and conditions of the Plan. Benefits are determined by the provisions of the Contract.

6.4 Payment

SelectHealth may pay Providers in one or more ways, such as discounted fee-for-service, capitation (fixed payment per Member per month), and payment of a year-end withhold.

6.4.1 Incentives

Some payment methods may encourage Providers to reduce unnecessary healthcare costs and efficiently utilize healthcare resources. No payment method is ever intended to encourage a Provider to limit Medically Necessary care.

6.4.2 Payments to Members

SelectHealth reserves the right to make payments directly to you or your Dependents instead of to Out-of-Network Providers and/or Facilities.

6.5 Provider/Patient Relationship

Providers and Facilities are responsible for establishing and maintaining appropriate Provider/patient relationships with you, and SelectHealth does not interfere with those relationships. SelectHealth is only involved in decisions about what Services will be covered and paid for by SelectHealth under the Plan. Decisions about your Services should be made between you and your Provider without reference to coverage under the Plan.

6.6 Continuity of Care

SelectHealth will provide you with 30 days' notice of In-Network Provider termination if you or your Dependent is receiving ongoing care from that Provider. However, if SelectHealth does not receive adequate notice of a Provider termination, SelectHealth will notify you within 30 days of receiving notice that the Provider is no longer In-Network with SelectHealth.

If you or your Dependent is under the care of a Provider when participation changes, SelectHealth will continue to treat the Provider as an In-Network Provider until the completion of the care (not to exceed 90 days), or until you or your Dependent is transferred to another In-Network Provider, whichever occurs first. However, if you or your Dependent is receiving maternity care in the second or third trimester, you or they may continue such care through the first postpartum visit.

To continue care, the In-Network Provider must not have been terminated by SelectHealth for quality reasons, remain in the Service Area, and agree to do all of the following:

a. Accept the Allowed Amount as payment in full;

b. Follow SelectHealth's Healthcare Management Program policies and procedures;

c. Continue treating you and/or your Dependent; and

d. Share information with SelectHealth regarding the treatment plan.

SECTION 7 ABOUT YOUR BENEFITS

7.1 General

You and your Dependents are entitled to receive Benefits while you are enrolled with SelectHealth and while the Contract is in effect. This section describes those Benefits in greater detail.

7.2 Member Payment Summary

Your Member Payment Summary lists variable information about your specific Plan. This includes information about Copay, Coinsurance, and/or Deductible requirements, Preauthorization requirements, visit limits, Limitations on the use of Out-of-Network Providers and Facilities, and expenses that do not count against your Out-of-Pocket Maximum.

7.3 Identification (ID) Cards

You will be given SelectHealth ID cards that will provide certain information about the Plan in which you are enrolled. Providers and Facilities may require the presentation of the ID card plus one other reliable form of identification as a condition to providing Services. The ID card does not guarantee Benefits.

If you or your enrolled Dependents permit the use of your ID card by any other person, the card will be confiscated by SelectHealth or by a Provider or Facility and all rights under the Plan will be immediately terminated for you and/or your Dependents.

7.4 Medical Necessity

To qualify for Benefits, Covered Services must be Medically Necessary. Medical Necessity is determined by the Medical Director of SelectHealth or another Physician designated by SelectHealth. A recommendation, order, or referral from a Provider or Facility, including In-Network Providers and Facilities, does not guarantee Medical Necessity.

7.5 Benefit Changes

Your Benefits may change if the Contract changes. Your employer is responsible for providing at least 30 days advance written notice of such changes.

7.6 Calendar-Year or Plan-Year Basis

Your Member Payment Summary will indicate if your Benefits are calculated on a calendar-Year or plan-Year basis. Out-of-Pocket Maximums, Limitations, and Deductibles that are calculated on a calendar-Year basis start over each January 1st. Out-of-Pocket Maximums, Limitations, and Deductibles that are calculated on a plan-Year basis start over each Year on the renewal date of the Contract.

7.7 Lifetime Maximums

Your Member Payment Summary will specify any applicable Lifetime Maximums.

7.8 Two Benefit Levels

7.8.1 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 SelectHealth pays for Covered Services. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

7.9 Emergency Conditions

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 SelectHealth 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 more than 40 miles away from any In-Network Provider or Facility.

7.11 Out-of-Area Benefits and Services

Other than for Emergency Conditions and Urgent Conditions, as described above, Out-of-Network Benefits apply for Covered Services rendered by Out-of-Network Providers or Facilities outside of SelectHealth's Service Area.

7.12 Third Party Payments

To the extent permissible under federal or state law, third-party payments (including discounts and coupons) may not apply towards your Deductible and Out-of-Pocket Maximum.

SECTION 8 COVERED SERVICES

You and your Dependents are entitled to receive Benefits for Covered Services while you are enrolled with SelectHealth and while the Contract is in effect. This section describes those Covered Services (except for pharmacy Covered Services, which are separately described in Section 9 Prescription Drug Benefits). Certain Services must be Preauthorized; failure to obtain Preauthorization for these Services may result in a reduction or denial of Benefits. Refer to Section 11 Healthcare Management for a list of Services that must be Preauthorized.

Benefits are limited. Services must satisfy all of the requirements of the Contract to be covered by SelectHealth. For additional information affecting Covered Services, refer to your Member Payment Summary and Section 10 Limitations and Exclusions. In addition to this Certificate, you can find further information about your Benefits by doing any of the following:

a. Log in to My Health at selecthealth.org/myhealth;
b. Visit selecthealth.org;
c. Refer to your Provider & Facility Directory; or
d. Call Member Services at 800-538-5038.

8.1 Facility Services

8.1.1 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 SelectHealth-approved treatment Facility for alcohol/drug dependency.
f. Maternity/obstetrical Services.
g. Services in connection with an otherwise covered inpatient Hospital stay.

8.1.3 Nutritional Therapy

Medical nutritional therapy Services are covered up to five visits per Year as a Preventive Service, regardless of diagnosis. Subsequent visits are covered as a medical Benefit.

Weight management as part of a program approved by SelectHealth is also covered once per year.

8.1.4 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.

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

General anesthesia, deep anesthesia, and Monitored Anesthesia Care (MAC) are only covered pursuant to SelectHealth policy when administered in connection with otherwise Covered Services and by a Physician certified as an anesthesiologist or by a Certified Registered Nurse Anesthetist (CRNA) under the direct supervision of a Physician certified as an anesthesiologist.

8.2.3 Dental Services

Only:

a. When rendered to diagnose or treat medical complications of a dental procedure and administered under the direction of a medical Provider whose primary practice is not dentistry or oral surgery.

b. When SelectHealth determines the following to be Medically Necessary:

   i. Maxillary and/or mandibular procedures;

   ii. Upper/lower jaw augmentation or reduction procedures, including developmental corrections or altering of vertical dimension;

   iii. Orthognathic Services; or

   iv. Services for Congenital Oligodontia/Anodontia.

c. For repairs of physical damage to sound natural teeth, crowns, and the natural supporting structures surrounding teeth when:

   i. Such damage is a direct result of an accident independent of disease or bodily infirmity or any other cause;

   ii. Medical advice, diagnosis, care, or treatment was recommended or received for the injury at the time of the accident; and

   iii. Repairs are initiated within one year of the date of the accident.

Bleaching to restore teeth to pre-accident condition is limited to $200.

Orthodontia and the replacement/repair of dental appliances are not covered, even after an accident. Repairs for physical damage resulting from biting or chewing are not covered.

8.2.4 Dietary Products

Only in the following limited circumstances:

a. For hereditary metabolic disorders when:

   i. You or your Dependent has an error of amino acid or urea cycle metabolism;

   ii. The product is specifically formulated and used for the treatment of errors of amino acid or urea cycle metabolism; and

   iii. The product is used under the direction of a Physician, and its use remains under the supervision of the Physician.

b. Certain enteral formulas according to SelectHealth policy.

8.2.5 Genetic Counseling

Only when rendered by an In-Network Provider.

8.2.6 Genetic Testing

Only when ordered or recommended by a medical geneticist, a genetic counselor, or a provider with

recognized expertise in the area being assessed and only when all of the following criteria are met:

a. Diagnostic results from physical examination, pedigree analysis, and conventional testing are inconclusive and a definitive diagnosis is uncertain;

b. The clinical utility of all requested genes and gene mutations must be established; and

c. The clinical record indicates how test results will guide decisions regarding disease treatment, prevention, or management.

8.2.7 Home Visits

Only if you are physically incapable of traveling to the Provider's office.

8.2.8 Infertility

Services for the diagnosis of Infertility are only covered in limited circumstances, including fulguration of ova ducts, hysteroscopy, hysterosalpingogram, certain laboratory tests, diagnostic laparoscopy, and some imaging studies.

8.2.9 Major Surgery

8.2.10 Mastectomy/Reconstructive Services

In accordance with the Women's Health and Cancer Rights Act (WHCRA), SelectHealth covers mastectomies and reconstructive surgery after a mastectomy. If you are receiving Benefits in connection with a mastectomy, coverage for reconstructive surgery, including modifications or revisions, will be provided according to SelectHealth's Healthcare Management Program criteria and in a manner determined in consultation with you and the attending Physician, for:

a. All stages of reconstruction on the breast on which the mastectomy was performed;

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Prophylactic mastectomies are covered in limited circumstances in accordance with SelectHealth's medical policy.

Benefits are subject to the same Deductibles, Copays, and Coinsurance amounts applicable to other medical and surgical procedures covered by the Plan.

8.2.11 Medical/Surgical

In an inpatient, outpatient, or Ambulatory Surgical Facility.

8.2.12 Maternity Services

Prenatal care, labor and delivery, and postnatal care, including complications of delivery. Newborns are subject to their own separate cost sharing, including Deductibles, Coinsurance, Copays, and Out-of-Pockets Maximums.

8.2.13 Office Visits

For consultation, diagnosis, and treatment.

8.2.14 Preventive Services

8.2.15 Sleep Studies

Only when provided by an In-Network provider who is a board-certified sleep specialist and:

a. The Service is performed at an In-Network Facility certified as a sleep center/lab by the American Board of Sleep Medicine; or

b. For home studies if the Member receiving Services is 18 or older.

8.2.16 Sterilization Procedures

8.3 Miscellaneous Services

8.3.1 Adoption Indemnity Benefit

SelectHealth provides an adoption indemnity Benefit as required pursuant to Utah Code Annotated 31A-22-610.1. In order to receive this Benefit, the child must be placed with you for adoption within 90 days of the child's birth. You must submit a claim for the Benefit within one year from the date of placement.

If you adopt more than one child from the same birth (e.g., twins), only one adoption indemnity Benefit applies. If you and/or your spouse are covered by multiple plans, SelectHealth will cover a prorated share of the adoption indemnity Benefit.

This Benefit is subject to Coinsurance, Copays, and Deductibles applicable to the maternity Benefit as indicated in your Member Payment Summary.

8.3.2 Ambulance/Transportation Services

Transport by a licensed service to the nearest Facility expected to have appropriate Services for the treatment of your condition. Only for Emergency Conditions and not when you could safely be transported by other means. Air ambulance transportation only when ground ambulance is either not available or, in the opinion of responding medical professionals, would cause an unreasonable risk of harm because of increased travel time. Transportation services in nonemergency situations must be approved in advance by SelectHealth.

8.3.3 Approved Clinical Trials

Services for an Approved Clinical Trial only to the extent required by federal or state law and only when the Member is:

a. Eligible to participate in the trial according to the trial protocol;

b. The treatment is for cancer or another life-threatening disease (any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted); and

c. Either:

   i. The referring health care professional is 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 Chemotherapy, Radiation Therapy, and Dialysis

8.3.5 Cochlear Implants

For prelingual deafness in children or postlingual deafness in adults in limited circumstances that satisfy SelectHealth criteria.

8.3.6 Durable Medical Equipment (DME)

Only:

a. When used in conjunction with an otherwise covered condition and when:

   i. Prescribed by a Provider;

   ii. Primarily used for medical purposes and not for convenience, personal comfort, or other nontherapeutic purposes;

   iii. Required for Activities of Daily Living;

   iv. Not for duplication or replacement of lost, damaged, or stolen items; and

   v. Not attached to a home or vehicle.

b. Batteries only when used to power a wheelchair, an insulin pump for treatment of diabetes, or for a covered Cochlear Implant.

c. Continuous passive motion therapy for any indication for up to 21 days of continuous coverage from the first day applied.

SelectHealth will not provide payment for rental costs exceeding the purchase price. For covered rental DME that is subsequently purchased, cumulative rental costs are deducted from the purchase price.

8.3.7 Home Healthcare

a. When you:

   i. Have a condition that requires the services of a licensed Provider;

   ii. Are home bound for medical reasons;

   iii. Are physically unable to obtain necessary medical care on an outpatient basis; and

   iv. Are under the care of a Physician.

b. In order to be considered home bound, you must either:

   i. Have a medical condition that restricts your ability to leave the home without the assistance of another individual or supportive device or because absences from the home are medically contraindicated; or

   ii. Leave the home only to receive medical treatment that cannot be provided in your home or other treatments that require equipment that cannot be made available in your home or infrequently and for short periods of time for nonmedical purposes.

You are not considered home bound if you leave the home regularly for social activities, drive a car, or do regular grocery or other shopping, work or business.

8.3.8 Hospice Care

8.3.9 Injectable Drugs and Specialty Medications

Up to a 30-day supply, though exceptions can be made for travel purposes. Injectable drugs and specialty medications must be provided by an In-Network Provider unless otherwise approved in writing in advance by SelectHealth. You may be required to receive the drug or medication in your Provider's office. Some Injectable Drugs and Specialty Medications may only be obtained from certain drug distributors. Call Member Services to determine if this is the case and to obtain information on In-Network drug vendors.

8.3.10 Miscellaneous Medical Supplies (MMS)

Only when prescribed by a Provider and not generally usable in the absence of an illness or injury. Only 90 days of diabetic supplies may be purchased at a time.

8.3.11 Neuropsychological Testing (Medical)

As a medical Benefit, only as follows:

a. Testing performed as part of the preoperative evaluation for patients undergoing:

   i. Seizure surgery;

   ii. Solid organ transplantation; or

   iii. Central nervous system malignancy.

b. Patients being evaluated for dementia/Alzheimer's disease;

c. Patients with Parkinson's Disease;

d. Stroke patients undergoing formal rehabilitation; and

e. Post-traumatic-brain-injury patients.

All other conditions are considered under the mental health Benefit, if applicable.

8.3.12 Organ Transplants

a. Only if:

   i. Provided by In-Network Providers in an In-Network Facility unless otherwise approved in writing in advance by SelectHealth.

b. And only the following:

   i. Bone marrow as outlined in SelectHealth criteria;

   ii. Combined heart/lung;

   iii. Combined pancreas/kidney;

   iv. Cornea;

   v. Heart;

   vi. Kidney (but only to the extent not covered by any government program);

   vii. Liver;

   viii. Pancreas after kidney;

   ix. Single or double lung and

   x. Small bowel.

For covered transplants, organ harvesting from donors is covered. Services for both the donor and the recipient are only covered under the recipient's coverage.

Costs of a chartered service if transportation to a transplant site cannot be accomplished within four hours by commercial carrier.

8.3.13 Orthotics and Other Corrective Appliances for the Foot

Not covered unless they are part of a lower foot brace, and they are prescribed as part of a specific treatment associated with recent, related surgery.

8.3.14 Osteoporosis Screening

Only central bone density testing (DEXA scan)

8.3.15 Private Duty Nursing

On a short-term, outpatient basis during a transition of care when ordered by a Provider. Not available for Respite Care or Custodial Care.

8.3.16 Rehabilitation Therapy

Physical, occupational, and speech rehabilitative therapy when required to correct an impairment caused by a covered accident or illness or to restore an individual's ability to perform Activities of Daily Living.

8.3.17 TeleHealth

Otherwise covered evaluation and management, genetic counseling and mental health Services when rendered by an In-Network Provider, and as otherwise indicated in medical policy.

8.3.18 Temporomandibular Joint (TMJ)

8.3.19 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 a Participating Provider

8.3.20 Vision Aids

Only:

a. Contacts if diagnosed with keratoconus, congenital cataracts, or when used as a bandage after eye trauma/injury; or

b. Monofocal intraocular lenses after cataract surgery.

8.4 Prescription Drug Services

Refer to Section 9 Prescription Drug Benefits for details.

SECTION 9 PRESCRIPTION DRUG BENEFITS

This section includes important information about how to use your Prescription Drug Benefits. Note: this section does not apply to you if your Member Payment Summary indicates that your Plan does not provide Prescription Drug Benefits.

9.1 Prescription Drug Benefit Resources

In addition to this Certificate, you can find additional information about your Pharmacy Benefits by doing any of the following:

a. Log in to My Health at selecthealth.org/myhealth and use Pharmacy Tools;

b. Visit selecthealth.org/pharmacy;

c. Refer to your Provider & Facility Directory; or

d. Call Member Services at 800-538-5038.

9.2 Use In-Network Pharmacies

To get the most from your Prescription Drug Benefits, use an In-Network Pharmacy and present your ID card when filing a prescription. SelectHealth contracts with pharmacy chains on a national basis and with independent pharmacies in Utah.

If you use an Out-of-Network Pharmacy, you must pay full price for the drug and submit to SelectHealth a Prescription Reimbursement Form with your itemized pharmacy receipt. If the drug is covered, you will be reimbursed the Allowed Amount minus your Copay/Coinsurance and/or Deductible.

9.3 Tiered Benefits

There are tiers (or levels) of covered prescriptions listed on your ID card and Member Payment Summary. This tiered Benefit allows you to choose the drugs that best meet your medical needs while encouraging you and your Provider to discuss treatment options and choose lower-tier drugs when therapeutically appropriate.

Drugs on each tier are selected by an expert panel of Physicians and pharmacists and may change periodically. To determine which tier a drug is assigned to, call Member Services or log in to My Health.

9.4 Filling Your Prescription

9.4.1 Copay/Coinsurance

You generally will be charged one Copay/Coinsurance per covered prescription up to a 30-day supply at a retail pharmacy. If your Provider prescribes a dose of a medication that is not available, you will be charged a Copay for each strength of the medication.

9.4.2 Quantity and Day Supply

Prescriptions are subject to SelectHealth quantity and day-supply Limitations that have been defined based upon FDA guidance or evidence-based literature. The most current information can be found by logging in to My Health.

9.4.3 Refills

Refills are allowed after 80 percent of the last refill has been used for a 30-day supply, and 50 percent for a 10-day supply. Some exceptions may apply; call Pharmacy Services for more information.

9.5 Generic Drug Substitution Required

Your Member Payment Summary will indicate if generic substitution is required. When generic substitution is required, if you purchase a brand-name drug instead of a Generic Drug, then you must pay the difference between the Allowed Amount for the Generic Drug and the Allowed Amount for the brand-name drug, plus your Copay/Coinsurance or Deductible. The difference in cost between the Generic Drug and brand-name drug will not apply to your pharmacy Deductible or Out-of-Pocket Maximum. Based upon clinical circumstances determined by SelectHealth's Pharmacy and Therapeutics Committee, some Prescription Drugs are excluded from this requirement.

9.6 Maintenance Drugs

SelectHealth offers a maintenance drug Benefit, allowing you to obtain a 90-day supply of certain drugs. This Benefit is available for maintenance drugs if you:

a. Have been using the drug for at least one month;

b. Expect to continue using the drug for the next year; and

c. Have filled the drug at least once within the past six months.

Maintenance drugs are identified by the letter (M) on the Prescription Drug List. You have two options when filling prescriptions under the maintenance drug Benefit: (1) Retail90SM, which is available at certain retail pharmacies; and (2) mail order. Please refer to your Member Payment Summary or contact Member Services to verify if the 90-day maintenance drug Benefit is available on your Plan.

9.7 Preauthorization of Prescription Drugs

There are certain drugs that require Preauthorization by your Provider to be covered by SelectHealth. Prescription drugs that require Preauthorization are identified on the Prescription Drug List. The letters (PA) appear next to each drug that requires Preauthorization. Preauthorization is also required if the drug is prescribed in excess of the Plan limits (quantity, duration of use, maximum dose, etc.). The most current information can be found at the SelectHealth website.

To obtain Preauthorization for these drugs, please have your Provider call SelectHealth Pharmacy Services at 800-442-3129.

If your Provider prescribes a drug that requires Preauthorization, you should verify that Preauthorization has been obtained before purchasing the medication. You may still buy these drugs if they are not Preauthorized, but they will not be covered and you will have to pay the full price.

9.8 Step Therapy

Certain drugs require your Provider to first prescribe an alternative drug preferred by SelectHealth. The alternative drug is generally a more cost-effective therapy that does not compromise clinical quality. If your Provider feels that the alternative drug does not meet your needs, SelectHealth may cover the drug without step therapy if SelectHealth determines it is Medically Necessary.

Prescription drugs that require step therapy are identified on the Prescription Drug List. The letters (ST) appear next to each drug that requires step therapy.

9.9 Coordination of Benefits (COB)

If you have other health insurance that is your primary coverage, claims must be submitted first to your primary insurance carrier before being submitted to SelectHealth. In some circumstances, your secondary policy may pay a portion of your out-of-pocket expense. When you mail a secondary claim to SelectHealth, you must include a Prescription Reimbursement Form and the pharmacy receipt in order for SelectHealth to process your claim. In some circumstances, an Explanation of Benefits (EOB) from your primary carrier may also be required.

9.10 Inappropriate Prescription Practices

In the interest of safety for our Members, SelectHealth reserves the right to not cover certain prescription drugs.

a. These drugs include:
    i. Narcotic analgesics;
    ii. Other addictive or potentially addictive drugs; and
    iii. Drugs prescribed in quantities, dosages, or usages that are outside the usual standard of care for the medication in question.
b. These drugs are not covered when they are prescribed:
    i. Outside the usual standard of care for the practitioner prescribing the drug;
    ii. In a manner inconsistent with accepted medical practice; or
    iii. For indications that are Experimental and/or Investigational.

This exclusion is subject to review by the SelectHealth Drug Utilization Panel and certification by a practicing clinician who is familiar with the drug and its appropriate use.

9.11 Prescription Drug Benefit Abuse

SelectHealth may limit the availability and filling of any Prescription Drug that is susceptible to abuse. SelectHealth may require you to:

a. Obtain prescriptions in limited dosages and supplies;

b. Obtain prescriptions only from a specified Provider;

c. Fill your prescriptions at a specified pharmacy;

d. Participate in specified treatment for any underlying medical problem (such as a pain management program);

e. Complete a drug treatment program; or

f. Adhere to any other specified limitation or program designed to reduce or eliminate drug abuse or dependence.

If you seek to obtain drugs in amounts in excess of what is Medically Necessary, such as making repeated emergency room/urgent care visits to obtain drugs, SelectHealth may deny coverage of any medication susceptible of abuse.

SelectHealth may terminate you from coverage if you make an intentional misrepresentation of material fact in connection with obtaining or attempting to obtain drugs, such as by intentionally misrepresenting your condition, other medications, healthcare encounters, or other medically relevant information. At the discretion of SelectHealth, you may be permitted to retain your coverage if you comply with specified conditions.

9.12 Pharmacy Injectable Drugs and Specialty Medications

Injectable drugs and specialty medications must be provided by an In-Network Provider unless otherwise approved in writing in advance by SelectHealth. Most drugs received in a Provider's office or Facility are covered by your medical Benefits. For more specific information, please contact Member Services. Infusion therapy is only covered at preapproved infusion locations.

9.13 Prescription Drug List (PDL)

The PDL is a list containing the most commonly prescribed drugs in their most common strengths and formulations. It is not a complete list of all drugs covered by your Formulary. Drugs not included on the PDL may be covered at reduced benefits, or not covered at all, by your Plan. For a printed copy of your PDL, contact Pharmacy Member Services at 1-800-538-5038. To view an electronic copy of the PDL or to search a complete list of drugs covered by your Formulary, visit selecthealth.org/pharmacy/pharmacy-benefits.

9.14 Exceptions Process

If your Provider believes that you require a certain drug that is not on your Formulary, normally requires step therapy, or exceeds a Quantity Limit, he or she may request an exception through the Preauthorization process.

9.15 Prescriptions Dispensed in a Provider's Office

Prescriptions dispensed in a Provider's office are not covered unless expressly approved by SelectHealth.

9.16 Disclaimer

SelectHealth refers to many of the drugs in this Certificate by their respective trademarks. SelectHealth does not own these trademarks. The manufacturer or supplier of each drug owns the drug's trademark. By listing these drugs, SelectHealth does not endorse or sponsor any drug, manufacturer, or supplier. Conversely, these manufacturers and suppliers do not endorse or sponsor any SelectHealth service or Plan, nor are they affiliated with SelectHealth.

SECTION 10 LIMITATIONS AND EXCLUSIONS

Unless otherwise noted in your Member Payment Summary or Appendix A Optional Benefits, the following Limitations and Exclusions apply.

10.1 Abortions/Termination of Pregnancy

Abortions are not covered except:

a. When determined by SelectHealth to be Medically Necessary to save the life of the mother; or

b. Where the pregnancy was caused by a rape or incest if evidence of the rape or incest is presented either from medical records or through the review of a police report or the filing of charges that a crime has been committed.

Medical complications resulting from an abortion are covered. Treatment of a miscarriage/spontaneous abortion (occurring from natural causes) is covered.

10.2 Acupuncture/Acupressure

Acupuncture and acupressure Services are not covered.

10.3 Administrative Services/Charges

Services obtained for administrative purposes are not covered. Such administrative purposes include Services obtained for or pursuant to legal proceedings, court orders, employment, continuing or obtaining insurance coverage, governmental licensure, home health recertification, travel, military service, school, or institutional requirements.

Provider and Facility charges for completing insurance forms, duplication services, interest (except where required by Utah Administrative Code R590-192), finance charges, late fees, shipping and handling, missed appointments, and other administrative charges are not covered.

10.4 Allergy Tests/Treatments

a. The following allergy tests are not covered:
   i. Cytotoxic Test (Bryan's Test);
   ii. Leukocyte Histamine Release Test;
   iii. Mediator Release Test (MRT);
   iv. Passive Cutaneous Transfer Test (P-K Test);
   v. Provocative Conjunctival Test;
   vi. Provocative Nasal Test;
   vii. Rebuck Skin Window Test;
   viii. Rinkel Test;
   ix. Subcutaneous Provocative Food and Chemical Test; and
   x. Sublingual Provocative Food and Chemical Test.

b. The following allergy treatments are not covered:
   i. Allergoids;
   ii. Autogenous urine immunization;
   iii. LEAP therapy;
   iv. Medical devices (filtering air cleaner, electrostatic air cleaner, air conditioners etc.);
   v. Neutralization therapy;
   vi. Photo-inactivated extracts; and
   vii. Polymerized extracts.

10.5 Anesthesia

General anesthesia rendered in a Provider's office is not covered.

10.6 Biofeedback/Neurofeedback

Biofeedback/neurofeedback is not covered.

10.7 Birthing Centers and Home Childbirth

Childbirth in any place other than a Hospital is not covered. This includes all Provider and/or Facility charges related to the delivery.

10.8 Certain Cancer Therapies

Neutron beam therapy is not covered.

Proton beam therapy is not covered except in the following limited circumstances:

a. Chordomas or chondrosarcomas arising at the base of the skull or along the axial skeleton without distant metastases;

b. Other central nervous system tumors located near vital structures;

c. Pituitary neoplasms;

d. Uveal melanomas confined to the globe (not distant metastases); or

e. In accordance with SelectHealth medical policy.

Proton beam therapy is not covered for treatment of prostate cancer.

10.9 Certain Illegal Activities

Subject to the nondiscrimination provisions of the Health Insurance Portability and Accountability Act (HIPAA), Services for an illness, condition, accident, or injury related directly to voluntary participation in an illegal activity are not covered. This exclusion does not apply for any injuries sustained from an act of domestic violence or a medical condition.

10.10 Chiropractic Services

Chiropractic Services are not covered. This Exclusion does not apply if your Member Payment Summary indicates that your Plan includes the Chiropractic Optional Benefit.

10.11 Claims After One Year

Claims are denied if submitted more than one year after the Services were provided unless notice was given, or proof of loss was filed, as soon as reasonably possible. Adjustments or corrections to claims can be made only if the supporting information is submitted within one year after the claim was first processed by SelectHealth unless the additional information relating to the claim was filed as soon as reasonably possible.

When SelectHealth is the secondary payer, coordination of benefits (COB) will be performed only if the supporting information is submitted to SelectHealth within one year after the claim was processed by the primary plan unless the information was provided as soon as reasonably possible.

10.12 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.

10.13 Custodial Care

Custodial Care is not covered.

10.14 Debarred Providers

Services from Providers debarred by any state or federal health care program are not covered.

10.15 Dental Anesthesia

Services including local, regional, general, and/or intravenous sedation anesthesia, are not covered except for at In-Network Facilities when members meet the following criteria:

a. You or your Dependent is developmentally delayed, regardless of his or her chronological age;

b. You or your Dependent, regardless of age, has a congenital cardiac or neurological condition and documentation is provided that the dental anesthesia is needed to closely monitor the condition; or

c. You or your Dependent is younger than five years of age and:

   i. The proposed dental work involves three or more teeth;

ii. The diagnosis is nursing bottle-mouth syndrome or extreme enamel hypoplasia; and

iii. The proposed procedures are restoration or extraction for rampant decay.

10.16 Dry Needling

Dry needling procedures are not covered.

10.17 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.

10.18 Exercise Equipment or Fitness Training

Fitness training, conditioning, exercise equipment, hot tubs, and membership fees to a spa or health club are not covered.

10.19 Experimental and/or Investigational Services

Except for Approved Clinical Trials, Experimental and/or Investigational Services are not covered.

10.20 Eye Surgery, Refractive

Radial keratotomy, LASIK, or other eye surgeries performed primarily to correct refractive errors are not covered.

10.21 Food Supplements

Except for Dietary Products, as described in Section 8 Covered Services, food supplements and substitutes are not covered.

10.22 Hearing Aids

Except for cochlear implants, as described in Section 8 Covered Services, and unless otherwise noted in your Member Payment Summary, the purchase, fitting, or ongoing evaluation of hearing aids, appliances, auditory brain implants, bone-anchored hearing aids, or any other procedure or device intended to establish or improve hearing or sound recognition is not covered.

10.23 Home Health Aides

Services provided by a home health aide are not covered.

10.24 Immunizations

The following immunizations are not covered: anthrax, BCG (tuberculosis), cholera, plague, typhoid, and yellow fever.

10.25 Mental Health

Inpatient and outpatient mental health and chemical dependency Services are not covered. This Exclusion does not apply if your Member Payment Summary indicates that your Plan includes the Mental Health/Chemical Dependency Optional Benefit.

10.26 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.

10.27 Pain Management Services

The following Services are not covered:

a. Prolotherapy;

b. Radiofrequency ablation of dorsal root ganglion; and

c. IV pamidronate therapy for the treatment of reflex sympathetic dystrophy.

10.28 Prescription Drugs/Injectable Drugs and Specialty Medications

The following are not covered:

a. Appetite suppressants and weight loss drugs;

b. Certain drugs with a therapeutic over-the-counter (OTC) equivalent;

c. Certain off-label drug usage, unless the use has been approved by a SelectHealth Medical Director or clinical pharmacist;

d. Compound drugs when alternative products are available commercially;

e. Cosmetic health and beauty aids;

f. Drugs not on your Formulary;

g. Drugs purchased from Out-of-Network Providers over the Internet;

h. Drugs purchased through a foreign pharmacy. However, please call Member Services if you have a special need for medications from a foreign pharmacy (for example, for an emergency while traveling out of the country);

i. Flu symptom drugs, except when approved by an expert panel of Physicians and SelectHealth;

j. Human growth hormone for the treatment of idiopathic short stature;

k. Infertility drugs;

l. Medical foods;

m. Drugs not meeting the minimum levels of evidence based upon one or more of the following:

   i. Food and Drug Administration (FDA) approval;

   ii. The drug has no active ingredient and/or clinically relevant studies as determined by the SelectHealth Pharmacy & Therapeutics Committee;

   iii. Nationally recognized compendium sources currently utilized by SelectHealth;

   iv. National Comprehensive Cancer Network (NCCN); or

   v. As defined within SelectHealth's Preauthorization criteria or medical policy.

n. Drugs used for infertility purposes;

o. Minerals, fluoride, and vitamins other than prenatal or when determined to be Medically Necessary to treat a specifically diagnosed disease;

p. Non-Sedating Antihistamines;

q. Over-the-counter (OTC) drugs, except as required by the Patient Protection and Affordable Care Act (ACA), or when all of the following conditions are met:

   i. The OTC drug is listed on a SelectHealth Formulary as a covered drug;

   ii. The SelectHealth Pharmacy & Therapeutics Committee has approved the OTC medication as a medically appropriate substitution of a Prescription Drug; and

iii. You or your Dependent has obtained a prescription for the OTC drug from a licensed Provider and filled the prescription at an In-Network Pharmacy.

r. Pharmaceuticals approved by the Food and Drug Administration as a medical device;

s. Prescription Drugs used for cosmetic purposes;

t. Prescription drugs used to inhibit and/or suppress drowsiness, sleepiness, tiredness, or exhaustion, unless preauthorized by the Plan;

u. Prescriptions written by a licensed dentist, except for the prevention of infection or pain in conjunction with a dental procedure;

v. Raw powders or chemical ingredients are not covered unless specifically approved by SelectHealth or submitted as part of a compounded prescription;

w. Replacement of lost, stolen, or damaged drugs;

x. Sexual dysfunction drugs. This Exclusion does not apply if your Member Payment Summary indicates that your Plan includes the Sexual Dysfunction Optional Benefit; and

y. Travel-related medications, including preventive medication for the purpose of travel to other countries. See Immunizations in Section 10 Limitations and Exclusions.

10.29 Reconstructive, Corrective, and Cosmetic Services

a. Services provided for the following reasons are not covered:

i. To improve form or appearance;

ii. To correct a deformity, whether congenital or acquired, without restoring physical function;

iii. To cope with psychological factors such as poor self-image or difficult social relations;

iv. As the result of an accident unless the Service is reconstructive and rendered within five years of the cause or onset of the injury, illness, or therapeutic intervention, or a planned, staged series of Services (as specifically documented in the Member's medical record) is initiated within the five-year period; or

v. To revise a scar, whether acquired through injury or surgery, except when the primary purpose is to improve or correct a functional impairment.

b. The following procedures and the treatment for the following conditions are not covered, except as indicated:

i. Congenital cleft lip except for treatment rendered within 12 months of birth, or a planned, staged series of Services (as specifically documented in you or your Dependent's medical record) is initiated, or when congenital cleft lip surgery is performed as part of a cleft palate repair; or

ii. Treatment for venous telangiectasias (spider veins).

10.30 Related Provider Services

Services provided, ordered, and/or directed for you or your Dependent by a Provider who ordinarily resides in the same household are not covered.

10.31 Respite Care

Respite Care is not covered.

10.32 Robot-Assisted Surgery

Direct costs for the use of a robot for robot-assisted surgery are not covered.

10.33 Sexual Dysfunction

Services related to sexual dysfunction are not covered. This Exclusion does not apply if your Member Payment Summary indicates that your Plan includes the Sexual Dysfunction Optional Benefit.

10.34 Specialty Services

Coverage for specific specialty Services may be restricted to only those Providers who are board certified or have other formal training that is considered necessary to perform those Services.

10.35 Specific Services

The following Services are not covered:

a. Anodyne infrared device for any indication;

b. Auditory brain implantation;

c. Automated home blood pressure monitoring equipment;

d. Chronic intermittent insulin IV therapy/metabolic activation therapy;

e. Coblation therapy of the soft tissues of the mouth, nose, throat, or tongue;

f. Computer-assisted interpretation of X-rays (except mammograms);

g. Computer-assisted navigation for orthopedic procedures;

h. Cryoablation therapy for plantar fasciitis and Morton's neuroma;

i. Extracorporeal shock wave therapy for musculoskeletal indications;

j. Freestanding/home cervical traction;

k. Infrared light coagulation for the treatment of hemorrhoids;

l. Interferential/neuromuscular stimulators;

m. Intimal Media Thickness (IMT) testing to assess risk of coronary disease;

n. Magnetic Source Imaging (MSI);

o. Manipulation under anesthesia for treatment of back and pelvic pain;

p. Mole mapping;

q. Nonsurgical spinal decompression therapy (e.g., VAX-D or DRS therapy);

r. Nucleoplasty or other forms of percutaneous disc decompression;

s. Oncofertility;

t. Pediatric/infant scales;

u. Peripheral nerve stimulation for occipital neuralgia and chronic headaches;

v. Platelet Rich Plasma or other blood derived therapies for orthopedic procedures;

w. Pressure Specified Sensory Device (PSSD) for neuropathy testing;

x. Prolotherapy;

y. Radiofrequency ablation for lateral epicondylitis;

z. Radiofrequency ablation of the dorsal root ganglion;

aa. Virtual colonoscopy as a screening for colon cancer; and

bb. Whole body scanning.

10.36 Telephone/E-mail Consultations

Except for TeleHealth Services, as described in Section 8 Covered Services, charges for Provider telephone, e-mail, or other electronic consultations are not covered.

10.37 Terrorism or Nuclear Release

Services for an illness, injury, or connected disability are not covered when caused by or arising out of an act of international or domestic terrorism, as defined by United States Code, Title 18, Section 2331, or from an accidental, negligent, or intentional release of nuclear material or nuclear byproduct material as defined by United States Code, Title 18, Section 831.

10.38 Travel-related Expenses

Costs associated with travel to a local or distant medical provider, including accommodation and meal costs, are not covered.

10.39 War

Services for an illness, injury, or connected disability are not covered when caused by or arising out of a war or an act of war (whether or not declared) or service in the armed services of any country.

SECTION 11 HEALTHCARE MANAGEMENT

SelectHealth works to manage costs while protecting the quality of care. The Healthcare Management Program reviews three aspects of medical care: appropriateness of the care setting, Medical Necessity, and appropriateness of Hospital lengths of stay. You benefit from this process because it reduces unnecessary medical expenses, enabling SelectHealth to maintain reasonable Premium rates. The Healthcare Management process takes several forms.

11.1 Preauthorization

Preauthorization is prior approval from SelectHealth for certain Services and is considered a Preservice Claim (refer to Section 12 Claims and Appeals). Preauthorization is not required when SelectHealth is your secondary plan. Obtaining Preauthorization does not guarantee coverage. Your Benefits for the Preauthorized Services are subject to the Eligibility requirements, Limitations, Exclusions and all other provisions of the Plan. Preauthorization requirements for Prescription Drugs are also found in Section 9 – Prescription Drug Benefits.

11.1.1 Services Requiring Preauthorization

Preauthorization is required for the following Services:

a. Advanced imaging including Magnetic Resonance Imaging (MRI), Computerized Tomography (CT) scans, Positron Emission Tomography (PET) scans, and cardiac imaging;

b. All admissions to facilities, including rehabilitation, transitional care, skilled nursing, and all hospitalizations that are not for Urgent or Emergency Conditions;

c. All nonroutine obstetrics admissions, maternity stays longer than two days for a normal delivery or longer than four days for a cesarean section, and deliveries outside of the Service Area;

d. All Services obtained outside of the United States unless for Routine Care, an Urgent, or an Emergency Condition;

e. Bariatric surgery;

f. Home Healthcare, Hospice Care, and Private Duty Nursing;

g. Joint replacement;

h. Surgeries on vertebral bodies, vertebral joints, spinal discs;

i. Pain management/pain clinic Services;

j. Certain genetic testing;

k. Certain ultrasounds;

l. Certain radiation therapies;

m. Certain sleep studies;

n. Certain medical oncology drugs;

o. Cochlear Implants;

p. Continuous glucose monitors;

q. Hysterectomy;

r. Tonsillectomy;

s. Adenoidectomy;

t. Outpatient Rehabilitative, Habilitative, and Chiropractic-therapy Services after 10 visits per therapy type, per calendar Year;

u. Organ Transplants;

v. The following Durable Medical Equipment:

   i. Insulin pumps;

   ii. Continuous Positive Airway Pressure (CPAP) and Bilevel Positive Airway Pressure (BiPAP);

   iii. Prosthetics (except eye prosthetics);

   iv. Negative pressure wound therapy electrical pump (wound vac);

   v. Motorized or customized wheelchairs; and

vi. DME with a purchase price over $5,000;

w. The medications listed on selecthealth.org/pharmacy/pharmacy-benefits. You may also request this list by calling Pharmacy Services at 800-538-5038.

In addition to these Services, In-Network Providers must Preauthorize other Services as specified in SelectHealth 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 a Out-of-Network Provider or Facility.

11.1.3 How to request Preauthorization

If you need to request Preauthorization, call Member Services at 800-538-5038. Generally, preauthorization is valid for up to six months.

You should call SelectHealth as soon as you know you will be using 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 percent and Benefits will apply to what remains according to regular Plan guidelines. You will be responsible for the 50 percent penalty, your Copay, Coinsurance, and Deductible, and you may be responsible for any amount that exceeds the Allowed Amount.

11.1.5 Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

11.2 Case Management

If you have certain serious or chronic conditions (such as spinal cord injuries, diabetes, asthma, or premature births), SelectHealth will work with you and your family, your Provider, and community resources to coordinate a comprehensive plan of care. This integrated approach helps you obtain appropriate care in cost-effective settings and reduces some of the burden that you and your family might otherwise face.

11.3 Benefit Exceptions

On a case-by-case basis, SelectHealth may extend or add Benefits that are not otherwise expressly covered or are limited by the Plan. In making this decision, SelectHealth will consider the medical appropriateness and cost effectiveness of the proposed exception.

When making such exceptions, SelectHealth reserves the right to specify the Providers, Facilities, and circumstances in which the additional care will be provided and to limit payment for additional Services to the amount SelectHealth would have paid had the Service been provided in accordance with the other provisions of the Plan. Benefits paid under this section are subject to all other Member payment obligations of the Plan such as Copays, Coinsurance, and Deductibles.

11.4 Second Opinions/Physical Examinations

After enrollment, SelectHealth has the right to request that you be examined by a mutually agreed upon Provider concerning a claim, a second opinion request, or a request for Preauthorization. SelectHealth will be responsible for paying for any such physical examination.

11.5 Medical Policies

SelectHealth has developed medical policies to serve as guidelines for coverage decisions. These guidelines detail when certain Services are considered Medically Necessary or Experimental and/or Investigational by SelectHealth. Medical policies do not supersede the express provisions of this Certificate. Coverage decisions are subject to all terms and conditions of the applicable Plan, including specific Exclusions and Limitations. Because medical policies are based on constantly changing science, they are periodically reviewed and updated by SelectHealth. For questions about SelectHealth's medical policies, call Member Services at 800-538-5038.

SECTION 12 CLAIMS AND APPEALS

12.1 Administrative Consistency

SelectHealth will follow administrative processes and safeguards designed to ensure and to verify that Benefit claim determinations are made in accordance with the provisions of the Plan and that its provisions have been applied consistently with respect to similarly situated Claimants.

12.2 Claims and Appeals Definitions

This section uses the following additional (capitalized) defined terms:

12.2.1 Adverse Benefit Determination

Any of the following: a Rescission of coverage or a denial, reduction, or termination of a claim for Benefits, or a failure to provide or make payment for such a claim in whole or in part, including determinations related to a Claimant's Eligibility, the application of a review under SelectHealth Healthcare Management Program, and determinations that particular Services are Experimental and/or Investigational or not Medically Necessary or appropriate.

12.2.2 Appeal(s)

Review by SelectHealth of an Adverse Benefit Determination.

12.2.3 Authorized Representative

Someone you have designated to represent you in the claims or Appeals process. To designate an Authorized Representative, you must provide written authorization on a form provided by the Appeals Department or Member Services. However, where an Urgent Preservice Claim is involved, a healthcare professional with knowledge of the medical condition will be permitted to act as your Authorized Representative without a prior written authorization. In this section, the words you and your include your Authorized Representative.

12.2.4 Benefit Determination

The decision by SelectHealth regarding the acceptance or denial of a claim for Benefits.

12.2.5 Claimant

Any Subscriber or Member making a claim for Benefits. Claimants may file claims themselves or may act through an Authorized Representative. In this section, the words you and your are used interchangeably with Claimant.

12.2.6 Concurrent Care Decisions

Decisions by SelectHealth regarding coverage of an ongoing course of treatment that has been approved in advance.

12.2.7 External Review

A review by an outside entity, at no cost to the Member, of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination).

12.2.8 Final Internal Adverse Benefit Determination

An Adverse Benefit Determination that has been upheld by SelectHealth at the completion of the mandatory Appeals process.

12.2.9 Independent Review Organization (IRO)

An entity that conducts independent External Reviews.

12.2.10 Postservice Appeal

A request to change an Adverse Benefit Determination for Services you have already received.

12.2.11 Postservice Claim

Any claim related to Services you have already received.

12.2.12 Preservice Appeal

A request to change an Adverse Benefit Determination on a Preservice Claim.

12.2.13 Preservice Claim

Any claim that requires approval prior to obtaining Services for you to receive full Benefits. For example, a request for Preauthorization under the Healthcare Management program is a Preservice Claim.

12.2.14 Urgent Preservice Claim

Any Preservice Claim that, if subject to the normal timeframes for determination, could seriously jeopardize your life, health or ability to regain maximum function or that, in the opinion of your treating Physician, would subject you to severe pain that could not be adequately managed without the requested Services. Whether a claim is an Urgent Preservice Claim will be determined by an individual acting on behalf of SelectHealth applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that your treating Physician determines is an Urgent Preservice Claim will be treated as such.

12.3 How to File a Claim for Benefits

12.3.1 Urgent Preservice Claims

In order to file an Urgent Preservice Claim, you must provide SelectHealth with:

a. Information sufficient to determine to what extent Benefits are covered by the Plan; and

b. A description of the medical circumstances that give rise to the need for expedited review.

Under certain circumstances provided by federal law, if you fail to follow the proper procedures for filing an Urgent Preservice Claim, SelectHealth will notify you of the failure and the proper procedures to be followed. SelectHealth will notify you as soon as reasonably possible, but no later than 24 hours after receiving the claim. This notice may be verbal unless you specifically request otherwise in writing.

Notice of a Benefit Determination will be provided as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receipt of the claim. However, if SelectHealth gives you notice of an incomplete claim, the notice will give you at least 48 hours to provide the requested information. SelectHealth will then provide a notice of Benefit Determination within 48 hours after receiving the specified information or the end of the period of time given you to provide the information, whichever occurs first. If the Benefit Determination is provided verbally, it will be followed in writing no later than three days after the verbal notice.

If the Urgent Preservice Claim involves a Concurrent Care Decision, notice of the Benefit Determination will be provided as soon as possible but no later than 24 hours after receipt of your claim for extension of treatment or care, as long as the claim is made at least 24 hours before the prescribed period of time expires or the prescribed number of treatments ends.

12.3.2 Other Preservice Claims

The procedure for filing most Preservice Claims (Preauthorization) is set forth in Section 11 Healthcare Management. If there is any other Benefit that would be subject to a Preservice Claim, you may file a claim for that Benefit by contacting Member Services. Under certain circumstances provided by federal law, if you fail to follow the proper procedures for filing a Preservice Claim, SelectHealth will provide notice of the failure and the proper procedures to be followed. This notification will be provided as soon as reasonably possible, but no later than five days after receipt of the claim, and may be verbal unless you specifically request it in writing.

Notice of a Benefit Determination will be provided in writing within a reasonable period appropriate to the medical circumstances, but no later than 15 days after receipt of the claim. However, SelectHealth may extend this period for up to an additional 15 days if SelectHealth: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 15-day period, of the circumstances requiring the extension and the date by which SelectHealth expects to render a decision. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information, and you will be given 60 days from your receipt of the notice to provide the requested information.

Notice of an Adverse Benefit Determination regarding a Concurrent Care Decision will be provided sufficiently in advance of any termination or reduction of Benefits to allow you to Appeal and obtain a determination before the Benefit is reduced or terminates.

12.3.3 Postservice Claims

a. In-Network Providers and Facilities. In-Network Providers and Facilities file Postservice Claims with SelectHealth and SelectHealth 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 SelectHealth. If an Out-of-Network Provider or Facility does not submit a Postservice Claim to SelectHealth or you pay the Out-of-Network Provider or Facility, you must submit the claim in writing in a form approved by SelectHealth. Call Member Services or your employer to find out what information is needed to submit a Postservice Claim. All claims must be received by SelectHealth within a 12-month period from the date of the expense or as soon as reasonably possible. Claims received outside of this timeframe will be denied. Failure to file a claim does not bar recovery under the policy if SelectHealth fails to show it was prejudiced by the failure.

Notice of Adverse Benefit Determinations will be provided in writing within a reasonable period of time, but no later than 30 days after receipt of the claim. However, SelectHealth may extend this period for up to an additional 15 days if SelectHealth: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which SelectHealth expects to render a decision.

The applicable time period for the Benefit Determination begins when your claim is filed in accordance with SelectHealth's procedures, even if you have not submitted all the information necessary to make a Benefit Determination.

12.4 Problem Solving

SelectHealth is committed to making sure that any concerns or problems regarding your claims are investigated and resolved as soon as possible. Many situations can be resolved informally by a Member Services representative. Call Member Services at 800-538-5038. SelectHealth offers foreign language assistance.

12.5 Formal Appeals

If you are not satisfied with the result of working with Member Services, you may file a written formal Appeal of any Adverse Benefit Determination. Written formal Appeals should be sent to the SelectHealth Appeals Department. As the delegated claims review fiduciary under your Employer's Plan, SelectHealth will conduct a full and fair review of your Appeal and has final discretionary authority and responsibility for deciding all matters regarding Eligibility and coverage.

12.5.1 General Rules and Procedures

You will have the opportunity to submit written comments, documents, records, and other information relating to your Appeal. SelectHealth will consider this information regardless of whether it was considered in the Adverse Benefit Determination.

During an Appeal, no deference will be afforded to the Adverse Benefit Determination, and decisions will be made by fiduciaries who did not make the Adverse Benefit Determination and who do not report to anyone who did. If the Adverse Benefit Determination was based on medical judgment, including determinations that Services are Experimental and/or Investigational or not Medically Necessary, the fiduciaries during any Appeal will consult with a medical professional with appropriate training and experience in the appropriate field of medicine and who was neither consulted in connection with the Adverse Benefit Determination nor is the subordinate of such an individual. Upon request, you will be provided the identification of any medical expert(s) whose advice was obtained on behalf of SelectHealth in connection with the Adverse Benefit Determination, whether or not the advice was relied upon in making the Adverse Benefit Determination.

Before SelectHealth can issue a Final Internal Adverse Benefit Determination, you will be provided with any new or additional evidence or rationale considered, relied upon, or generated by SelectHealth in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of a Final Internal Benefit Determination is required to be provided to give you a reasonable opportunity to respond prior to the date.

12.5.2 Form and Timing

All requests for an Appeal of an Adverse Benefit Determination (other than those involving an Urgent Preservice Claim) must be in writing and should include a copy of the Adverse Benefit Determination and any other pertinent information that you want SelectHealth to review in conjunction with your Appeal. Send all information to the SelectHealth Appeals Department at the following address:

Appeals Department
P.O. Box 30192
Salt Lake City, Utah 84130-0192

You may Appeal an Adverse Benefit Determination of an Urgent Preservice Claim on an expedited basis either verbally or in writing. You may Appeal verbally by calling the SelectHealth Appeals Department at 844-208-9012, by fax at 801-442-0762, or by emailing appeals@imail.org.

You must file a formal Appeal within 180 days from the date you received notification of the Adverse Benefit Determination.

Appeals that do not comply with the above requirements are not subject to review by SelectHealth or legal challenge.

12.5.3 Appeals Process

The Appeals process includes both mandatory and voluntary reviews. You must exhaust all mandatory reviews before you may pursue civil action, including, if applicable, under ERISA Section 502(a). It is your choice, however, whether or not to seek voluntary review, and you are not required to do so before pursuing civil action. SelectHealth agrees that any statute of limitations or other legal defense based on timeliness is suspended during the time that any voluntary Appeal is pending. Your decision whether or not to seek voluntary review will have no effect on your rights to any other Benefits. SelectHealth will provide you, upon request, sufficient information to enable you to make an informed decision about whether or not to engage in a voluntary review.

After a mandatory review process, you may choose to pursue civil action, including, if applicable, under ERISA Section 502(a). Failure to properly pursue the mandatory Appeals process may result in a waiver of the right to challenge the original decision of SelectHealth.

12.5.4 Preservice Appeals

The process for appealing a Preservice Claim provides one mandatory review, possible voluntary reviews, and the right to pursue civil action, including, if applicable, under ERISA Section 502(a).

Mandatory Review

Your Appeal will be investigated by the Appeals Department. All relevant, available information will be reviewed. The Appeals Department will notify you in writing of the Appeal decision within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after the receipt of your Appeal. However, SelectHealth may extend this period if SelectHealth: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which SelectHealth expects to render a decision.

If your Appeal involves an Urgent Preservice Claim, you may request an expedited review. You will be notified of the Appeal decision on an expedited review as soon as possible, taking into account the medical circumstances, but no later than 72 hours after the receipt of your Appeal. A decision communicated verbally will be followed up in writing.

Voluntary Review

After completing the mandatory review process described above, you may pursue a voluntary External Review or a voluntary internal review. However, External Review is only available in the circumstances described below. If you choose to pursue a voluntary External Review, you may not pursue the voluntary internal review process.

Voluntary External Review

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, or a Rescission of coverage. To request an External Review, you must complete the Independent Review Request Form. For a copy of this form, or for other questions, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City, UT 84114; by phone at 801-538-3077; or electronically at healthappeals.uid@utah.gov. An External Review request must be made within 180 days from the date the Appeals Department notifies you of the Final Internal Adverse Benefit Determination. An authorization to obtain medical records may be required. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. The IRO will provide written notice of its decision within 45 days after receipt of the request.

If your Appeal involves an Urgent Preservice Claim, you may request an expedited review. You will be notified by the IRO of the Appeal decision on an expedited review as soon as possible, taking into account the medical circumstances, but no later than 72 hours after the receipt of your Appeal. A decision communicated verbally will be followed up in writing.

If you pursue a voluntary External Review, it will be your last level of Appeal.

Voluntary Internal Review

If you choose to pursue the voluntary internal review process, you may request a review of your Appeal. Depending on the nature of the Appeal, it will be considered by the Administrative and Clinical Appeal Review Committee. Such a request must be made in writing to the Appeals Department within 60 days of the date the Appeals Department notifies you of the Final Internal Adverse Benefit Determination. SelectHealth will notify you of the result of the review in writing within 30 days of the date you requested the review. However, SelectHealth may extend this period if SelectHealth: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which SelectHealth expects to render a decision. If you are not satisfied with the decision made by the reviewing committee, you may request a review by the SelectHealth Appeals Committee. Such a request must be made in writing to the Appeals Department within 60 days of the date the reviewing committee notifies you of its decision.

12.5.5 Postservice Appeals

The process for appealing a Postservice Claim provides one mandatory review, possible voluntary reviews, and the right to pursue civil action, including, if applicable, under ERISA Section 502(a).

Mandatory Review

Your Appeal will be investigated by the Appeals Department. All relevant information will be reviewed. The Appeals Department will notify you in writing of the Appeal decision within a reasonable period of time appropriate to the medical circumstances, but no later than 60 days after the receipt of your Appeal. However, SelectHealth may extend this period if SelectHealth: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 60-day period, of the circumstances requiring the extension and the date by which SelectHealth expects to render a decision.

Voluntary Review

After completing the mandatory review process described above, you may pursue either a voluntary External Review or a voluntary internal review. However, External Review is only available in the circumstances described below. If you choose to pursue the voluntary External Review process, you may not pursue the voluntary internal review process.

Voluntary External Review

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, or a Rescission of coverage. To request an External Review you must complete the Independent Review Request Form. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. For a copy of this form, or for other questions, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City, UT 84114; by phone at 801-538-3077; or electronically at healthappeals.uid@utah.gov. An External Review request must be made within 180 days from the date SelectHealth sends the Final Internal Adverse Benefit Determination. An authorization to obtain medical records may be required. The IRO will provide written notice of its decision within 45 days after receipt of the request.

If you pursue a voluntary External Review, it will be your last level of Appeal.

Voluntary Internal Review

If you choose to pursue the voluntary internal review process, you may request a review of your Appeal. Depending on the nature of the Appeal, it will be considered by the Administrative and Clinical Appeal Review Committee. Such a request must be made in writing to the Appeals Department within 60 days of the date the Appeals Department notifies you of the Final Internal Adverse Benefit Determination. SelectHealth will notify you of the result of the review in writing within 30 days of the date you requested the review. However, SelectHealth may extend this period if SelectHealth: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which SelectHealth expects to render a decision. If you are not satisfied with the decision made by the reviewing committee, you may request a review by the SelectHealth Appeals Committee. Such a request must be made in writing to the Appeals Department within 60 days of the date the reviewing committee notifies you of its decision.

SECTION 13 OTHER PROVISIONS AFFECTING YOUR BENEFITS

13.1 Coordination of Benefits (COB)

When you or your Dependents have healthcare coverage under more than one health benefit plan, SelectHealth will coordinate Benefits with the other healthcare coverage according to the COB rules set forth in Utah Administrative Code R590-131.

13.1.1 Required Cooperation

You are required to cooperate with SelectHealth in administering COB. Cooperation may include providing notice of other health benefit coverage, copies of divorce decrees, bills and payment notices from other payers, and/or signing documents required by SelectHealth to administer COB. Failure to cooperate may result in the denial of claims.

13.1.2 Direct Payments

SelectHealth may make a direct payment to another health benefit plan when the other plan has made a payment that was the responsibility of SelectHealth. This amount will be treated as though it was a Benefit paid by the Plan, and SelectHealth will not have to pay that amount again.

13.2 Subrogation, Reimbursement and Recovery

13.2.1 Payment of Claims When a Third Party is Liable

When you or your Dependents have an illness or injury caused by another, a third party (including an insurance company) may be liable for damages or may be willing to pay money in settlement of a claim. This Plan does not cover Benefits for Services you or your Dependents receive for illnesses and injuries when the medical expenses are the responsibility of, or are paid by, a third party (or a third party's insurer) who has caused the illness or injury. In situations where SelectHealth determines that a third party may be liable for your or your Dependent's medical expenses, SelectHealth may nonetheless agree to conditionally pay the claims relating to such expenses in advance pending a final determination of a) whether a third party or you are responsible for such expenses instead of SelectHealth; and/or b) the claims are excluded from coverage under this Plan. Each Member agrees to reimburse SelectHealth for such conditional payments when a final determination is made by SelectHealth that it is not responsible for the payment of such claims.

13.2.2 SelectHealth's Recovery Rights

If SelectHealth pays benefits under this Plan for an illness or injury and SelectHealth determines that a third party is or may be responsible or liable for damages to you or your Dependents, SelectHealth has the right to recover Benefits paid under this Plan and is subrogated to all and any of your or your Dependent's rights to recover from the third party and to any money paid in settlement of a claim, but only up to the amount of the Benefits provided by the Plan. SelectHealth is entitled to reimbursement and/or recovery under this section 13.2 from any judgment, award, and other types of recovery or settlement received by you, your Dependents and/or your or your Dependent's representatives, regardless of whether the recovery is characterized as relating to medical expenses. SelectHealth is entitled to reimbursement even if you or your covered Dependent is not made whole or fully compensated by the recovery. You and your Dependents are required by this Plan, and agree, to promptly notify SelectHealth when the terms of this Section 13.2 might apply.

If the person for whom Plan Benefits are paid is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this section 13.2 regardless of whether the minor's representative has access to or control of the recovered funds. The provisions of this section 13.2 are binding upon you and your Dependents and binding upon your and your Dependent's guardians, heirs, executors, assigns and other representatives.

13.2.3 Agreement by Members

As a condition to receiving Benefits under the Plan, you and your Dependent(s) agree (a) that SelectHealth is automatically subrogated to, and has a right to receive restitution from, any right of recovery you may have against any third party as the result of an accident, illness, injury, or other condition involving the third party that causes you or your Dependents to obtain Covered Services that are paid for by SelectHealth; (b) that SelectHealth is entitled to receive as restitution the proceeds of any judgment, settlement, or other payment paid or payable in satisfaction of any claim or potential claim that you or your Dependents have or could assert against the third party to the extent of all Benefits paid by SelectHealth or payable in the future because of the third-party; (c) not to bring or assert a make whole, common fund, collateral source or other apportionment action or claim in contravention of SelectHealth's rights described in this section 13.2; (d) not to spend or otherwise disburse funds received under a settlement agreement or from an insurance company or other third party until such time as SelectHealth has been paid or reimbursed for the amounts due to SelectHealth under this section 13.2; (e) to cooperate with SelectHealth to effectuate the terms of this section 13.2 and to do whatever may be necessary to secure the recovery by SelectHealth of the amount of the Benefits paid, including execution of all appropriate papers, furnishing of information and assistance; and (f) not to interfere with SelectHealth's rights under this Section 13.2 and not to take any action that prejudices SelectHealth's rights under this Section 13.2, including settling a dispute with a third party without protecting SelectHealth's rights under this Section 13.2.

If requested to do so by SelectHealth, you and your Dependents must execute a written recovery agreement as a condition of payment on claims arising from injuries or illnesses caused by third parties. If your Dependent is so injured or has such an illness, both you and your Dependent are required to execute the written recovery agreement. If the injured or ill person is a minor or legally incompetent, the written recovery agreement must be executed by the person's parent(s), managing conservator and/or guardian. If you or your Dependent has died, your or your Dependent's legal representative must execute the agreement. Any Plan benefits paid must be returned to SelectHealth immediately in the event that SelectHealth requests that a written recovery agreement be signed and there is a failure or refusal to execute the recovery agreement. SelectHealth's rights, however, are not waived if SelectHealth does not request a written recovery agreement under this section 13.2.

13.2.4 Constructive Trust and First Lien

Any funds you and/or your Dependents (or your or your Dependent's agent or attorney) recover by way of settlement, judgment, or other award from a third party or from your or your Dependent's own insurance shall be held by you and/or your Dependents (or your or your Dependent's agent or attorney) in a constructive trust for the benefit of SelectHealth until SelectHealth's rights under this section 13.2 have been satisfied.

SelectHealth will have, and you and your Dependents grant, a first lien upon any recovery, whether by settlement, judgment, arbitration or mediation, that you or your covered Dependents receive or are entitled to receive from any source, regardless of whether you or your covered Dependents receive a full or partial recovery. Any settlement or recovery received shall first be deemed to be reimbursement of medical expenses paid under this Plan. These first priority rights will not be reduced due to you or your covered Dependent's own negligence. You and/or your Dependents (or your or your Dependent's agent or attorney) will be personally liable for the restitution amount required under this section 13.2 to the extent that SelectHealth does not recover that amount due to a failure by you and/or your Dependents (or your or your Dependent's agent or attorney) to follow the required process.

13.2.5 Rights to Intervene and Sue

SelectHealth shall have the right to intervene in any lawsuit, threatened lawsuit, or settlement negotiation involving a third party for purposes of asserting and collecting SelectHealth's restitution and other interests described in this section 13.2. SelectHealth shall have the right to bring a lawsuit against, or assert a counterclaim or cross-claim against, you (or your agent or attorney) for purposes of collecting restitution or other interests under this section 13.2, to enforce the constructive trust required by this section 13.2, and/or take any other action to collect funds from you.

SelectHealth is entitled to institute these actions in its own name or in your or your Dependent's name or to join any action brought by you, your Dependents or your representatives, with or without specific consent, and to participate in any judgment, award or settlement to the extent of SelectHealth's interest. You and your Dependents must notify SelectHealth before filing any suit or settling any claim so as to enable SelectHealth to participate in the suit or settlement to protect and enforce SelectHealth's rights under this subrogation provision. You and your Dependents agree to keep SelectHealth fully informed and advised of all developments in any such suit or settlement negotiations.

The amount that SelectHealth is entitled to recover from you and your Dependents under this section 13.2 is specifically unreduced by any attorney, legal or other fees and costs incurred by you or your Dependents in seeking recovery from a third party (whether the third party is the responsible party or is an insurer), except if SelectHealth specifically agrees in writing to participate in these fees.

If you or your Dependents fail to fully cooperate with SelectHealth or its designated agents in asserting its rights under this section 13.2, SelectHealth may reduce or deny coverage under the Plan and offset against any future claims. Further, SelectHealth may compromise with you or your Dependents on any issue involving subrogation/restitution in a way that includes you or your Dependents surrendering the right to receive further Services under the Plan.

13.2.6 Special Subrogation Rules for Utah

Notwithstanding anything else in this Section 13.2 to the contrary, SelectHealth's rights under this section 13.2, when SelectHealth is asserting rights against underinsured/uninsured motorist coverage subject to Utah Code Annotated sections 31A-22-305 or 31A-22-305.3 shall be limited to situations in which you or your Dependents have been made whole.

13.3 Excess Payment

SelectHealth will have the right to recover any payment made in excess of the obligations of SelectHealth under the Contract. Such recoveries are limited to a time period of 12 months (or 24 months for a COB error) from the date a payment is made unless the recovery is due to fraud or intentional misrepresentation of material fact by you or your Dependents. This right of recovery will apply to payments made to you, your Dependents, your employer, Providers, or Facilities. If an excess payment is made by SelectHealth to you, you agree to promptly refund the amount of the excess. SelectHealth may, at its sole discretion, offset any future Benefits against any overpayment. SelectHealth may recover excess payment made to a provider by withholding other amounts payable to the provider from any plan under which SelectHealth makes payment.

SECTION 14 SUBSCRIBER RESPONSIBILITIES

As a condition to receiving Benefits, you are required to:

14.1 Payment

Pay applicable contributions to your employer, and pay the Coinsurance, Copay, and/or Deductible amounts listed in your Member Payment Summary to your Provider(s) and/or Facilities.

14.2 Changes in Eligibility or Contact Information

Notify your employer when there is a change in your situation that may affect your Eligibility, the Eligibility of your Dependents, or if your contact information changes. Your employer has agreed to notify SelectHealth of these changes.

14.3 Other Coverage

Notify SelectHealth if you or your Dependents obtain other healthcare coverage. This information is necessary to accurately process and coordinate your claims.

14.4 Information/Records

Provide SelectHealth all information necessary to administer your coverage, including the medical history and records for you and your Dependents and, if requested, your social security number(s).

14.5 Notification of Members

Notify your enrolled Dependents of all Benefit and other Plan changes.

SECTION 15 EMPLOYER RESPONSIBILITIES

15.1 Enrollment

Your employer makes initial Eligibility decisions and communicates them to SelectHealth. SelectHealth reserves the right to verify that the Eligibility requirements of the Contract are satisfied. Your employer is obligated to promptly notify SelectHealth whenever there is a change in your situation that may affect your Eligibility or the Eligibility of your Dependents. This includes FMLA and other leaves of absence.

15.2 Payment

All enrollments are conditioned upon the timely payment of Premiums to SelectHealth.

15.3 Contract

The Contract is with your employer, and only your employer can change or terminate it. Your employer is responsible for notifying you of any changes to the Plan and for providing you at least 30 days written notice if the Contract is terminated for any reason.

15.4 Compliance

Your employer is responsible for complying with all reporting, disclosure, and other requirements for your Employer's Plan under federal law.

SECTION 16 DEFINITIONS

This Certificate of Coverage contains certain defined terms that are capitalized in the text and described in this section. Words that are not defined have their usual meaning in everyday language.

16.1 Activities of Daily Living

Eating, personal hygiene, dressing, and similar activities that prepare an individual to participate in work or school. Activities of Daily Living do not include recreational, professional, or school-related sporting activities.

16.2 Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 and associated regulations.

16.3 Allowed Amount

The dollar amount allowed by SelectHealth for a specific Covered Service.

16.4 Ambulatory Surgical Facility

A Facility licensed by the state where Services are provided to render surgical treatment and recovery on an outpatient basis to sick or injured persons under the direction of a Physician. Such a Facility does not provide inpatient Services.

16.5 Annual Open Enrollment

A period of time each year that may be offered by your employer during which you are given the opportunity to enroll yourself and your Dependents in the Plan.

16.6 Anodontia

The condition of congenitally missing all teeth, either primary or permanent.

16.7 Application

The form on which you apply for coverage under the Plan.

16.8 Approved Clinical Trials

A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease (any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted) and is described in any of the following:

a. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

   i. The National Institutes of Health.

   ii. The Centers for Disease Control and Prevention.

   iii. The Agency for Health Care Research and Quality.

   iv. The Centers for Medicare & Medicaid Services.

   v. Cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

   vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

   vii. Any of the following if the appropriate review and approval through a system of peer review has been attained:

      1) The Department of Veterans Affairs.

      2) The Department of Defense.

      3) The Department of Energy.

b. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

c. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

16.9 Autism Spectrum Disorder

Autism Spectrum Disorder includes disorders characterized by delays in the development of multiple basic functions, including socialization and communication. Autism Spectrum Disorder includes:

a. Asperger's Syndrome;

b. Autistic Disorder;

c. Childhood Disintegrative Disorder; and

d. Pervasive developmental disorder not otherwise specified.

16.10 Benefit(s)

The payments and privileges to which you are entitled by this Certificate and the Contract.

16.11 Certificate of Coverage (Certificate)

This document, which describes the terms and conditions of the health insurance Benefits provided by your employer’s Group Health Insurance Contract with SelectHealth. Your Member Payment Summary is attached to and considered part of this Certificate.

16.12 COBRA Coverage

Coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

16.13 Coinsurance

A percentage of the Allowed Amount stated in your Member Payment Summary that you must pay for Covered Services to the Provider and/or Facility.

16.14 Continuation Coverage

COBRA Coverage and/or Utah mini-COBRA coverage.

16.15 Contraceptive

A Service for a woman that temporarily or permanently prevents pregnancy by interfering with ovulation, fertilization, or implantation. The Food and Drug Administration identifies the following contraceptive methods: sterilization surgery; surgical sterilization implant; implantable rod; intrauterine device (IUD) copper; IUD with progestin; shot/injection; oral contraceptives (combined pill); oral contraceptives (progestin only); oral contraceptives extended/continuous use; patch; vaginal contraceptive ring; diaphragm; sponge; cervical cap; female condom; spermicide; and emergency contraception.

16.16 Contract

The Group Health Insurance Contract between SelectHealth and your employer.

16.17 Copay (Copayment)

A fixed amount stated in your Member Payment Summary that you must pay for Covered Services to a Provider or Facility.

16.18 Covered Services

The Services listed as covered in Section 8 Covered Services, Section 9 Prescription Drug Benefits, Section 10 Limitations and Exclusions, and applicable Optional Benefits, and not excluded by this Certificate.

16.19 Custodial Care

Services provided primarily to maintain rather than improve a Member's condition or for the purpose of controlling or changing the Member's environment. Services requested for the convenience of the Member or the Member's family that do not require the training and technical skills of a licensed Nurse or other licensed Provider, such as convalescent care, rest cures, nursing home services, etc. Services that are provided principally for personal hygiene or for assistance in daily activities.

16.20 Deductible(s)

An amount stated in your Member Payment Summary that you must pay each Year for Covered Services before SelectHealth makes any payment. Some categories of Benefits may be subject to separate Deductibles.

16.21 Dental Services

Services rendered to the teeth, the tooth pulp, the gums, or the bony structure supporting the teeth.

16.22 Dependents

Your Eligible dependents as set forth in Section 2 Eligibility.

16.23 Durable Medical Equipment (DME)

Medical equipment that is able to withstand repeated use and is generally not useful in the absence of an illness or injury.

16.24 Effective Date

The date on which coverage for you and/or your Dependents begins.

16.25 Eligible, Eligibility

In order to be Eligible, you or your Dependents must meet the criteria for participation specified in Section 2 Eligibility and in the Group Application.

16.26 Emergency Condition(s)

A condition of recent onset and sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to reasonably expect that failure to obtain immediate medical care could result in:

a. Placing a Member's health in serious jeopardy;

b. Placing the health of a pregnant woman or her unborn child in serious jeopardy;

c. Serious impairment to bodily functions; or

d. Serious dysfunction of any bodily organ or part.

16.27 Employer Waiting Period

The period that you must wait after becoming Eligible for coverage before your Effective Date. Subject to approval by SelectHealth, your employer specifies the length of this period in the Group Application.

16.28 Employer's Plan

The group health plan sponsored by your employer and insured under the Contract.

16.29 Endorsement

A document that amends the Contract.

16.30 ERISA

The Employee Retirement Income Security Act (ERISA), a federal law governing employee benefit plans.

16.31 Excess Charges

Charges from Providers and Facilities that exceed the Allowed Amount for Covered Services. You are responsible to pay for Excess Charges from Out-of-Network Providers and Facilities. These charges do not apply to your Out-of-Pocket Maximum.

16.32 Exclusion(s)

Situations and Services that are not covered by SelectH**e**alth under the Plan. Most Exclusions are set forth in Section 10 Limitations and Exclusions, but other provisions throughout this Certificate and the Contract may have the effect of excluding coverage in particular situations.

16.33 Experimental and/or Investigational

A Service for which one or more of the following apply:

a. It cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use;

b. It is the subject of a current investigational new drug or new device application on file with the FDA;

c. It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial;

d. It is being or should be delivered or provided subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS); or

e. If the predominant opinion among appropriate experts as expressed in the peer-reviewed medical literature is that further research is necessary in order to define safety, toxicity, effectiveness, or comparative effectiveness, or there is no clear medical consensus about the role and value of the Service.

16.34 Facility

An institution that provides certain healthcare Services within specific licensure requirements.

16.35 Formulary

The Prescription Drugs covered by your Plan.

16.36 Generic Drug(s)

A medication that has the same active ingredients, safety, dosage, quality, and strength as its brand-name counterpart. Both the brand-name drug and the Generic Drug must get approval from the FDA before they can be sold.

16.37 Group Application

A form used by SelectHealth both as an application for coverage by your employer and to specify group-specific details of coverage. The Group Application may contain modifications to the language of the Contract. It also demonstrates your employer's acceptance of the Contract. Other documents, such as Endorsements, may be incorporated by reference into the Group Application.

16.38 Group Health Insurance Contract

The agreement between your employer and SelectHealth that contains the terms and conditions under which SelectHealth provides group insurance coverage to you and your Dependents. The Group Application and this Certificate are part of the Group Health Insurance Contract. If your employer is not directly sponsoring the Plan, references to employer throughout the Certificate of Coverage can also include the party contracting with SelectHealth for Benefits provided to you.

16.39 Healthcare Management Program

A program designed to help you obtain quality, cost-effective, and medically appropriate care, as described in Section 11 Healthcare Management.

16.40 Home Healthcare

Services provided to Members at their home by a licensed Provider who works for an organization that is licensed by the state where Services are provided.

16.41 Hospice Care

Supportive care provided on an inpatient or outpatient basis to a terminally ill Member not expected to live more than six months.

16.42 Hospital

A Facility that is licensed by the state in which Services are provided that is legally operated for the medical care and treatment of sick or injured individuals.

A Facility that is licensed and operating within the scope of such license, which:

a. Operates primarily for the admission, acute care, and treatment of injured or sick persons as inpatients;

b. Has a 24-hour-a-day nursing service by or under the supervision of a graduate registered Nurse (R.N.) or a licensed practical Nurse (L.P.N.);

c. Has a staff of one or more licensed Physicians available at all times; and

d. Provides organized facilities for diagnosis and surgery either on its premises or in facilities available to the Hospital on a contractual prearranged basis.

16.43 Infertility

A condition resulting from a disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the male or female reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery.

16.44 Injectable Drugs and Specialty Medications

A class of drugs that may be administered orally, as a single injection, intravenous infusion or in an inhaled/nebulized solution. Injectable drugs and specialty medications include all or some of the following:

a. Are often products of a living organism or produced by a living organism through genetic manipulation of the organism's natural function;

b. Are generally used to treat an ongoing chronic illness;

c. Require special training to administer;

d. Have special storage and handling requirements;

e. Are typically limited in their supply and distribution to patients or Providers; and

f. Often have additional monitoring requirements.

Certain drugs used in a Provider's office to treat common medical conditions (such as intramuscular penicillin) are not considered Injectable Drugs and specialty medications, because they are widely available, distributed without limitation, and are not the product of bioengineering.

16.45 Initial Eligibility Period

The period determined by SelectHealth and your employer during which you may enroll yourself and your Dependents in the Plan. The Initial Eligibility Period is identified in the Group Application.

16.46 In-Network Benefits

The higher level of Benefits available to you when you obtain Covered Services from an In-Network Provider or Facility.

16.47 In-Network Facility

Facilities under contract with SelectHealth to accept Allowed Amounts as payment in full for Covered Services.

16.48 In-Network Pharmacies

Pharmacies under contract with SelectHealth to accept Allowed Amounts as payment in full for Covered Services.

16.49 In-Network Providers

Providers under contract with SelectHealth to accept Allowed Amounts as payment in full for Covered Services.

16.50 Lifetime Maximum

The maximum accumulated amount that SelectHealth will pay for certain Covered Services (as allowed by the Affordable Care Act) during a Member's lifetime. This includes all amounts paid on behalf of the Member under any prior health benefit plans insured by SelectHealth (including those sponsored by former employers) or any of its affiliated or subsidiary companies. In addition, some categories of Benefits are subject to a separate lifetime maximum amount. If applicable, lifetime maximums are specified in your Member Payment Summary.

16.51 Limitation(s)

Situations and Services in which coverage is limited by SelectHealth under the Plan. Most Limitations are set forth in Section 10 Limitations and Exclusions, but other provisions throughout this Certificate and the Contract may have the effect of limiting coverage in particular situations.

16.52 Major Diagnostic Tests

Diagnostic tests categorized as major by SelectHealth. SelectHealth categorizes tests based on several considerations such as the invasiveness and complexity of the test, the level of expertise required to interpret or perform the test, and where the test is commonly performed. Examples of common major diagnostic tests are:

a. Cardiac nuclear studies or cardiovascular procedures such as coronary angiograms;

b. Gene-based testing and genetic testing;

c. Imaging studies such as MRIs, CT scans, and PET scans; and

d. Neurologic studies such as EMGs and nerve conduction studies.

If you have a question about the category of a particular test, please contact Member Services.

16.53 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.

16.54 Maximum Annual Out-of-Network Payment

The maximum accumulated amount SelectHealth will pay each Year for Covered Services applied to the Out-of-Network Benefit.

The limit includes all amounts paid on behalf of the Member under any prior Plans provided by SelectHealth or any of its affiliated or subsidiary companies for any one Year. The Maximum Annual Out-of-Network Payment amount is specified in your Member Payment Summary.

16.55 Medical Director

The Physician(s) designated as such by SelectHealth.

16.56 Medical Necessity/Medically Necessary

Services that a prudent healthcare professional would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

a. In accordance with generally accepted standards of medical practice in the United States;

b. Clinically appropriate in terms of type, frequency, extent, site, and duration; and

c. Not primarily for the convenience of the patient, Physician, or other Provider.

When a medical question-of-fact exists, Medical Necessity shall include the most appropriate available supply or level of service for the Member in question, considering potential benefit and harm to the Member.

Medical Necessity is determined by the treating Physician and by SelectHealth's Medical Director or his or her designee. The fact that a Provider or Facility, even a 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.

16.57 Member

You and your Dependents, when properly enrolled in the Plan and accepted by SelectHealth.

16.58 Member Payment Summary

A summary of your Benefits by category of service, attached to and considered part of this Certificate.

16.59 Minor Diagnostic Tests

Tests not categorized as Major Diagnostic Tests. Examples of common minor diagnostic tests are:

a. Bone density tests;

b. Certain EKGs;

c. Echocardiograms;

d. Common blood and urine tests;

e. Simple X-rays such as chest and long bone X-rays; and

f. Spirometry/pulmonary function testing.

16.60 Miscellaneous Medical Supplies (MMS)

Supplies that are disposable or designed for temporary use.

16.61 Nurse

A graduate Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who is licensed by the state where Services are provided to provide medical care and treatment under the supervision of a Physician.

16.62 Oligodontia

The condition of congenitally missing more than six teeth, not including third molars or wisdom teeth.

16.63 Optional Benefit

Additional coverage purchased by your employer as noted in your Member Payment Summary that modifies Limitations and/or Exclusions.

16.64 Out-of-Network Benefits

A lower level of Benefits available for Covered Services obtained from a Out-of-Network Provider or Facility, even when such Services are not available through In-Network Providers or Facilities.

16.65 Out-of-Network Facility

Healthcare Facilities that are not under contract with SelectHealth.

16.66 Out-of-Network Pharmacies

Pharmacies that are not under contract with SelectHealth.

16.67 Out-of-Network Provider

Providers that are not under contract with SelectHealth.

16.68 Out-of-Pocket Maximum

The maximum amount specified in your Member Payment Summary that you must pay each Year to Providers and/or Facilities as Deductibles, Copays, and Coinsurance. Except when otherwise noted in your Member Payment Summary, SelectHealth will pay 100 percent of Allowed Amounts during the remainder of the Year once the Out-of-Pocket Maximum is satisfied. Some categories of Benefits may be subject to separate Out-of-Pocket Maximum amounts. Payments you make for Excess Charges, non-Covered Services, and certain categories of Services specified in your Member Payment Summary are not applied to the Out-of-Pocket Maximum.

16.69 Physician

A doctor of medicine or osteopathy who is licensed by the state in which he or she provides Services and who practices within the scope of his or her license.

16.70 Plan

The specific combination of Covered Services, Limitations, Exclusions, and other requirements agreed upon between SelectHealth and your employer as set forth in this Certificate and the Contract.

16.71 Plan Sponsor

As defined in ERISA. The Plan Sponsor is typically your employer.

16.72 Preauthorization (Preauthorize)

Prior approval from SelectHealth for certain Services. Refer to Section 11 Healthcare Management and your Member Payment Summary.

16.73 Premium(s)

The amount your Employer periodically pays to SelectHealth as consideration for providing Benefits under the Plan. The Premium is specified in the Group Application.

16.74 Prescription Drugs

Drugs and medications, including insulin, that by law must be dispensed by a licensed pharmacist and that require a Provider's written prescription.

16.75 Preventive Services

Periodic healthcare that includes screenings, checkups, and patient counseling to prevent illness, disease, or other health problems not previously known to exist in the individual, and as defined by the Affordable Care Act and/or SelectHealth. Some examples of these services are well-child exams, immunizations, pediatric vision screenings, and Contraceptives as required by the ACA. Preventive services also include a Contraceptive that is medically necessary for you as determined by your Provider and evidenced through written documentation submitted to SelectHealth.

16.76 Primary Care Physician or Primary Care Provider (PCP)

A general practitioner who attends to common medical problems, provides Preventive Services, and health maintenance. The following types of Physicians and Providers, and their associated physician assistants and nurse practitioners, are PCPs:

a. Certified Nurse Midwives;

b. Family Practice;

c. Geriatrics;

d. Internal Medicine;

e. Obstetrics and Gynecology (OB/GYN); and

f. Pediatrics.

16.77 Private Duty Nursing

Services rendered by a Nurse to prepare and educate family members and other caregivers on proper procedures for care during the transition from an acute Hospital setting to the home setting.

16.78 Provider

A vendor of healthcare Services licensed by the state where Services are provided and that provides Services within the scope of its license.

16.79 Qualified Medical Child Support Order (QMCSO)

A court order for the medical support of a child as defined in ERISA.

16.80 Rescission (Rescind)

A cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required Premiums or contributions towards the cost of coverage.

16.81 Residential Treatment Center

A licensed psychiatric facility which provides 24-hour continuous, individually-planned programs of therapeutic treatment and supervision.

16.82 Respite Care

Care provided primarily for relief or rest from caretaking responsibilities.

16.83 Routine Care

Care that is intended to monitor identified health conditions or assess new symptoms or signs of possible health conditions in a non-urgent or non-emergency setting.

16.84 Secondary Care Physician or Secondary Care Provider (SCP)

Physicians and other Providers who are not a Primary Care Physician or Primary Care Provider. Examples of an SCP include:

a. Cardiologists;

b. Dermatologists;

c. Neurologists;

d. Ophthalmologists;

e. Orthopedic Surgeons; and

f. Otolaryngologists (ENTs).

16.85 Service Area

The geographical area in which SelectHealth arranges for Covered Services for Members from In-Network Providers and Facilities. Contact SelectHealth for Service Area information if the U.S. Postal Service changes or adds ZIP codes after the beginning of the Year.

The SelectHealth Med® Service Area is the State of Utah.

16.86 Service(s)

Services, care, tests, treatments, drugs, medications, supplies, or equipment.

16.87 Skilled Nursing Facility

A Facility that provides Services that improve, rather than maintain, your health condition, that requires the skills of a Nurse in order to be provided safely and effectively, and that:

a. Is being operated as required by law;

b. Is primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a Physician;

c. Provides 24 hours a day, seven days a week nursing service by or under the supervision of a Registered Nurse (R.N.); and

d. Maintains a daily medical record of each patient.

A Skilled Nursing Facility is not a place that is primarily used for rest or for the care and treatment of mental diseases or disorders, chemical dependency, alcoholism, Custodial Care, nursing home care, or educational care.

16.88 Special Enrollment Right

An opportunity to enroll in the Plan outside of your employer's Annual Open Enrollment period under defined circumstances described in Section 3 Enrollment.

16.89 Subscriber

You, the individual with an employment or another defined relationship to the Plan Sponsor, through whom Dependents may be enrolled with SelectHealth.

16.90 TeleHealth

Services provided via interactive (synchronous) video and audio telecommunications systems.

16.91 Urgent Condition(s)

An acute health condition with a sudden, unexpected onset that is not life threatening but that poses a danger to a person's health if not attended by a Physician within 24 hours, e.g., high fevers, possible fractures.

16.92 Utah mini-COBRA

Continuation coverage required by Utah law for employers with fewer than 20 employees.

16.93 Year

Benefits are calculated on either a calendar-year or plan-year basis, as indicated on your Member Payment Summary.

a. The calendar year begins on January 1 at 12:00 a.m. Mountain Standard Time and ends on December 31, at 11:59 p.m. Mountain Standard Time.

b. The plan year, if applicable, is indicated in the Group Application.

appendix A
optional benefits

selecthealth℠

MENTAL HEALTH/CHEMICAL DEPENDENCY OPTIONAL BENEFIT

1. Your Mental Health Benefits

This Optional Benefit provides mental health and chemical dependency Benefits for the treatment of emotional conditions or chemical dependency listed as a mental disorder in the Diagnostic and Statistical Manual, as periodically revised, and which require professional intervention for as long as Services are considered Medically Necessary. These Benefits are subject to all the provisions, limitations, and exclusions of your medical Benefits that are listed in the Certificate.

If you have any questions regarding any aspect of the Benefits described in this Optional Benefit, please call the Behavioral Health Advocates[SM] weekdays, from 8:00 a.m. to 6:00 p.m. at 800-876-1989.

2. Using In-Network Mental Health Providers

Mental health Services will be covered only when rendered by a In-Network Provider unless otherwise noted on your Member Payment Summary.

3. Services requiring Preauthorization

Preauthorization is required for the following mental health services that are not for Emergency Conditions:

a. Inpatient psychiatric/detoxification admissions;
b. Residential treatment (when indicated as a covered Benefit on your Member Payment Summary);
c. Day treatment;
d. Partial hospitalization; and
e. Intensive outpatient treatment.

If you need to request Preauthorization, call the Behavioral Health Advocates. Refer to Section 11 – "Healthcare Management" of your Certificate of Coverage for additional information.

4. Exclusions

4.1 The following Services are not covered:

a. Behavior modification;
b. Counseling with a patient's family, friend(s), employer, school authorities, or others, except for approved Medically Necessary collateral visits, with or without the patient present, in connection with otherwise covered treatment of the patient's mental illness;
c. Education or training;
d. Long-term care;
e. Milieu therapy;
f. Rest cures;
g. Self-care or self-help training (nonmedical); and
h. Surgical procedures to remedy a condition diagnosed as psychological, emotional, or mental.

4.2 In addition, Services for conduct disorder are not covered.

SelectHealth, Inc. (domiciled in Utah)

ASH CHIROPRACTIC OPTIONAL BENEFIT

Your Chiropractic Benefits are administered by American Specialty Health Group, Inc ("ASH"). If you have any questions, concerns, or complaints about your chiropractic Benefits, please call ASH Member Services Department at 800-678-9133, or write to the following address:

American Specialty Health Group Incorporated
Attn: ASH Member Services Department
P.O. Box 509002
San Diego, CA 92150-9002

1. Definitions

This Optional Benefit uses the following capitalized defined terms in addition to Section 16Ð"Definitions" of the Contract. If there is a conflict between these terms and those in Section 16, these terms prevail.

1.1 Administrative Appeals

Administrative Appeals may result from Adverse Benefit Determinations that are based on issues that arise from administrative procedures.

Examples of Administrative Appeals may include the following scenarios:

a. Treatment plan was denied for not meeting authorization and/or claim timeframe requirements.
b. Necessary information was not received from Practitioner according to ASH timelines.

1.2 ASH Quality Management and Improvement ("QI") Program

Those standards, protocols, policies, and procedures adopted by ASH to monitor and improve the quality of clinical care and quality of Services provided to you.

1.3 ASH Service Area

The geographic area in which ASH arranges Chiropractic Services in Utah.

1.4 ASH Utilization Management Program

Those standards, protocols, policies, and procedures adopted by ASH regarding the management, review, and approval of the provision of Covered Chiropractic Services to you.

1.5 Chiropractic Appliances

Chiropractic appliances are support-type devices prescribed by a In-Network Chiropractor. Following are the only items that could be covered: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces/supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units (cervical or lumbar), ankle braces, knee braces, rib supports, and wrist braces.

1.6 Chiropractic Services

The Services rendered or made available to you by a chiropractor for treatment or diagnosis of Musculoskeletal and Related Disorders.

1.7 Clinical Appeals

Clinical Appeals may result from Adverse Benefit Determinations that are based on Medical Necessity, Experimental and/or Investigational treatment, or similar Exclusions or Limitations. Examples of Clinical Appeals may include the following scenarios:

a. Treatment plan was denied or modified due to lack of Medical Necessity.
b. The number of visits requested by the Practitioner did not meet clinical criteria.

1.8 Covered Chiropractic Services

The Chiropractic Services that ASH determines to be Medically Necessary, as limited by this Optional Benefit.

1.9 Emergency Chiropractic Services

Services provided to manage an injury or condition with a sudden and unexpected onset, which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate clinical attention to result in:

a. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
b. Serious impairment to bodily functions;
c. Serious dysfunction of any bodily organ or part; or
d. Decreasing the likelihood of maximum recovery.

1.10 Medical Necessity/Medically Necessary

Chiropractic Services that are:

a. Necessary, appropriate, safe, effective, and rendered in accordance with professionally recognized, valid, evidence-based standards and guidelines that have been adopted by ASH for its use in determining whether Chiropractic Services are appropriate for reimbursement;
b. Directly applicable to the diagnosis and treatment of a covered condition;
c. Verified by ASH as being rendered for the purpose of reaching a defined and appropriate functional outcome or maximum therapeutic benefit (defined as your return to your pre-illness/pre-injury daily functional status and activity);
d. Rendered in a manner that appropriately assesses and manages your response to the clinical intervention;
e. Rendered for the diagnosis and treatment of a covered condition;
f. Rendered in accordance with the Clinical Services Management Program and Clinical Performance Management Program standards as published in the ASH Chiropractic Provider Operations Manual;
g. Appropriate for the severity and complexity of symptoms and consistent with the covered condition (diagnosis) and appropriate for your response to care; and
h. Not considered to be an elective Chiropractic Service or a Chiropractic Service for any condition that is not a covered condition. Examples of elective services are:
    i. Preventive maintenance services;
    ii. Wellness services;
    iii. Services not necessary to return you to pre-illness/pre-injury functional status
    iv. and activity; and
    v. Services provided after you have reached maximum therapeutic benefit.

1.11 Musculoskeletal and Related Disorders

Musculoskeletal and Related Disorders are conditions with associated signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or biomechanical dysfunction of the joints of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs, and synovial structures), and related neurological manifestations or conditions.

1.12 Out-of-Area Services

Those Emergency Chiropractic Services provided while you are outside the ASH Service Area that would have been the financial responsibility of ASH had the Services been provided within the ASH Service Area. Covered Chiropractic Services that are to be provided outside the ASH Service Area, and are arranged by ASH for assigned Members, are not considered Out-of-Area Services.

1.13 In-Network Chiropractor

A chiropractor who is duly licensed to practice chiropractic in the state in which they provide the Service and who has entered into an agreement with ASH to provide covered Chiropractic Services to you.

1.14 Out-of-Network Chiropractor

A chiropractor not under contract with ASH to provide covered Chiropractic Services to you.

2. Using Your Chiropractic Benefits

Using your chiropractic Benefits is easy. Simply use an In-Network Chiropractor listed in the Chiropractic Provider Directory.

You may receive Covered Chiropractic Services from any In-Network Chiropractor without a referral. Except for Medically Necessary Emergency Chiropractic Services, ASH will not pay for Services received from any Out-of-Network Chiropractor.

3. Preauthorization/Utilization Management and Quality Improvement

After the initial examination, the In-Network Chiropractor must obtain Preauthorization for any additional Covered Chiropractic Services that you receive. The In-Network Chiropractor will be responsible for filing all claims with ASH. You must cooperate with ASH in the operation of its Utilization Management and Quality Improvement Programs.

4. Emergency Chiropractic Services

You may receive Emergency Chiropractic Services from any chiropractor, including an Out-of-Network Chiropractic if the delay caused by seeking immediate chiropractic attention from an In-Network Chiropractor could decrease the likelihood of maximum recovery. ASH will pay the out-of-network chiropractic Provider for the Emergency Chiropractic Service to the extent they are Covered Chiropractic Services.

5. Types of Covered Chiropractic Services

Each office visit to an In-Network Chiropractor, as described below, requires a Copay by you at the time Covered Chiropractic Services are provided. A maximum number of visits per calendar Year will apply to each Member as specified in your Member Payment Summary.

a. A new patient examination is performed by an In-Network Chiropractor to determine the nature of your problem, and if Covered Chiropractic Services appear warranted, a Medical Necessity Review Form (MNR Form) is prepared by the In-Network Chiropractor. A new patient examination will be provided for each new patient. A Copay will be required.
b. An established patient examination may be performed by the In-Network Chiropractor to assess the need to continue, extend or change an MNR Form approved by ASH. A reevaluation may be performed during a subsequent office visit or separately. If performed separately, a Copay is required.
c. Subsequent office visits, as set forth in an MNR Form approved by ASH, may involve an adjustment, a brief re-examination, and other Services in various combinations. A Copay will be required for each visit to the office.
d. Adjunctive therapy, as set forth in an MNR Form approved by ASH, may involve modalities such as ultrasound, hot packs, cold packs, electrical muscle stimulation, and other therapies.
e. X-rays and lab tests are payable in full when prescribed by an In-Network Chiropractor and authorized by ASH. Radiological consultations are a covered Benefit when authorized by ASH as Medically Necessary and provided by a licensed chiropractic radiologist, medical radiologist, radiology group, or Hospital that has contracted with ASH to provide those services.
f. Chiropractic appliances are payable up to a maximum of $50.00 per year when

prescribed by an In-Network Chiropractor and approved by ASH.

6. Chiropractic Exclusions and Limitations

ASH will not pay for or otherwise cover the following:

a. Any Services or treatments not authorized by ASH, except for a new patient examination and Emergency Chiropractic Services;
b. Any Services or treatments not delivered by an In-Network Chiropractor for the delivery of chiropractic care to you, except for Emergency Chiropractic Services; services that are provided pursuant to a continuity of care plan approved by ASH Networks; or services that are provided upon referral by ASH Networks in situations where such services are not available and accessible to a Member from a Contracted Practitioner within the Service Area;
c. Services for examinations (other than an initial examination to determine the appropriateness of Chiropractic Services) and/or treatments for conditions other than those related to Musculoskeletal and Related Disorders;
d. Hypnotherapy, behavior training, sleep therapy, and weight programs;
e. Thermography;
f. Services, lab tests, x-rays, and other treatments not documented as Medically Necessary, as appropriate, or classified as Experimental and/or Investigational, or as being in the research stage, as determined in accordance with professionally recognized standards of practice;
g. Services that are not documented as Medically Necessary;
h. Services for children 12 and younger;
i. Magnetic resonance imaging (MRI), CAT scans, and any types of diagnostic radiology;
j. Transportation costs including local ambulance charges;
k. Education programs, nonmedical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing;
l. Services or treatments for pre-employment physicals or vocational rehabilitation;
m. Any services or treatments caused by or arising out of the course of employment or covered under any public liability insurance;
n. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices or appliances, all chiropractic appliances, or Durable Medical Equipment, except as specified herein;
o. All chiropractic appliances or Durable Medical Equipment, except as specified herein;
p. Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order;
q. Services provided by a chiropractor practicing outside of the Service Area, except for Emergency Chiropractic Services.
r. Hospitalization, anesthesia, manipulation under anesthesia, or other related services;
s. All auxiliary aids and services, including interpreters, transcription services, written materials, telecommunication devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids;
t. Adjunctive therapy not associated with spinal, muscle, or joint manipulation;
u. Vitamins, minerals, nutritional supplements, injectable supplements and injection services,or other similar products;
v. Any services or treatments that are furnished before the date the Member becomes eligible or after the date the member ceases to be eligible under the Member's plan;
w. Massage Therapy, venipuncture, or Natural childbirth services;
x. Services rendered in excess of visits or benefit maximums;
y. Any service or supply that is not permitted by state law with respect to the provider's scope of practice;
z. Any services provided by a person who is a Family Member. Family Member means a person who is related to the covered person in any of the following ways: spouse, domestic partner, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-

law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child). A Family Member also includes individuals who normally live in the covered person's household; or

aa. Any services rendered for elective or maintenance care (e.g., services provided to a Member whose treatment records indicate he or she has reached Maximum Therapeutic Benefit).

7. This Optional Benefit

This Optional Benefit is subject to all provisions, Limitations, Exclusions, and agreements of the Certificate of Coverage and the Contract (available from your employer).

8. Claims and Appeals

ASH will follow administrative processes and safeguards designed to ensure and to verify that Benefit claim determinations are made in accordance with the provisions of this Optional Benefit administered by ASH and that the provisions have been applied consistently with respect to similarly situated Claimants.

8.1 Defined Terms

This section uses the following additional (capitalized) defined terms:

8.1.1 Adverse Benefit Determination

Any of the following: a Rescission of coverage or a denial, reduction, or termination of a claim for Benefits, or a failure to provide or make payment for such a claim in whole or in part, including determinations related to a Claimant's Eligibility, the application of a review under ASH Utilization Management Program, and determinations that particular Services are Experimental and/or Investigational or not Medically Necessary or appropriate.

8.1.2 Appeal(s)

Review by ASH of an Adverse Benefit Determination.

8.1.3 Authorized Representative

Someone you have designated to represent you in the claims or Appeals process. To designate an Authorized Representative, you must provide written authorization on a form provided by the ASH Appeals Department or ASH Member Services. However, where an Urgent Preservice Claim is involved, a healthcare professional with knowledge of the medical condition will be permitted to act as your Authorized Representative without a prior written authorization. In this section, the words you and your include your Authorized Representative.

8.1.4 Benefit Determination

The decision by ASH regarding the acceptance or denial of a claim for Benefits.

8.1.5 Claimant

Any Subscriber or Member making a claim for Benefits. Claimants may file claims themselves or may act through an Authorized Representative. In this section, the words you and your are used interchangeably with Claimant.

8.1.6 Concurrent Care Decisions

Decisions by ASH regarding coverage of an ongoing course of treatment that has been approved in advance.

8.1.7 External Review

A review by an outside entity, at no cost to the Member, of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination).

8.1.8 Final Internal Adverse Benefit Determination

An Adverse Benefit Determination that has been upheld by ASH at the completion of the mandatory Appeals process.

8.1.9 Independent Review Organization (IRO)

An entity that conducts independent External Reviews.

8.1.10 Postservice Appeal

A request to change an Adverse Benefit Determination for Services you have already received.

8.1.11 Postservice Claim

Any claim related to care or treatment that has already been received by the Member.

8.1.12 Preservice Appeal

A request to change an Adverse Benefit Determination on a Preservice Claim.

8.1.13 Preservice Claim

Any claim related to care or treatment that has not been received by the Member.

8.1.14 Urgent Preservice Claim

Any Preservice Claim that if subject to the normal timeframes for determination could seriously jeopardize your life, health, or ability to regain maximum function or that, in the opinion of your treating Physician, would subject you to severe pain that could not adequately be managed without the requested Services. Whether a claim is an Urgent Preservice Claim will be determined by an individual acting on behalf of ASH applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that your treating Physician determines is an Urgent Preservice Claim will be treated as such.

8.2 How to File a Claim for Benefits

8.2.1 Urgent Preservice Claims

In order to file an Urgent Preservice Claim, you must provide ASH with:

a. Information sufficient to determine to what extent Benefits are covered by the Plan; and
b. A description of the medical circumstances that give rise to the need for expedited review.

Under certain circumstances provided by federal law, if you fail to follow the proper procedures for filing an Urgent Preservice Claim, ASH will notify you of the failure and the proper procedures to be followed. ASH will notify you as soon as reasonably possible, but no later than 24 hours after receiving the claim. This notice may be verbal unless you specifically request otherwise in writing.

Notice of a Benefit Determination will be provided as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receipt of the claim. However, if ASH gives you notice of an incomplete claim, the notice will give you at least 48 hours to provide the requested information. ASH will then provide a notice of Benefit Determination within 48 hours after receiving the specified information or the end of the period of time given you to provide the information, whichever occurs first. If the Benefit Determination is provided verbally, it will be followed in writing no later than three days after the verbal notice.

If the Urgent Preservice Claim involves a Concurrent Care Decision, notice of the Benefit Determination will be provided as soon as possible but no later than 24 hours after receipt of your claim for extension of treatment or care, as long as the claim is made at least 24 hours before the prescribed period of time expires or the prescribed number of treatments ends.

8.2.2 Other Preservice Claims

The procedure for filing most Preservice Claims (Preauthorization) is set forth in Section 11Ð"Healthcare Management." If there is any other Benefit that would be subject to a Preservice Claim, you may file a claim for that Benefit by contacting ASH Member Services. Under certain circumstances provided by federal law, if you fail to follow the proper procedures for filing a Preservice Claim, ASH will provide notice of the failure and the proper procedures to be followed. This notification will be provided as soon as reasonably possible, but no later than five days after receipt of the claim, and may be verbal unless you specifically request it in writing.

Notice of a Benefit Determination will be provided in writing within a reasonable period appropriate to the medical circumstances, but no later than 15 days after receipt of the claim. However, ASH may extend this period for up to an additional 15 days if ASH: (1) determines that such an extension is necessary due to matters beyond its control; and (2) provides you written notice, prior to the end of the original 15-day period, of the circumstances requiring the extension and the date by which ASH expects to render a decision. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information, and you will be given 60 days from your receipt of the notice to provide the requested information.

Notice of an Adverse Benefit Determination regarding a Concurrent Care Decision will be provided sufficiently in advance of any termination or reduction of Benefits to allow you to Appeal and obtain a determination before the Benefit is reduced or terminates.

8.2.3 Postservice Claims

a. In-Network Chiropractors file Postservice Claims with ASH and ASH makes payment to the Providers and Facilities.
b. Out-of-Network Chiropractors are not required to file claims with ASH. If an Out-of-Network Chiropractor does not submit a Postservice Claim to ASH or you pay the Out-of-Network Chiropractor, you must submit the claim in writing in a form approved by ASH. Call ASH Member Services or your employer to find out what information is needed to submit a Postservice Claim. All claims must be received by ASH within a 12-month period from the date of the expense or as soon as reasonably possible. Claims received outside of this timeframe will be denied.

Notice of Adverse Benefit Determinations will be provided in writing within a reasonable period of time, but no later than 30 days after receipt of the claim. However, ASH may extend this period if ASH: (1) determines that such an extension is necessary due to matters beyond its control; and (2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which ASH expects to render a decision.

The applicable time period for the Benefit Determination begins when your claim is filed in accordance with ASH's procedures, even if you have not submitted all the information necessary to make a Benefit Determination.

8.3 Problem Solving

ASH is committed to making sure that any concerns or problems regarding your claims are investigated and resolved as soon as possible. Many situations can be resolved informally by contacting ASH Member Services at 800-678-9133.

8.4 Formal Appeals

If you are not satisfied with the result of working with ASH Member Services, you may file a written formal Appeal of any Adverse Benefit Determination. Written formal Appeals should be sent to the ASH Appeals Department. As the delegated claims review fiduciary under your Employer's Plan, ASH will conduct a full and fair review of your Appeal and has final discretionary authority and responsibility for deciding all matters regarding Eligibility and coverage.

8.4.1 General Rules and Procedures

You will have the opportunity to submit written comments, documents, records, and other information relating to your Appeal. ASH will consider this information regardless of whether it was considered in the Adverse Benefit Determination.

During an Appeal, no deference will be afforded to the Adverse Benefit Determination, and decisions will be made by fiduciaries who did not make the Adverse Benefit Determination and who do not report to anyone who did. If the Adverse Benefit Determination was based on medical judgment, including determinations that Services are Experimental and/or Investigational or not Medically Necessary, the fiduciaries during any Appeal will consult with a medical professional with appropriate training and experience in the appropriate field of medicine and who was neither consulted in connection with the Adverse Benefit Determination nor is the subordinate of such an individual. Upon request, you will be provided the identification of any medical expert(s) whose advice was obtained on behalf of ASH in connection with the Adverse Benefit Determination, whether or not the advice was relied upon in making the Adverse Benefit Determination.

Before ASH can issue a Final Internal Adverse Benefit Determination, you will be provided with any new or additional evidence or rationale considered, relied upon, or generated by us in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of a Final Internal Benefit Determination is required to be provided to give you a reasonable opportunity to respond prior to the date.

8.4.2 Form and Timing

All requests for an Appeal of an Adverse Benefit Determination (other than those involving an Urgent Preservice Claim) must be in writing and should include a copy of the Adverse Benefit Determination and any other pertinent information that you want ASH to review in conjunction with your Appeal. Send all information to the ASH Appeals Department at the following address:

ASH Appeals Coordinator
P.O. Box 509001
San Diego, CA 92150-9002

You may Appeal an Adverse Benefit Determination of an Urgent Preservice Claim on an expedited basis either verbally or in writing. You may Appeal verbally by calling the ASH Appeals Department at 800-678-9133.

If the request is made verbally, the ASH Appeals Department will within 24 hours send written confirmation acknowledging the receipt of your request.

You must file a formal Appeal within 180 days from the date you received notification of the Adverse Benefit Determination.

Appeals that do not comply with the above requirements are not subject to review by ASH or legal challenge.

8.4.3 Appeals Process

The Appeals process includes both mandatory and voluntary reviews. You must exhaust all mandatory reviews before you may pursue civil action under ERISA Section 502(a). It is your choice, however, whether or not to seek voluntary review, and you are not required to do so before pursuing civil action. ASH agrees that any statute of limitations or other legal defense based on timeliness is suspended during the time that any voluntary Appeal is pending. Your decision whether or not to seek voluntary review will have no effect on your rights to any other Benefits. ASH will provide you, upon request, sufficient information to enable you to make an informed decision about whether or not to engage in a voluntary review.

After a mandatory review process, you may choose to pursue civil action under ERISA Section 502(a). Failure to properly pursue the mandatory Appeals process may result in a waiver of the right to challenge ASH's original decision.

8.4.4 Preservice Appeals

The process for appealing a Preservice Claim provides one mandatory review, possible voluntary reviews, and the right to pursue civil action under ERISA Section 502(a).

Mandatory Review

Your Appeal will be investigated by the ASH Appeals Department. All relevant, available information will be reviewed. The ASH Appeals Department will notify you in writing of the Appeal decision within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after the receipt of your Appeal. However, ASH may extend this period if ASH: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which ASH expects to render a decision.

If your Appeal involves an Urgent Preservice Claim, you may request an expedited review. You will be notified of the Appeal decision on an expedited review as soon as possible, taking into account the medical circumstances, but no later than 72 hours after the receipt of your Appeal. A decision communicated verbally will be followed up in writing.

Voluntary Review

After completing the mandatory review process described above, you may pursue a voluntary External Review or a voluntary internal review. However, External Review is only available in the circumstances described below. If you choose to pursue a voluntary External Review, you may not pursue the voluntary internal review process.

Voluntary External Review

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, or a Rescission of coverage. To request an External Review, you must complete the Independent Review Request Form. For a copy of this form, or for other questions, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City, UT 84114; by phone at 801-538-3077; or electronically at healthappeals.uid@utah.gov. An External Review request must be made within 180 days from the date the ASH Appeals Department notifies you of the Final Internal Adverse Benefit Determination.

An authorization to obtain medical records may be required. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. The IRO will provide written notice of its decision within 45 days after receipt of the request.

If your Appeal involves an Urgent Preservice Claim, you may request an expedited review. You will be notified by the IRO of the Appeal decision on an expedited review as soon as possible, taking into account the medical circumstances, but no later than 72 hours after the receipt of your Appeal. A decision communicated verbally will be followed up in writing.

If you pursue a voluntary External Review, it will be your last level of Appeal.

Voluntary Internal Review

If you choose to pursue the voluntary internal review process, you may first request a review of your Appeal by the ASH Grievance Committee. Such a request must be made in writing to the ASH Appeals Department within 60 days of the date the ASH Appeals Department notifies you the Final Internal Adverse Benefit Determination. ASH will notify you of the result of the review in writing within 30 days of the date you requested the review. However, ASH may extend this period if ASH: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which ASH expects to render a decision. If you are not satisfied with the decision made by the ASH Grievance Committee, you may request a review by the ASH Appeals Committee. Such a request must be made in writing to the ASH Appeals Department within 60 days of the date the ASH Grievance Committee notifies you of its decision.

8.4.5 Postservice Appeals

The process for appealing a Postservice Claim provides two mandatory reviews, possible voluntary reviews, and the right to pursue civil action under ERISA Section 502(a).

Mandatory Review

Your Appeal will be investigated by the ASH Appeals Department. All relevant information will be reviewed and the ASH Appeals Department will notify you in writing of the Appeal decision within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after the receipt of your Appeal. However, ASH may extend this period if ASH: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which ASH expects to render a decision.

Voluntary Review

After completing the mandatory review process described above, you may pursue either a voluntary External Review or a voluntary internal review. However, External Review is only available in the circumstances described below. If you choose to pursue the voluntary External Review process, you may not pursue the voluntary internal review process.

Voluntary External Review

You may request an External Review of your Appeal by an Independent Review Organization (IRO) if you are appealing a Final Internal Adverse Benefit Determination regarding Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Benefit, utilization review, Experimental and/or Investigational, or a Rescission of coverage. To request an External Review you must complete the Independent Review Request Form. Also, you will be subject to additional requirements for an External Review regarding Experimental and/or Investigational Services. For a copy of this form, or for other questions, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City, UT 84114; by phone at 801-538-3077; or electronically at healthappeals.uid@utah.gov. An External Review request must be made within 180 days from the date of ASH's Final Internal Adverse Benefit Determination. An authorization to obtain medical records may be required. The IRO will provide written notice of its decision within 45 days after receipt of the request.

If you pursue a voluntary External Review, it will be your last level of Appeal.

Voluntary Internal Review

If you choose to pursue the voluntary internal review process, you may request a review of your Appeal. Such a request must be made in writing to the ASH Appeals Department within 60 days of the date the ASH Appeals Department notifies you of the Final Internal Adverse Benefit Determination. ASH will notify you of the result of the review in writing within 30 days of the date you requested the review. If you are not satisfied with the decision made by the reviewing committee, you may request a review by the Appeals Committee. Such a request must be made in writing to the ASH Appeals Department within 60 days of the date the reviewing committee notifies you of its decision.

MEMORANDUM TO THE BOARD

TO: Utah Transit Authority Board of Trustees
THROUGH: Carolyn Gonot, Executive Director
FROM: Mary DeLoretto, Chief Service Development Officer
PRESENTER(S): Paul Drake, Director of Real Estate & TOD

BOARD MEETING DATE: May 6, 2020

SUBJECT:	**Disposition of Real Property for Porter Rockwell Bridge Project - Parcels 215:B, 215:C, and 215:E (Utah Department of Transportation)**
AGENDA ITEM TYPE:	**Revenue Contract**
RECOMMENDATION:	Approve the disposition of the Subject Property to the Utah Department of Transportation (UDOT) and authorize the Executive Director to execute two right of way contracts with a combined selling price of $457,300 ($371,761 + $85,539).
BACKGROUND:	UDOT is currently constructing the Porter Rockwell Boulevard Project in Bluffdale. The boulevard will serve as a connector between 11600th South Street and Redwood Road. As part of the project, UDOT will construct a bridge over the UTA FrontRunner corridor as well as a maintenance access road down in the pinch-point area known as the Narrows. Property is owned by UTA and is needed for the UDOT project. UTA Capital Development Department has reviewed UDOT's design plans and feels comfortable there are no current system impacts by selling this property and have determined there will be adequate room for future FrontRunner double tracking needs with the disposition of subject property. Furthermore, UTA will retain access rights on a maintenance access road to be constructed by UDOT and maintained by Salt Lake City. Access rights will also be granted to The East Jordan Irrigation Company to maintain their current canal access.
DISCUSSION:	The UTA disposition Subject Property is located at approximately 15702 S Pony Express Road, Bluffdale, UT and includes 15,129 square feet of fee property to be granted to UDOT (Parcel 215B), an 82,248 square foot perpetual access easement to be granted to The East Jordan Irrigation Company (Parcel 215:E), and the remaining fee rights on that 82,248 square foot parcel to be granted to Salt Lake City (reserving UTA access rights in the deed)(Parcel 215:C). In exchange for the subject parcel dispositions, UTA will receive a total of $457,300.This disposition is needed for the UDOT project. Their offer to purchase is based upon the appraised value of the land and has been performed in compliance with all applicable laws and processes. The subject property was not purchased with Federal assistance. The funds received and cooperation granted to UDOT will facilitate the transaction for UTA to acquire the 0.874 acre ("teardrop parcel") from UDOT.

ALTERNATIVES:	There is no viable alternative for UDOT.
FISCAL IMPACT:	UTA will receive $457,300 for the property dispositions.
ATTACHMENTS:	• Right of Way Contract Parcel 215B - $85,539 • Right of Way Contract Parcels 215:C, 215:E - $371,761 • Quit Claim Deeds (3) • Map

Utah Department of Transportation
Right of Way Contract
Fee Simple Acquisition - Strip

Project No: S-R299(261) Parcel No.(s): 215B

Pin No: 15670 Job/Proj No: 72717 Project Location: Porter Rockwell (Bridge)
County of Property: SALT LAKE Tax ID / Sidwell No: 33-22-200-021, 33-15-400-031, 33-15-400-035, 33-15-400-022
Property Address: 15702 South Pony Express Road BLUFFDALE UT, 84065
Owner's Address: 669 W 200 S,Salt Lake City,UT,84101
Primary Phone: 801-237-1995 Owner's Home Phone: Owner's Work Phone: (801)237-1995
Owner / Grantor (s): Utah Transit Authority, "a public transit district organized pursuant to Title 17A, Chapter 2, Part10, Utah Code Annotated 1953 as amended"
Grantee: Utah Department of Transportation (UDOT)/The Department

IN CONSIDERATION of the foregoing and other considerations hereinafter set forth, it is mutually agreed by the parties as follows:
The Grantor hereby agrees to convey and sell by Quit Claim a parcel(s) of land known as parcel number(s) 215B for transportation purposes. This contract is to be returned to: Wendy Hansen (Consultant), Right of Way Agent c/o Utah Department of Transportation, 4501 South 2700 West, P.O. Box 148420, Salt Lake City, UT 84114-8420.

1. Grantor will transfer property free of all liens and encumbrances except recorded easements.
2. Grantor agrees to transfer property free of all debris and any hazardous materials (including paint or other household products.)
3. Grantor shall leave the property in the same condition, as it was when this contract was signed. No work, improvement, or alteration will be done to the property other than what is provided for in this agreement. Grantor agrees to maintain the property until the Department takes possession.
4. Grantor agrees to pay any and all taxes assessed against this property to the date of closing.
5. The Department shall pay the Grantor and or other parties of interest for the real property in the deed(s) and/or easement(s) referenced above.
6. "Transportation Purposes" is defined as follows: The public use for which the property or property right is being acquired herein, may include but is not limited to the following possible uses: the construction and improvement of a highway, which may include interchanges, entry and exit ramps, frontage roads, bridges, overpasses, rest areas, buildings, signs and traffic control devices, placement of utilities, clear zones, maintenance facilities, detention or retention ponds, environmental mitigation, maintenance stations, material storage, bio fuel production, slope protections, drainage appurtenance, noise abatement, landscaping, transit, project caused statutory relocations, and other related transportation uses.
7. The Grantor(s) is aware that Utah Code Ann. Sect. 78B-6-520.3 provides that in certain circumstances, the seller of property which is being acquired for a particular public use, is entitled to receive an offer to repurchase the property at the same price that the seller received, before the property can be put to a different use. Grantor(s) waives any right grantor may have to repurchase the property being acquired herein, and waives any rights Grantor(s) may have under Utah Code Ann. Sect. 78B-6-520.3.
8. Grantor shall indemnify and hold harmless Grantee from and against any and all claims, demands and actions, including costs, from lien holders or lessees of the property.
9. Upon execution of this contract by the parties, Grantor grants the Department, its contractors, permittees, and assigns, including but not limited to, utilities and their contractors, the right to immediately occupy and commence construction or other necessary activity on the property acquired for the state transportation project.

Additional Terms:

CONFIRMATION OF AGENCY DISCLOSURE. Buyer and Seller acknowledge prior written receipt of agency disclosure provided by their respective agent that has disclosed the agency relationships confirmed below. At the signing of the Purchase Contract;

Buyer's Agent Wendy Hansen, represents purchaser.
Buyer's Brokerage WLC Consulting, LLC, represents purchaser.

Total Selling Price $85,539.00

Grantor's Initials

Utah Department of Transportation
Right of Way Contract
Fee Simple Acquisition - Strip

Project No: S-R299(261) Parcel No.(s): 215B

Pin No: 15670 Job/Proj No: 72717 Project Location: Porter Rockwell (Bridge)
County of Property: SALT LAKE Tax ID / Sidwell No: 33-22-200-021, 33-15-400-031, 33-15-400-035, 33-15-400-022
Property Address: 15702 South Pony Express Road BLUFFDALE UT, 84065
Owner's Address: 669 W 200 S,Salt Lake City,UT,84101
Primary Phone: 801-237-1995 Owner's Home Phone: Owner's Work Phone: (801)237-1995
Owner / Grantor (s): Utah Transit Authority, "a public transit district organized pursuant to Title 17A, Chapter 2, Part10, Utah Code Annotated 1953 as amended"
Grantee: Utah Department of Transportation (UDOT)/The Department

Grantor's Initials

Grantor understands this agreement is an option until approved by the Director of Right of Way.
Grantors acknowledge and accept the percent of ownership listed below and agree that the portion of the total selling price they each receive, will correspond with their respective percent of ownership.
This Contract may be signed in counterparts by use of counterpart signature pages, and each counterpart signature page shall constitute a part of this Contract as if all Grantors signed on the same page.

	Percent		**Date**
_____	100%	_____ Utah Transit Authority	_____
_____	100%	_____ Utah Transit Authority	_____

Right of Way Agents

_____ Wendy Hansen (Consultant) / Acquisition Agent _____

_____ Krissy Plett / Team Leader _____

_____ Approved by Director of Right of Way _____

Utah Department of Transportation
Right of Way Contract
Fee Simple Acquisition - Strip

Project No: S-R299(261) Parcel No.(s): 215:C, 215:E

Pin No: 15670 Job/Proj No: 72717 Project Location: Porter Rockwell (Bridge)
County of Property: SALT LAKE Tax ID / Sidwell No: 33-22-200-021, 33-15-400-022, 33-15-400-031, 33-15-400-035
Property Address: 15702 South Pony Express Road BLUFFDALE UT, 84066
Owner's Address: 669 W 200 S,Salt Lake City,UT,84101
Primary Phone: 801-237-1995 Owner's Home Phone: Owner's Work Phone: (801)237-1995
Owner / Grantor (s): Utah Transit Authority, "a public transit district organized pursuant to Title 17A, Chapter 2, Part10, Utah Code Annotated 1953 as amended"
Grantee: Utah Department of Transportation (UDOT)/The Department

IN CONSIDERATION of the foregoing and other considerations hereinafter set forth, it is mutually agreed by the parties as follows:
The Grantor hereby agrees to convey and sell by Quit Claim, Perpetual Easement a parcel(s) of land known as parcel number(s) 215:C, 215:E for transportation purposes. This contract is to be returned to: Wendy Hansen (Consultant), Right of Way Agent c/o Utah Department of Transportation, 4501 South 2700 West, P.O. Box 148420, Salt Lake City, UT 84114-8420.

1. Grantor will transfer property free of all liens and encumbrances except recorded easements.
2. Grantor agrees to transfer property free of all debris and any hazardous materials (including paint or other household products.)
3. Grantor shall leave the property in the same condition, as it was when this contract was signed. No work, improvement, or alteration will be done to the property other than what is provided for in this agreement. Grantor agrees to maintain the property until the Department takes possession.
4. Grantor agrees to pay any and all taxes assessed against this property to the date of closing.
5. The Department shall pay the Grantor and or other parties of interest for the real property in the deed(s) and/or easement(s) referenced above.
6. "Transportation Purposes" is defined as follows: The public use for which the property or property right is being acquired herein, may include but is not limited to the following possible uses: the construction and improvement of a highway, which may include interchanges, entry and exit ramps, frontage roads, bridges, overpasses, rest areas, buildings, signs and traffic control devices, placement of utilities, clear zones, maintenance facilities, detention or retention ponds, environmental mitigation, maintenance stations, material storage, bio fuel production, slope protections, drainage appurtenance, noise abatement, landscaping, transit, project caused statutory relocations, and other related transportation uses.
7. The Grantor(s) is aware that Utah Code Ann. Sect. 78B-6-520.3 provides that in certain circumstances, the seller of property which is being acquired for a particular public use, is entitled to receive an offer to repurchase the property at the same price that the seller received, before the property can be put to a different use. Grantor(s) waives any right grantor may have to repurchase the property being acquired herein, and waives any rights Grantor(s) may have under Utah Code Ann. Sect. 78B-6-520.3.
8. Grantor shall indemnify and hold harmless Grantee from and against any and all claims, demands and actions, including costs, from lien holders or lessees of the property.
9. Upon execution of this contract by the parties, Grantor grants the Department, its contractors, permittees, and assigns, including but not limited to, utilities and their contractors, the right to immediately occupy and commence construction or other necessary activity on the property acquired for the state transportation project.

Additional Terms:

CONFIRMATION OF AGENCY DISCLOSURE. Buyer and Seller acknowledge prior written receipt of agency disclosure provided by their respective agent that has disclosed the agency relationships confirmed below. At the signing of the Purchase Contract;

Buyer's Agent Wendy Hansen, represents purchaser.
Buyer's Brokerage WC Consulting, LLC, represents purchaser.

Total Selling Price $371,761.00

Utah Department of Transportation
Right of Way Contract
Fee Simple Acquisition - Strip

Project No: S-R299(261) Parcel No.(s): 215:C, 215:E

Pin No: 15670 Job/Proj No: 72717 Project Location: Porter Rockwell (Bridge)
County of Property: SALT LAKE Tax ID / Sidwell No: 33-22-200-021, 33-15-400-022, 33-15-400-031, 33-15-400-035
Property Address: 15702 South Pony Express Road BLUFFDALE UT, 84066
Owner's Address: 669 W 200 S,Salt Lake City,UT,84101
Primary Phone: 801-237-1995 Owner's Home Phone: Owner's Work Phone: (801)237-1995
Owner / Grantor (s): Utah Transit Authority, "a public transit district organized pursuant to Title 17A, Chapter 2, Part10, Utah Code Annotated 1953 as amended"
Grantee: Utah Department of Transportation (UDOT)/The Department

Grantor's Initials

Grantor understands this agreement is an option until approved by the Director of Right of Way.
Grantors acknowledge and accept the percent of ownership listed below and agree that the portion of the total selling price they each receive, will correspond with their respective percent of ownership.
This Contract may be signed in counterparts by use of counterpart signature pages, and each counterpart signature page shall constitute a part of this Contract as if all Grantors signed on the same page.

	Percent		**Date**
_____	100%	_____ Utah Transit Authority	_____
_____	100%	_____ Utah Transit Authority	_____

Right of Way Agents

_____ Wendy Hansen (Consultant) / Acquisition Agent _____

_____ Krissy Plett / Team Leader _____

_____ Approved by Director of Right of Way _____

WHEN RECORDED, MAIL TO:
Utah Department of Transportation
Right of Way, Fourth Floor
Box 148420
Salt Lake City, Utah 84114-8420

Quit Claim Deed

(CORPORATION)
Salt Lake County

Tax ID No. 33-15-400-029
33-15-400-031
33-15-400-035
33-22-200-021
PIN No. 15670
Project No. S-R299(261)
Parcel No.R299:215

Utah Transit Authority, a public transit district organized pursuant to Title 17A, Chapter 2, Part10, Utah Code Annotated 1953 as amended, Grantor, hereby QUIT CLAIMS to the UTAH DEPARTMENT OF TRANSPORTATION, Grantee, at 4501 South 2700 West, Salt Lake City, Utah 84114, for the sum of TEN ($10.00), Dollars, and other good and valuable considerations, the following described parcel of land in Salt Lake County, State of Utah, to-wit:

A parcel of land in fee, being part of an entire tract of property situate in Government Lot 1 of Section 22 and Lot 8 of Section 15, Township 4 South, Range 1 West, Salt Lake Base and Meridian, incident to the construction of Porter Rockwell Boulevard known as Project No S-R299(261). The boundaries of said parcel of land are described as follows:

Beginning in the westerly boundary line of said entire tract at a point 114.50 feet perpendicularly distant northerly from the right of way control line of said Project, opposite approximate Engineers Station 129+34.59; which point is 1737.51 feet S.89°43'00"E. along the Section line and 8.91 feet North from the North Quarter Corner of said section 22; and running thence N.74°27'23"E. 68.54 feet parallel with said right of way control line to a point in the easterly boundary line of said entire tract at a point 114.50 feet perpendicularly distant northerly from the right of way control line of said Project, opposite approximate Engineers Station 130+03.13; thence S.7°20'27"W. 243.14 feet along said easterly boundary line to a point 109.50 feet perpendicularly distant southerly from the right of way control line of said Project, opposite approximate Engineers Station 129+08.58; thence S.74°27'23"W. 66.54 feet parallel with said right of way control line to a point in the westerly

Continued on Page 2

PIN No. 15670
Project No. S-R299(261)
Parcel No.R299:215

boundary line of said entire tract at a point 109.50 feet perpendicularly distant southerly from the right of way control line of said Project, opposite approximate Engineers Station 128+42.04; thence N.6°54'14"E. 242.37 feet along said westerly boundary line to the point of beginning as shown on the official map of said project on file in the office of the Utah Department of Transportation..

The above described part of an entire tract contains 15,129 square feet in area or 0.347 acres.

Basis of Bearing is S.89°43'00"E between the North Quarter Corner and Northeast Corner of Section 22 T4.S, R1.W, SLB&M

Continued on Page 3

PIN No. 15670
Project No. S-R299(261)
Parcel No.R299:215

UTAH TRANSIT AUTHORITY

BY:_____
Paul Drake Senior Manager Real Estate & TOD

BY:_____
Spencer Burgoyne Manager Property Administration

APPROVED AS TO FORM:

BY:_____
UTA Legal Counsel UTAH TRANSIT AUTHORITY

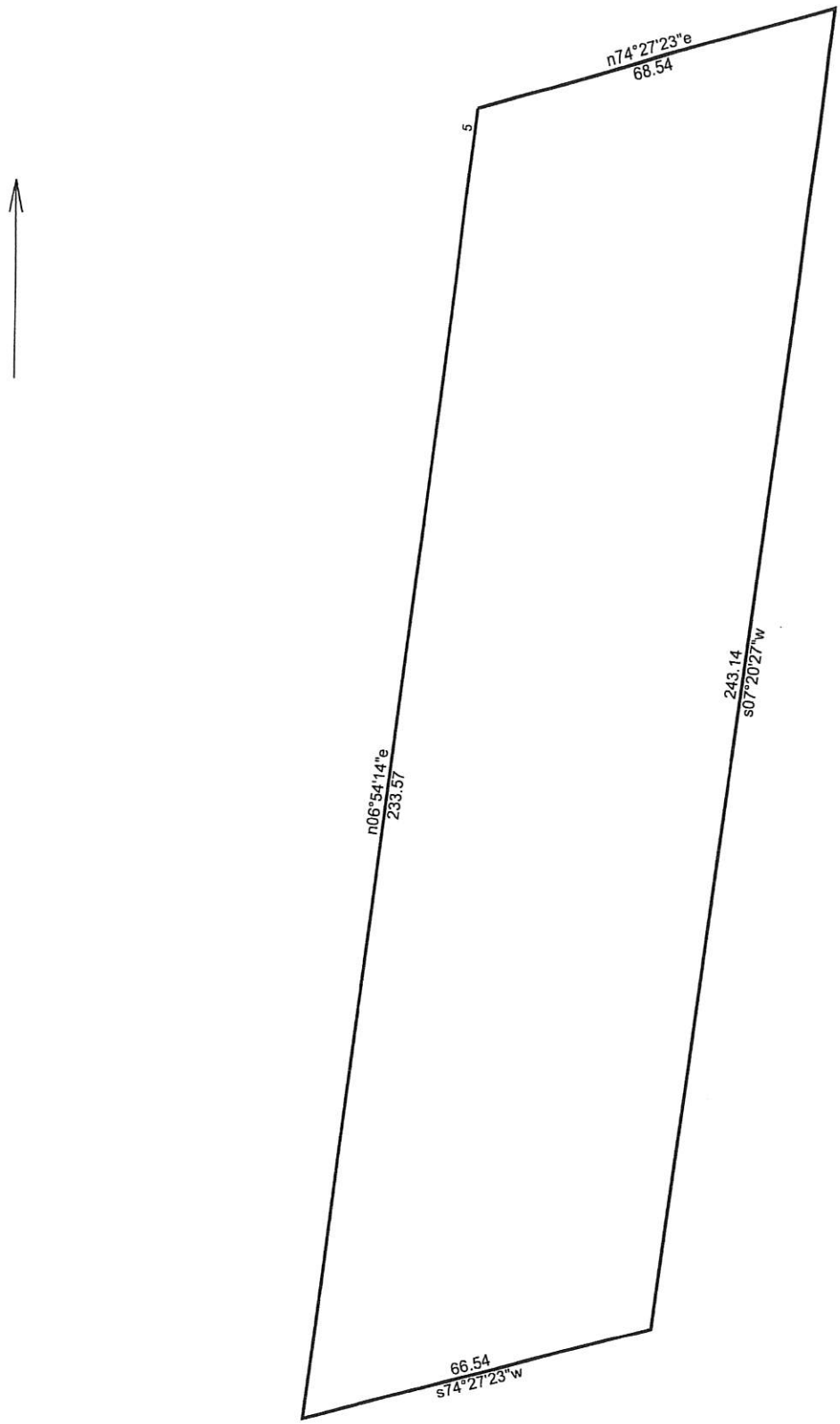
IN WITNESS WHEREOF, said Utah Transit Authority has caused this instrument to be executed by its proper officers thereunto duly authorized, this _____ day of_____, A.D. 20 ____.

STATE OF UTAH)
) ss.
COUNTY OF)

On the _____ of _____, 20_____ personally appeared before me_____ Paul Drake, the Senior Manager Real Estate & TOD and Spencer Burgoyne, Manager, Property Administration for Utah Transit Authority, the signer(s) of the within and foregoing instrument, who duly acknowledged to me that he/they executed the same.

WITNESS my hand and official stamp the date in this certificate first above written:

_____
Notary Public



15670_S-R299(261)_03P_215_DeedPlot	10/25/2019
Scale: 1 inch= 30 feet	File: 15670_S-R299(261)_03P_215_DeedPlot.ndp

Tract 1: 0.3473 Acres (15129 Sq. Feet), Closure: s75.4238e 0.01 ft. (1/107256), Perimeter=621 ft.

01 n74.2723e 68.54
02 s07.2027w 243.14
03 s74.2723w 66.54
04 n06.5414e 233.57
05 n06.5414e 8.8

WHEN RECORDED, MAIL TO:
Utah Department of Transportation
Right of Way, Fourth Floor
Box 148420
Salt Lake City, Utah 84114-8420

Easement

(CORPORATION)

Salt Lake County

Tax ID No. 33-15-400-029
33-15-400-031
33-15-400-035
33-22-200-021
PIN No. 15670
Project No. S-R299(261)
Parcel No. R299:215:E

Utah Transit Authority , a large public transit district also known as Transit District of the State of Utah, Grantor, hereby GRANTS AND CONVEYS to the Utah Department Of Transportation, and The East Jordan Irrigation Company, Grantees, for the sum of TEN ($10.00), Dollars, and other good and valuable considerations, the following described easement in Salt Lake County, State of Utah, to-wit:

A Perpetual non-exclusive cross access easement for ingress and egress upon part of an entire tract of property situate in the Lot 8 of Section 15, Township 4 South, Range 1 West, Salt Lake Base and Meridian, Salt Lake County, Utah. This easement shall run with the real property and shall be binding upon the Grantor, successors, heirs and assigns. The boundaries of said perpetual easement are described as follows:

Beginning in the northerly highway right of way line of said Porter Rockwell Blvd, at a point 114.50 feet perpendicularly distant northerly from the right of way control line of said Project, opposite approximate Engineers Station 129+34.59; which point is 1737.51 feet S.89°43'00"E. along the Section line and 8.91 feet North from the South Quarter Corner of said Section 15; and running thence the following (5) courses and distances along the westerly boundary line of said entire tract: (1) N.6°54'14"E. 397.88 feet to a point 478.17 feet radially distant northerly from the right of way control line of said Project, opposite approximate Engineers Station 131+37.45; (2) thence N.82°19'03"W. 44.64 feet to a point

Continued on Page 2

PIN No. 15670
Project No. S-R299(261)
Parcel No. R299:215:E

UTAH TRANSIT AUTHORITY

BY:_____
Paul Drake Senior Manager Real Estate & TOD

BY:_____
Spencer Burgoyne Manager Property Administration

APPROVED AS TO FORM:

BY:_____
UTA Legal Counsel UTAH TRANSIT AUTHORITY

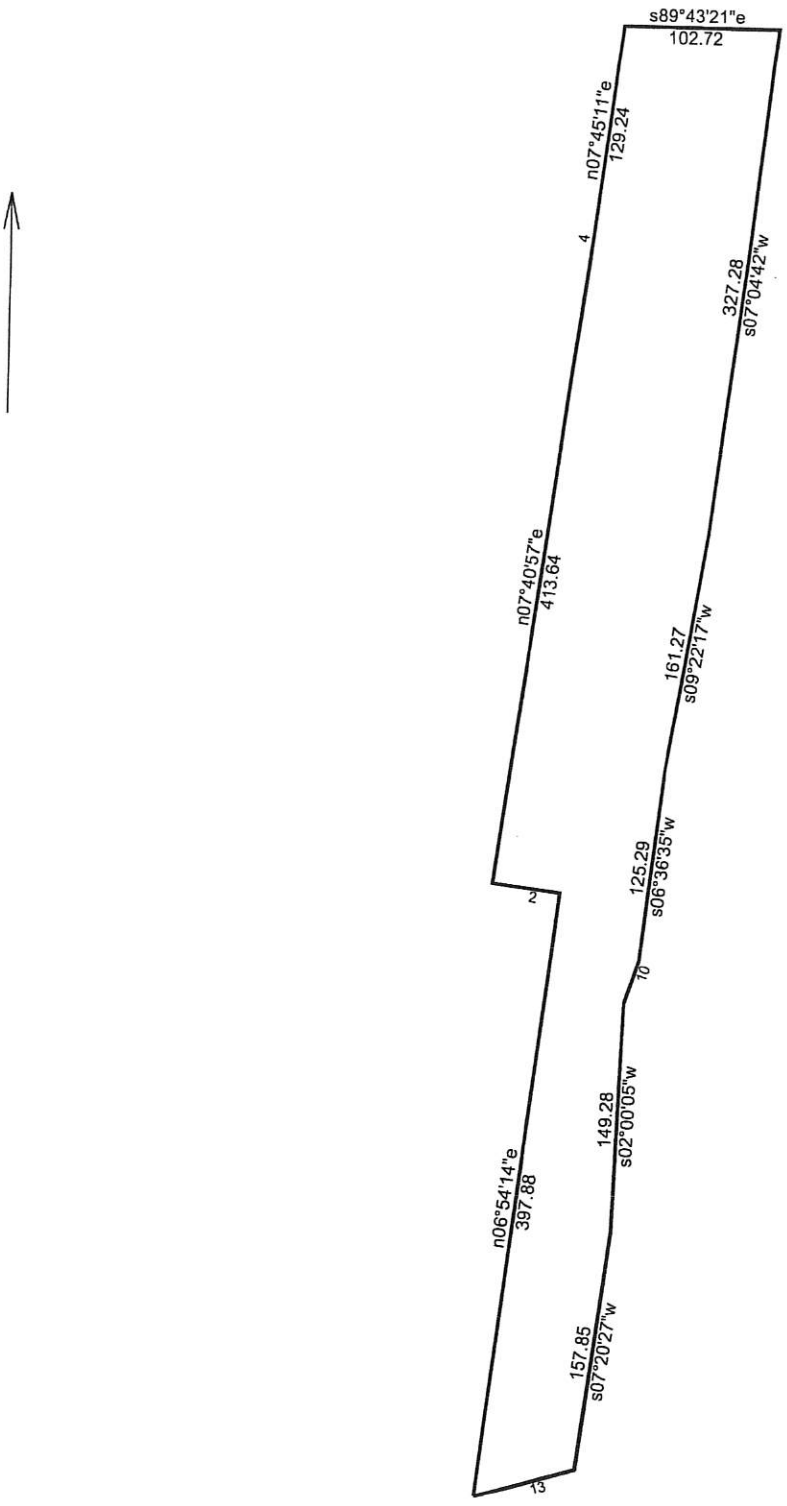
IN WITNESS WHEREOF, said Utah Transit Authority has caused this instrument to be executed by its proper officers thereunto duly authorized, this _____ day of_____, A.D. 20 ____.

STATE OF UTAH)
) ss.
COUNTY OF)

On the _____ of _____, 20_____ personally appeared before me_____ Paul Drake, the Senior Manager Real Estate & TOD and Spencer Burgoyne, Manager, Property Administration for Utah Transit Authority, the signer(s) of the within and foregoing instrument, who duly acknowledged to me that he/they executed the same.

WITNESS my hand and official stamp the date in this certificate first above written:

_____
Notary Public



15670_S-R299(261)_03P_215_E_DeedPlot

10/25/2019

Scale: 1 inch= 120 feet | File: 15670_S-R299(261)_03P_215_E_DeedPlot.ndp

Tract 1: 1.8881 Acres (82248 Sq. Feet), Closure: s59.0015w 0.01 ft. (1/194089), Perimeter=2129 ft.

01 n06.5414e 397.88
02 n82.1903w 44.64
03 n07.4057e 413.64
04 n07.4358e 22.15
05 n07.4511e 129.24
06 s89.4321e 102.72
07 s07.0442w 327.28
08 s09.2217w 161.27
09 s06.3635w 125.29
10 s18.5631w 29.52
11 s02.0005w 149.28
12 s07.2027w 157.85
13 s74.2723w 68.54

WHEN RECORDED, MAIL TO:
Utah Department of Transportation
Right of Way, Fourth Floor
Box 148420
Salt Lake City, Utah 84114-8420

Quit Claim Deed

(CORPORATION)
Salt Lake County

Tax ID No. 33-15-400-029
33-15-400-031
33-15-400-035
33-22-200-021
PIN No. 15670
Project No. S-R299(261)
Parcel No.R299:215:C

Utah Transit Authority , a public transit district of the State of Utah, Grantor, hereby QUIT CLAIMS to the Salt Lake City Corporation, Grantee, at PO Box 145460, Salt Lake City, Utah 84114, for the sum of TEN ($10.00) Dollars, and other good and valuable considerations, the following described parcel of land in Salt Lake County, State of Utah, to-wit:

A parcel of land in fee, being part of an entire tract of property situate in Government Lot 8 of Section 15, Township 4 South, Range 1 West, Salt Lake Base and Meridian, incident to the construction of Porter Rockwell Boulevard known as Project No S-R299(261). The boundaries of said parcel of land are described as follows:

Beginning in the northerly highway right of way line of said Porter Rockwell Blvd, at a point 114.50 feet perpendicularly distant northerly from the right of way control line of said Project, opposite approximate Engineers Station 129+34.59; which point is 1737.51 feet S.89°43'00"E. along the Section line and 8.91 feet North from the South Quarter Corner of said Section 15; and running thence the following (5) courses and distances along the westerly boundary line of said entire tract: (1) N.6°54'14"E. 397.88 feet to a point 478.17 feet radially distant northerly from the right of way control line of said Project, opposite approximate Engineers Station 131+37.45; (2) thence N.82°19'03"W. 44.64 feet to a point 498.94 feet radially distant northerly from the right of way control line of said Project, opposite approximate Engineers Station 130+70.79; (3) thence N.7°40'57"E. 413.64 feet; (4) thence N.7°43'58"E. 22.15 feet; (5) thence N.7°45'11"E. 129.24 feet to a point 894.90

Continued on Page 2

PIN No. 15670
Project No. S-R299(261)
Parcel No.R299:215:C

feet radially distant northerly from the right of way control line of said Project, opposite approximate Engineers Station 139+32.65; thence S.89°43'21"E. 102.72 feet to a point in the easterly boundary line of said entre tract at a point 809.72 feet radially distant northerly from the right of way control line of said Project, opposite approximate Engineers Station 139+90.04; thence the following six (6) courses and distances along said westerly boundary line (1) S.7°04'42"W. 327.28 feet; (2) thence S.9°22'17"W. 161.27 feet; (3) thence S.6°36'35"W. 125.29 feet; (4) thence S.18°56'31"W. 29.52 feet; (5) thence S.2°00'05"W. 149.28 feet; (6) thence S.7°20'27"W. 157.85 feet to a point in the northerly highway right of way line of said Porter Rockwell Blvd at a point 114.50 feet perpendicularly distant northerly from the right of way control line of said Project, opposite approximate Engineers Station 130+03.13; thence S.74°27'23"W. 68.54 feet along said northerly highway right of way line to the point of beginning as shown on the official map of said project on file in the office of the Utah Department of Transportation.

The above described parcel of land contains 82,248 square feet in area or 1.888 acres.

Basis of Bearing is S.89°43'00"E between the North Quarter Corner and Northeast Corner of Section 22 T4.S, R1.W, SLB&M

Reserving unto the Grantor: a Perpetual non-exclusive cross access easement for ingress and egress upon the above described parcel of land.

Continued on Page 3

PIN No. 15670
Project No. S-R299(261)
Parcel No.R299:215:C

UTAH TRANSIT AUTHORITY

BY:_____
Paul Drake Senior Manager Real Estate & TOD

BY:_____
Spencer Burgoyne Manager Property Administration

APPROVED AS TO FORM:

BY:_____
UTA Legal Counsel UTAH TRANSIT AUTHORITY

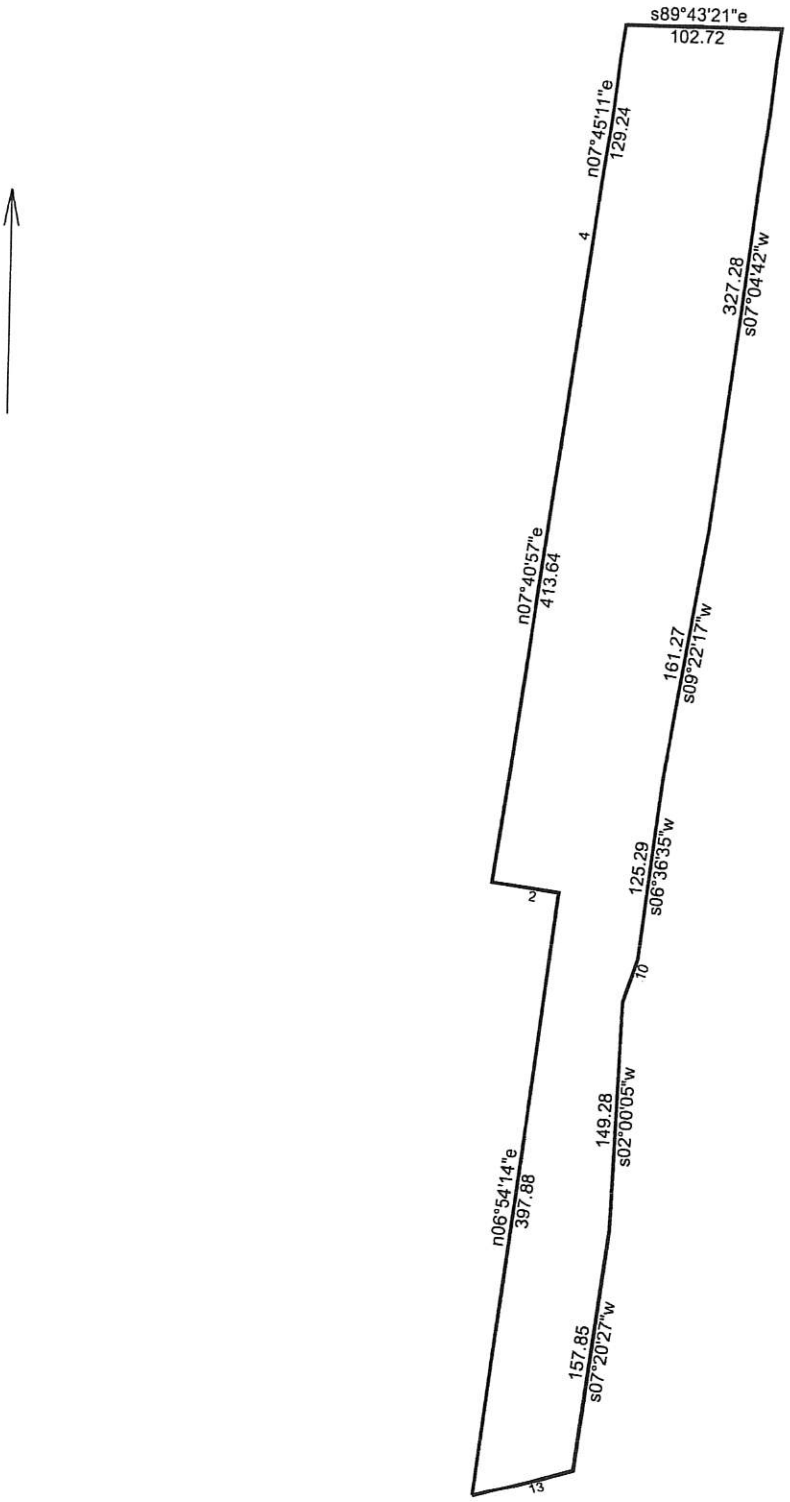
IN WITNESS WHEREOF, said Utah Transit Authority has caused this instrument to be executed by its proper officers thereunto duly authorized, this _____ day of_____, A.D. 20 ____.

STATE OF UTAH)
) ss.
COUNTY OF)

On the _____ of _____, 20_____ personally appeared before me_____ Paul Drake, the Senior Manager Real Estate & TOD and Spencer Burgoyne, Manager, Property Administration for Utah Transit Authority, the signer(s) of the within and foregoing instrument, who duly acknowledged to me that he/they executed the same.

WITNESS my hand and official stamp the date in this certificate first above written:

_____
Notary Public



15670_S-R299(261)_03P_215_C_DeedPlot

10/23/2019

Scale: 1 inch= 120 feet

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Tract 1: 1.8881 Acres (82248 Sq. Feet), Closure: s59.0015w 0.01 ft. (1/194089), Perimeter=2129 ft.

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02 n82.1903w 44.64
03 n07.4057e 413.64
04 n07.4358e 22.15
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06 s89.4321e 102.72
07 s07.0442w 327.28
08 s09.2217w 161.27
09 s06.3635w 125.29
10 s18.5631w 29.52
11 s02.0005w 149.28
12 s07.2027w 157.85
13 s74.2723w 68.54

Exhibit "C"

PARCEL 214:X

UTA AERIAL
EASEMENT

PARCEL 215

PARTIAL
ACQUISITION

FIRST
PARCEL 215:E

UTA WILL GRANT AN ACCESS EASEMENT TO UDOT AND EAST JORDAN CANAL

SECOND
PARCEL 215:C

PARTIAL ACQUISITION FOR SLCPU, UTA WILL RETAIN ACCESS EASEMENT

PIN 15670 - UTA (DRAFT)

MEMORANDUM TO THE BOARD

TO: Utah Transit Authority Board of Trustees
THROUGH: Carolyn Gonot, Executive Director
FROM: Robert Biles, Chief Financial Officer
PRESENTER(S): Monica Morton, Fares Director

BOARD MEETING DATE: May 6, 2020

SUBJECT:	**Ogden Twilight Concert Series Tickets for Transit Agreements (Ogden City)**
AGENDA ITEM TYPE:	Fare Approval
RECOMMENDATION:	Approve and authorize the Executive Director to execute a contract with Ogden City for the Special Events Pass Agreement in the amount of $23,405.
BACKGROUND:	UTA has contracted in the past for a Tickets for Transit program whereby ticket holders can use their event ticket to ride UTA services to the event. Both Ogden City and Salt Lake City plan to participate in the program for their Twilight Concert series. Twilight Concert Series ticket holders can use their event ticket to ride UTA services to the concert on the date printed on the ticket. Valid services include Bus, TRAX, Frontrunner, Streetcar, and BRT. Passes are not valid as fare on Park City, Ski and Paratransit Services.
DISCUSSION:	Staff recommends continuing to partner with Ogden City to offer the Special Events Pass Agreement for their respective Twilight Concert Series as described below. In 2020, Ogden City will host 10 shows at the Ed Kennley Amphitheatre in Ogden. The show dates start in July and end in September. This specific program has been in place since June 2015. Prior to 2020, the Event contract was priced at $0.50 per ticket sold. Ogden provided UTA with total ticket sales for the concert series, and UTA invoiced Ogden City for the tickets sold at the rate of $0.50. The pricing for the 2020 concert series will be a flat contract rate of $23,405. To calculate the pricing for this contract, 2019 FrontRunner APC data on the dates of the concerts was analyzed as well as zip code data obtained from ticket sales. Actual usage was estimated, then a discount of 30% was applied.
CONTRACT SUMMARY:	Contractor Name: Ogden City

	Contract Number: 19 F0037-2	Existing Contract Value: Ogden City:
	Base Contract Effective Dates: Ogden City: June 1, 2020-October 1, 2020	Extended Contract Dates: NA
	Amendment Amount: NA	New/Total Amount Contract Value: $23,405
	Procurement Method: NA	Funding Sources: NA
ALTERNATIVES:	Eliminate the ticket-as-fare offering, foregoing any anticipated revenue and ridership	
FISCAL IMPACT:	It is estimated that the contract revenue will be $23,405 total	
ATTACHMENTS:	• Ogden City Contract	

TICKETS FOR TRANSIT AGREEMENT
Ogden City Twilight Concert Series

This Tickets for Transit Agreement ("Agreement") is entered into on this _____, 2020, by and between Ogden City, a Utah municipal corporation, located in Ogden City, Utah ("City"), and Utah Transit Authority, a public transit district organized under the laws of the State of Utah ("UTA"). City and UTA hereafter collectively referred to as the "parties" and either of the foregoing may be individually referred to as "party," all as governed by the context in which such words are used.

RECITALS

WHEREAS, City sponsors a Twilight Concert Series on a weekly basis from June 13, 2020 through September 25, 2020.

WHEREAS, City desires to purchase transit passes for transportation to its Twilight Concert Series using UTA's transit system.

WHEREAS, the parties desire to establish a program whereby City is authorized to purchase transit passes for those attending its Twilight Concert Series.

AGREEMENT

NOW THEREFORE, on the stated Recitals, which are incorporated herein by reference, and for and in consideration of the mutual covenants herein and in the Agreements and in the Agreement, the mutual benefits to the parties to be derived here from, and for other valuable consideration, the receipt and sufficiency of which the parties acknowledge, it is hereby agreed as follows:

1. Tickets for Transit Program. The Parties agree to establish a Tickets for Transit Program, whereby the City purchases transit passes for ticket holders to its Twilight Concert Series (the "Tickets for Transit Pass").

2. Authorized Users. Upon the terms and conditions contained herein, UTA agrees to allow City to provide a Tickets for Transit Pass to Twilight Concert Series ticket holders ("Authorized Users") attending concerts at the Ogden Amphitheater on the following dates in 2020: June 13; July 7; July 17; July 28; August 12; August 22; August 26; September 12; September 21; and September 25. Concert dates are subject to change due to Covid 19 Health Concerns and Regulations. City agrees to give UTA a (2) week notice prior to a concert date being changed.

3. Price. City shall pay UTA the flat rate of $23,405 for shows held on the dates shown in Paragraph 2 above provided cumulative ticket sales reach or exceed 46,000 tickets. If ticket sales do not reach or exceed 46,000 tickets, Ogden will provide UTA with total ticket sales per show, whereupon City and UTA reduce the rate in proportion to the original amount of $23,405.

4. Pass Recognized as Fare Payment. An Authorized User's ticket to a Twilight Concert shall serve as a Tickets for Transit Pass when: (1)Printed with the UTA logo, attached hereto as Exhibit "A" (the UTA Logo) and/or printed with the wording "Valid as UTA fare on the date indicated" or similar wording approved by UTA and (2) used for fare payment on the date of the concert stated on the ticket. The Tickets for Transit Pass shall be recognized by UTA as fare payment on all Local Bus Routes, TRAX Light Rail Routes, Streetcar Light Rail, FrontRunner Commuter Rail Routes and BRT Routes on the day of the concert. The Special Event Transit Pass shall not be recognized as fare payment on Paratransit Service, Park City-Salt Lake City Connect Service, or any other special service.

5. Payment. UTA shall invoice City for the amount owed as described in Paragraph 3. City shall pay the invoiced amount within seven days of its receipt of the invoice. City shall pay a one percent (1%) late fee on balances due under this Agreement which remain unpaid within thirty (30) days from the due date indicated on the invoice.

6. Use of the UTA Logo

   a. The UTA Logo, which is attached hereto as Exhibit A, is the sole and exclusive property of UTA. UTA hereby grants City, so long as it is not in breach of this Agreement or a limited and revocable license to use or print the UTA logo as specified herein. The interpretation and enforcement (or lack thereof) of these terms and conditions, and compliance therewith, shall be in UTA's sole discretion. The UTA Logo may not be altered in any way and must be displayed in the same form as produced by UTA. The UTA Logo must be printed in either black or in the official color of blue and red.

   b. The UTA Logo shall be used in a professional manner on all Twilight Concert Series tickets; on the Twilight Concert Series main entrance, VIP area, stage banners, website, and posters; and in print advertising for the Series.

   c. Notwithstanding the foregoing, the UTA Logo may not be used in any manner that, in the sole discretion of UTA: discredits UTA or tarnishes its reputation and goodwill; is false or misleading; violates the rights of others, violates any law, regulation or other public policy; or mischaracterizes the relationship between UTA and the user, including but not limited to any use of the UTA Logo that might be reasonably construed as an endorsement, approval, sponsorship or certification by UTA of City, City's business or organization, or City's products or services or that might be reasonably construed as support or encouragement to purchase or utilize City's products or services.

   d. Use of the UTA Logo shall create no rights for City in or to the UTA Logo or their use beyond the terms and conditions of this limited and revocable license. The UTA Logo shall remain at all times the sole and exclusive intellectual property of UTA. UTA shall have the right, from time to time, to request samples of use of the UTA Logo from which it may determine compliance with these terms and conditions. Without further notice, UTA reserves the right to prohibit use of the UTA Logo if it determines, in its sole discretion, that City's UTA Logo usage, whether willful or negligent, is not in strict accordance with the terms and conditions of this license, otherwise could discredit UTA or tarnish its reputation and goodwill, or City is otherwise in breach of this Agreement.

7. Pass Distribution. City shall be solely responsible for issuing Tickets for Transit Passes to Authorized Users.

8. Public Transit Services. The Parties understand that the transit services being purchased under this Agreement are public transit services. As such, Authorized Users must comply with all UTA Rider Rules and rules governing the use of public transit services. Authorized Users must present their Tickets for Transit Passes as proof of fare payment to UTA bus operators and fare inspectors. Authorized Users who do not have possession of a Tickets for Transit Pass must pay the regular fare for the transit service they use. UTA reserves the right to modify its service and schedules as it deems appropriate in its sole discretion.

9. Indemnification. Each party hereby agrees to be responsible and assume liability for its own negligent or wrongful acts or omissions or those of its officers, agents or employees to the full extent required by law, and agrees to indemnify and hold the other party harmless from any such liability, damage, expense, cause of action, suit, claim, judgment, or other action arising from participation in this Agreement. Both parties are subject to the provisions of the Utah Governmental Immunity Act. Neither party waives any legal defenses or benefits available to them under applicable law, and both agree to cooperate in good faith in resolving any disputes that may arise under this Agreement.

10. Termination. This Agreement shall continue in full force and effect during the term of this Agreement unless it is terminated earlier by either party. Each party may terminate this Agreement in its sole discretion by giving the other party written notice of termination at least forty-five (45) days prior to the termination date. If UTA terminates this Agreement before the Twilight Concert Series ends, City shall pay a prorated amount for the concerts for which UTA actually provides transportation services. City may also terminate all or part of this agreement in the event the Covid-19 pandemic precludes performance of all or part of the concert series and pay UTA a pro-rated amount only for the shows actually performed.

11. Nondiscrimination. City agrees that it shall not exclude any individual from participation in or deny any individual the benefits of this Agreement, on the basis of race, color, national origin, creed, sex, or age in accordance with the requirements of 49 U.S.C. §5332.

12. Third Party Interests. No person not a party to this Agreement shall have any rights or entitlements of any nature under it.

13. Entire Agreement. This Agreement contains the entire agreement between the parties hereto for the term stated and cannot be modified except by written agreement signed by both parties. Neither party shall be bound by any oral agreements or special arrangements contrary to or in addition to the terms and conditions as stated herein.

14. Costs and Attorney's Fees. If either party pursues legal action to enforce any covenant of this Agreement, the parties agree that all costs and expenses of the prevailing party incident to such legal action, including reasonable attorney fees and court costs shall be paid by the non-prevailing party.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first set forth herein.

OGDEN CITY

By: _____Date:_____

Name:_____

Title:_____

UTAH TRANSIT AUTHORITY

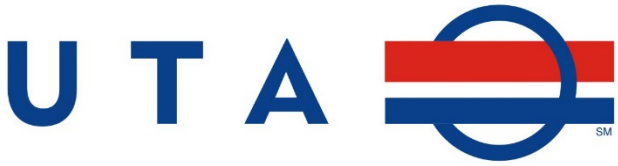
By: _____Date:_____
Monica Morton
Fares Director

By: _____Date:_____
Kensey Kunkel
Mgr. Business Development and Sales

Approved as to Form:

By: _____Date:_____
Michael Bell
Assistant Attorney General
Counsel for UTA

Exhibit "A"
UTA Logo



MEMORANDUM TO THE BOARD

TO: Utah Transit Authority Board of Trustees
THROUGH: Carolyn Gonot, Executive Director
FROM: Robert Biles, Chief Financial Officer
PRESENTER(S): Monica Morton, Fares Director

BOARD MEETING DATE: May 6, 2020

SUBJECT:	**Salt Lake Twilight Concert Series Tickets for Transit Agreement (S&S Presents)**	
AGENDA ITEM TYPE:	Fare Approval	
RECOMMENDATION:	Approve and authorize the Executive Director to execute a contract with S&S Presents for the Special Events Pass Agreement in the amount of $7,185.	
BACKGROUND:	UTA has contracted in the past for a Tickets for Transit program whereby ticket holders can use their event ticket to ride UTA services to the event. S&S Presents plans to participate in the program for their Salt Lake City Twilight Concert series. Salt Lake City Twilight Concert Series ticket holders can use their event ticket to ride UTA services to the concert on the date printed on the ticket. Valid services include Bus, TRAX, Frontrunner, Streetcar, and BRT. Passes are not valid as fare on Park City, Ski and Paratransit Services.	
DISCUSSION:	Staff recommends partnering with S&S Presents to offer the Special Events Pass Agreement for their Twilight Concert Series as described below. In 2020, S&S Presents will host 5 shows at the Gallivan Center in Salt Lake. The show dates start in July and end in August. UTA has not contracted with S&S Presents to offer ticket as fare prior to this year. The pricing for the 2020 concert series will be a flat contract rate of $7,185. To calculate the pricing for this contract, 2019 TRAX APC data on the dates of the concerts was analyzed as well as zip code data obtained from ticket sales. Actual usage was estimated, then a discount of 20% was applied. This discount rate is lower due to a smaller ticket volume purchase.	
CONTRACT SUMMARY:	Contractor Name: S&S Presents	
	Contract Number: 20-F0098	Existing Contract Value: NA

	Base Contract Effective Dates: Salt Lake City: July 1, 2020- September 1, 2020	Extended Contract Dates: NA
	Amendment Amount: NA	New/Total Amount Contract Value: $7,185
	Procurement Method: NA	Funding Sources: NA
ALTERNATIVES:	Eliminate the ticket-as-fare offering, foregoing any anticipated revenue and ridership	
FISCAL IMPACT:	It is estimated that the contract revenue will be $7,185	
ATTACHMENTS:	• S&S Presents Contract	

TICKETS FOR TRANSIT AGREEMENT
Salt Lake City Twilight Concert Series

This Tickets for Transit Agreement ("Agreement") is entered into on this _____, 2020, by and between S&S Presents, located in Salt Lake City, Utah ("S&S"), and Utah Transit Authority, a public transit district organized under the laws of the State of Utah ("UTA"). City and UTA hereafter collectively referred to as the "parties" and either of the foregoing may be individually referred to as "party," all as governed by the context in which such words are used.

RECITALS

WHEREAS, S&S sponsors a Twilight Concert Series on a weekly basis from July 30, 2020 through August 27, 2020.

WHEREAS, S&S desires to purchase transit passes for transportation to its Twilight Concert Series using UTA's transit system.

WHEREAS, the parties desire to establish a program whereby S&S is authorized to purchase transit passes for those attending its Twilight Concert Series.

AGREEMENT

NOW THEREFORE, on the stated Recitals, which are incorporated herein by reference, and for and in consideration of the mutual covenants herein and in the Agreements and in the Agreement, the mutual benefits to the parties to be derived here from, and for other valuable consideration, the receipt and sufficiency of which the parties acknowledge, it is hereby agreed as follows:

1. Tickets for Transit Program. The Parties agree to establish a Tickets for Transit Program, whereby the S&S purchases transit passes for ticket holders to its Twilight Concert Series (the "Tickets for Transit Pass").

2. Authorized Users. Upon the terms and conditions contained herein, UTA agrees to allow S&S to provide a Tickets for Transit Pass to Twilight Concert Series ticket holders ("Authorized Users") attending concerts at the Gallivan Center Plaza on the following dates in 2020: July 30; August 6; August 13; August 20, and August 27. Concert dates are subject to change due to Covid 19 Health Concerns and Regulations. S&S agrees to give UTA a (2) week notice prior to a concert date being changed.

3. Price. S&S shall pay UTA the flat rate of $7,185 for shows held on the dates shown in Paragraph 2 above provided cumulative ticket sales reach or exceed 23,000 tickets. If ticket sales do not reach or exceed 23,000 tickets, S&S will provide UTA with total ticket sales per show, whereupon S&S and UTA shall negotiate a mutually agreeable rate proportional to the original amount of $7,185.

4. Pass Recognized as Fare Payment. An Authorized User's ticket to a Twilight Concert shall serve as a Ticket for Transit Pass when: (1) printed with the UTA logo, attached hereto as Exhibit "A" (the "UTA Logo") and/or printed with the wording "Valid as UTA fare on the

date indicated" or similar wording approved by UTA, and (2) used for fare payment on the date of the concert stated on the ticket. The Ticket for Transit Pass shall be recognized by UTA as fare payment on all Local Bus Routes, TRAX Light Rail Routes, Streetcar Light Rail, FrontRunner Commuter Rail Routes and BRT Routes on the day of the concert. The Tickets for Transit Pass shall not be recognized as fare payment on Paratransit Service, Park City-Salt Lake City Connect Service, or any other special service.

5. Payment. UTA shall invoice S&S for the amount owed as described in Paragraph 3. S&S shall pay the invoiced amount by July 1, 2020. S&S shall pay a one percent (1%) late fee on balances due under this Agreement which remain unpaid within thirty (30) days from the due date indicated on the invoice.

6. Use of the UTA Logo

   a. The UTA Logo, which is attached hereto as Exhibit A, is the sole and exclusive property of UTA. UTA hereby grants S&S, so long as it is not in breach of this Agreement or a limited and revocable license to use or print the UTA logo as specified herein. The interpretation and enforcement (or lack thereof) of these terms and conditions, and compliance therewith, shall be in UTA's sole discretion. The UTA Logo may not be altered in any way and must be displayed in the same form as produced by UTA. The UTA Logo must be printed in either black or in the official color of blue and red.

   b. The UTA Logo shall be used in a professional manner on all Twilight Concert Series tickets; on the Twilight Concert Series main entrance, VIP area, stage banners, website, and posters; and in print advertising for the Series.

   c. Notwithstanding the foregoing, the UTA Logo may not be used in any manner that, in the sole discretion of UTA: discredits UTA or tarnishes its reputation and goodwill; is false or misleading; violates the rights of others, violates any law, regulation or other public policy; or mischaracterizes the relationship between UTA and the user, including but not limited to any use of the UTA Logo that might be reasonably construed as an endorsement, approval, sponsorship or certification by UTA of S&S, S&S's business or organization, or S&S's products or services or that might be reasonably construed as support or encouragement to purchase or utilize S&S's products or services.

   d. Use of the UTA Logo shall create no rights for City in or to the UTA Logo or their use beyond the terms and conditions of this limited and revocable license. The UTA Logo shall remain at all times the sole and exclusive intellectual property of UTA. UTA shall have the right, from time to time, to request samples of use of the UTA Logo from which it may determine compliance with these terms and conditions. Without further notice, UTA reserves the right to prohibit use of the UTA Logo if it determines, in its sole discretion, that City's UTA Logo usage, whether willful or negligent, is not in strict accordance with the terms and conditions of this license, otherwise could discredit UTA or tarnish its reputation and goodwill, or City is otherwise in breach of this Agreement.

7. Pass Distribution. City shall be solely responsible for issuing Ticket for Transit Passes to Authorized Users.

8. Public Transit Services. The Parties understand that the transit services being purchased under this Agreement are public transit services. As such, Authorized Users must comply with all UTA Rider Rules and rules governing the use of public transit services. Authorized Users must present their Ticket for Transit Passes as proof of fare payment to UTA bus operators and fare inspectors. Authorized Users who do not have possession of a Ticket for Transit Pass must pay the regular fare for the transit service they use. UTA reserves the right to modify its service and schedules as it deems appropriate in its sole discretion.

9. Indemnification. Each party hereby agrees to be responsible and assume liability for its own negligent or wrongful acts or omissions or those of its officers, agents or employees to the full extent required by law, and agrees to indemnify and hold the other party harmless from any such liability, damage, expense, cause of action, suit, claim, judgment, or other action arising from participation in this Agreement. Both parties are subject to the provisions of the Utah Governmental Immunity Act. Neither party waives any legal defenses or benefits available to them under applicable law, and both agree to cooperate in good faith in resolving any disputes that may arise under this Agreement.

10. Termination. This Agreement shall continue in full force and effect during the term of this Agreement unless it is terminated earlier by either party. Each party may terminate this Agreement in its sole discretion by giving the other party written notice of termination at least forty-five (45) days prior to the termination date. If UTA terminates this Agreement before the Twilight Concert Series ends, City shall pay a prorated amount for the concerts for which UTA actually provides transportation services. City may also terminate all or part of this agreement in the event the Covid-19 pandemic precludes performance of the entire concert series and pay UTA a pro-rated amount only for the shows actually performed.

11. Nondiscrimination. City agrees that it shall not exclude any individual from participation in or deny any individual the benefits of this Agreement, on the basis of race, color, national origin, creed, sex, or age in accordance with the requirements of 49 U.S.C. §5332.

12. Third Party Interests. No person not a party to this Agreement shall have any rights or entitlements of any nature under it.

13. Entire Agreement. This Agreement contains the entire agreement between the parties hereto for the term stated and cannot be modified except by written agreement signed by both parties. Neither party shall be bound by any oral agreements or special arrangements contrary to or in addition to the terms and conditions as stated herein.

14. Costs and Attorney's Fees. If either party pursues legal action to enforce any covenant of this Agreement, the parties agree that all costs and expenses of the prevailing party incident to such legal action, including reasonable attorney fees and court costs shall be paid by the non-prevailing party.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first set forth herein.

S&S Presents

By: _____Date:_____

Name:_____

Title:_____

UTAH TRANSIT AUTHORITY

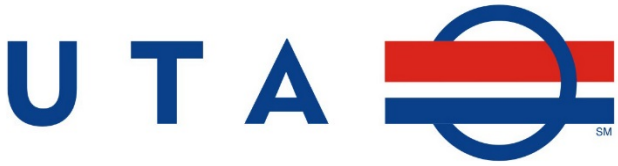
By: _____Date:_____
Monica Morton
Fares Director

By: _____Date:_____
Kensey Kunkel
Mgr. Business Development and Sales

Approved as to Form:

By: _____Date:_____
Michael Bell
Assistant Attorney General
Counsel for UTA

Exhibit "A"
UTA Logo



MEMORANDUM TO THE BOARD

TO: Utah Transit Authority Board of Trustees
THROUGH: Carolyn Gonot, Executive Director
FROM: Mary DeLoretto, Chief Service Development Officer
PRESENTER(S): Mary DeLoretto, Hal Johnson

BOARD MEETING DATE: May 6, 2020

SUBJECT:	**Memorandum of Understanding between Utah Transit Authority and Rocky Mountain Power**
AGENDA ITEM TYPE:	**Discussion**
RECOMMENDATION:	Informational item for discussion
BACKGROUND:	In 2016 Salt Lake City (SLC) and Rocky Mountain Power (RMP) signed a master agreement to guide future development of electrical infrastructure in SLC. RMP is interested in developing a similar master agreement with UTA as well. To date, UTA has received grants to purchase up to 27 battery-electric buses. It has been identified that 1/3 of the bus fleet in the future could be battery electric buses or other zero emission technology. Managing the grid impacts becomes critical as the number of electric buses grows. Additionally, UTA has 50 traction power substations and hundreds of electrical connections to the grid.
DISCUSSION:	UTA and RMP are intending to execute a Memorandum of Understanding (MOU) to help guide the development and implementation of future projects and initiatives to the benefit of both entities. The MOU will focus on five areas: Energy Efficiency, Electric Vehicles, Electrical Infrastructure, Grid Resilience, Grants and Research. *Energy Efficiency:* UTA has had great success with the RMP Wattsmart Program. Under Wattsmart, UTA and RMP evaluate energy usage on UTA buildings and property. RMP will provide incentives to help purchase fixtures and equipment that use less energy. *Electric Vehicles:* RMP is interested in seeing wider deployments of electric vehicles. RMP is interested in maximizing the new service feeds and connections provided for electric buses by incorporating additional vehicles. Each user would only pay for costs incurred. *Electrical Infrastructure*: Working with UTA, RMP can optimize the infrastructure to provide additional system capacity for medium and light-duty vehicle charging. Under this section, RMP may be willing to provide financing for substation replacement as well as support expansion of light rail and electrification of FrontRunner. UTA is also interested in developing a transit hub in the area of the North Temple Power Station

	light rail platform. The hub would provide bays for up to 10 buses with charging infrastructure. Depending on the final site selection UTA may be interested in purchasing or leasing property from RMP. *Grid Resilience:* Under the Grid Resilience section, RMP would work with UTA to maintain power in times of emergency or outages. Additionally, having battery-electric buses can help absorb energy when renewable resources are overproducing energy. Under the Research section UTA and RMP are interested in working together to minimize the impacts of adding electric buses to the UTA fleet. *Grants and Research:* Plugging in buses can have a significant impact on the grid. The graphic is for depot charging. Two buses connected to a fast charger can pull almost 1 megawatt of energy which is the equivalent energy use of 400-900 residential units. RMP has partially funded research with Utah State University (USU) to evaluate how to reduce the impact on the grid from connecting electric buses. This research is also evaluating electrical load spikes from light rail trains. RMP with a number of partners are applying for a number of Department of Energy grants to help advance a number of elements noted in the partnership agreement. There are several potential benefits to UTA for entering into an MOU with RMP. • Grid resilience and efficiency • Infrastructure replacement and financing • Improved power availability in times of emergency • Development of a bus hub on property owned by RMP on North Temple • Depending on the internal desire, UTA could purchase green power from RMP • Lower energy cost • Green power purchase options • Development of solar power infrastructure
ALTERNATIVES:	If UTA does not enter into this MOU, some of the advantages of the joint collaboration between UTA and RMP may not be realized.
FISCAL IMPACT:	This MOU does not include any financial commitments between parties. Activities are voluntary and each party is responsible for its own costs and expenses.
ATTACHMENTS:	• Memorandum of Understanding

DRAFT REV. 2 4-18-2020

Utah Transit Authority Rocky Mountain Power Memorandum of Understanding

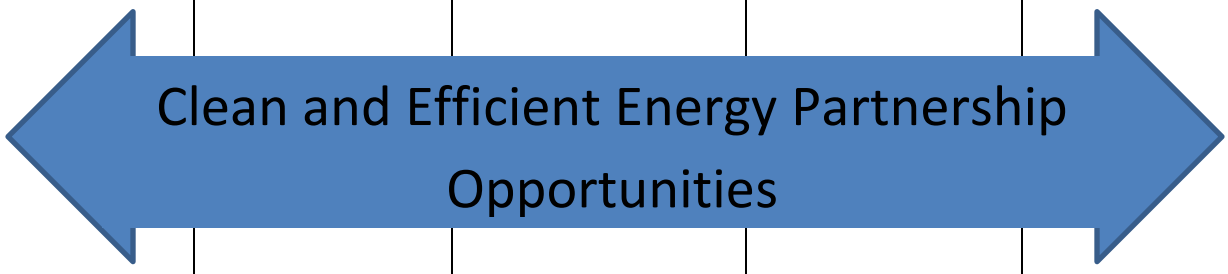
This Memorandum of Understanding ("MOU") is entered into effective the _____ day of _____, 2020 between Rocky Mountain Power (RMP), and Utah Transit Authority ("UTA"), a public transit district organized under the laws of the State of Utah (collectively the "Parties").

1. PURPOSE. The purpose of this MOU is to establish a cooperative partnership between the Parties intended to lead to the discovery of innovative solutions to their shared concerns of public safety, equal access and opportunity, air quality, and the demands of population growth. UTA and Rocky Mountain Power are both committed to responsibly using clean energy to power Utah's future. With this common vision in mind, both Parties will collaborate in joint consideration of a range of joint projects and opportunities.

2. SCOPE. The following table summarizes the collaborative initiatives the Parties intend to pursue under the MOU:

Powering Utah Forward

Energy Efficiency	Electric Vehicles	Electrical Infrastructure	Grid Resilience	Research and Grants
Wattsmart Program Power Usage Evaluation Upgrading Old Systems	Electric Buses FrontRunner Electrification Autonomous Vehicles	Bus and Car Charging Stations Power Storage and Substations Rail Expansion and Electrification North Temple Transit Hub	System Redundancy Smart Grid Solar-supplemented Grid	Vehicle Drive System Batteries and Peak Demand Management Grant Initiatives



A. Energy Efficiency

UTA and Rocky Mountain Power strive each day to reduce wasteful energy consumption. Since the transportation sector is one of the largest contributors to energy consumption in the United States, UTA is stepping forward to become a leader in energy conservation. With assistance from Rocky Mountain Power, UTA intends to better manage its power usage and achieve the highest energy efficiency standards in the industry.

a. **Wattsmart Program:** This program has helped and can continue to help UTA finance the installation of new energy efficient equipment. Rocky Mountain Power's wattsmart program provides businesses cash incentives for installing electrical systems and equipment that meet the highest energy efficiency standards. Both UTA and Rocky Mountain Power strive to conserve energy wherever possible to encourage others to be mindful of their energy consumption. Conserving energy by using energy efficient equipment helps Utah grow sustainably into the future.
b. **UTA Power Usage Evaluation:** With the aid of Rocky Mountain Power energy experts, UTA can evaluate its energy usage to find areas where energy can be used more efficiently. Together, UTA and Rocky Mountain Power can create an energy management plan to implement innovative solutions to increase energy efficiency.
c. **Upgrading Outdated Systems:** UTA carries out routine preventative maintenance of its electrical equipment (e.g. signaling equipment, train and bus repair shop equipment, wayside storage, and distribution systems) to increase the lifespan of the equipment and to ensure everything is in safe and working order. As electrical systems age and become outdated, however, they need to be replaced with new equipment. Rocky Mountain Power energy experts can help UTA identify outdated systems and plan how to replace the systems with the most up-to-date equipment.

B. Electric Vehicles

Currently, diesel buses comprise just over 80% of UTA's bus fleet. By 2035, UTA hopes to achieve an even distribution of diesel, compressed natural gas (CNG), and battery electric buses (BEB), with diesel-electric hybrid vehicles eventually phased out of the bus fleet mix. UTA also plans to evaluate a more

expansive zero-emitting goal as part of the State's Olympic plan which calls for a zero-emissions transportation system. UTA is also considering electrifying paratransit buses, vanpool vans, on demand service vehicles, white fleet vehicles, and eventually FrontRunner (commuter rail). The large increase in electric vehicles (EVs) will require power storage upgrades and an expanded network of charging stations. One of UTA's goals is to improve air quality, and EVs give UTA the opportunity to greatly decrease its carbon emissions. With the help of Rocky Mountain Power, this electric vision can be made possible.

a. **Electric Buses:** With help from federal grants and interagency partnerships (including Rocky Mountain Power), UTA has acquired five electric buses which have been in operation since late 2019. Electric buses are a big step for the promotion of clean energy in Utah and UTA is looking to acquire more, starting with electric buses for the Park City - Salt Lake City Connect Route. UTA was awarded funding from the VW settlement for the incremental cost to purchase 20 battery electric buses. Bus rapid transit (BRT) is proving to be an effective means of mass transit. Future BRT projects in Ogden and South Davis as well as the Sandy/South Jordan Circulator could use electric buses as long as funding is available. Ogden BRT is moving forward to acquire 10 electric buses and charging infrastructure. Working with Rocky Mountain Power to secure funding for the vehicles and charging equipment will ensure progress towards more zero-emissions vehicles.
b. **FrontRunner Electrification:** The 2018 Future of FrontRunner report outlines plans to eventually electrify FrontRunner. There are several ways a train can be electrified, but the most effective method is to combine the locomotive and passenger cars into an electrical multiple unit, or EMU, powered by overhead catenary wires. This configuration removes the need for a separate locomotive and is similar to the system currently used for TRAX (light rail), but at a larger scale. The extensive infrastructure implications of electrifying FrontRunner would require a close collaboration between UTA and Rocky Mountain Power early on in the planning and design phases of the project.
c. **Autonomous Vehicles:** There is a growing trend in America towards the adoption of autonomous vehicles, which have the potential to drastically decrease the number of traffic-related deaths. UTA is currently experimenting with autonomous vehicles to study how they can enhance people's accessibility to transit by shuttling them to and from transit stops, thus tackling the first-mile last-mile problem of

transit accessibility. Assuming the autonomous vehicles would be electric, a partnership between UTA and Rocky Mountain Power would make the planning, design, and installation of necessary charging infrastructure a much smoother process.

C. Electrical Infrastructure

Electrical power networks are the lifeblood of modern civilization. Almost every aspect of daily life, including transportation, is made possible through this electrical infrastructure. UTA needs to maintain a robust electrical infrastructure for TRAX to safely and reliably move people to their destinations. UTA is also in the process of electrifying a third of its bus fleet and eventually FrontRunner. Establishing an efficient system to power these vehicles is one of UTA's top priorities. A partnership with Rocky Mountain Power is essential to making sure these systems are implemented effectively.

a. **Bus and Car Charging Stations:** As UTA obtains more electric buses—and possibly electric vanpool vans, paratransit buses, and white fleet vehicles—major investments will need to be made in charging infrastructure. Large-scale charging stations and high capacity electrical storage are needed to maintain consistent power to the fleet vehicles. UTA also hopes to install EV charging stations at park and ride facilities and other UTA facilities. By doing this, UTA hopes to join Rocky Mountain Power in supporting the Live Electric community partnership. These added amenities also create the possibility of partnering with transportation network companies (TNC) that use EVs, like Lyft and Uber, to provide customers with free rides to and from transit stations. Partnering with Rocky Mountain Power will ensure that these systems are integrated into the existing electrical infrastructure without compromising the stability of the electrical grid.
b. **Power Storage and Substations:** As UTA expands its network of TRAX, FrontRunner, and streetcar lines, additional substations and power storage facilities need to be built to power the vehicles. Some of the lines from the initial TRAX system have already expanded to the point where the original substations are insufficient and need to be upgraded. A thorough assessment of existing and future electrical infrastructure will identify locations where upgrades are needed most. Having Rocky Mountain Power as a project partner and financial

contributor for these infrastructure improvements will help keep these systems in excellent condition.

c. **Rail Expansion and Electrification:** UTA's 2040 Strategic Plan includes the expansion of both TRAX and FrontRunner lines, including Frontrunner extensions to Brigham City and Santaquin and TRAX extensions to Lehi and southwest Salt Lake County. As mentioned above, extending rail lines requires large-scale electrical infrastructure investments. All TRAX lines are powered solely by electricity, and eventually FrontRunner will also run on electricity. Partnering with Rocky Mountain Power during the planning phases of these projects is essential to ensure sufficient electrical infrastructure expansions can reasonably be constructed.

d. **North Temple Transit Hub:** UTA is interested in developing a transit hub in the area of the North Temple Power Station light rail platform. Salt Lake is doing a study to identify the location. Depending on the final site selection UTA may be interested in purchasing or leasing property from Rocky Mountain Power. This property may have the potential to be used for a transit hub that would facilitate electric buses and their needed charging infrastructure. Having this facility would help UTA implement clean energy transportation for the west side of SLC.

D. Grid Resilience

As previously mentioned, the transportation sector takes its place as one of the largest consumers of energy. While petroleum based fuels are currently the most common energy source for vehicles, a transition to EVs is underway and is becoming a more popular choice. A rapid adoption of EVs will put an unprecedented strain on the electrical grid. Consequently, UTA is seeking grid resilience solutions to prepare for the increased electricity use at UTA's various facilities. Together with Rocky Mountain Power, UTA can employ system redundancy, smart grid, and renewable energy strategies to maintain a stable electric grid.

a. **System Redundancy:** Electrifying buses and trains can pose risks to reliable public transportation if a resilient power system is not in place. If the power goes out during an emergency, vehicles would not be able to run their routes, leaving many people stranded. A partnership with Rocky Mountain Power would help UTA establish system redundancy and backup power sources to mitigate adverse effects of a power failure.

b. **Smart Grid:** Advancements in sensor and data collection technologies have given rise to the possibility of constructing a smart grid. As these sensors are installed in more and more electricity consuming devices, appliances, and vehicles, the electrical grid can become a two-way communication between energy providers and energy consumers. Rocky Mountain Power could use this real-time energy usage data to manage its energy resources more efficiently. In an effort to be more environmentally responsible, UTA can install smart grid capabilities in its electric vehicles and equipment to aid in constructing a reliable and efficient smart grid.
c. **Solar-Supplemented Grid:** Enhanced grid resilience can be achieved by adding solar power as an additional energy source. Solar power has the flexibility of being produced on- or off-site and can be produced virtually anywhere via photovoltaic cells. The ability to generate power on-site is an excellent way to sustain an ample reserve of backup energy and can reduce strain on the energy grid at peak usage times. In 2013, funds from Rocky Mountain Power's Blue Sky Program were used to construct 4 solar powered TRAX stations on the Green Line. With the help of Rocky Mountain Power and its Blue Sky Program, UTA can implement solar power generation at more TRAX stations and facilities such as the future Depot District Clean Fuels Technology Center.

E. Research and Grants

UTA is constantly seeking new opportunities to research cutting edge ideas and technology to improve the performance of transit and the quality of life for members of the community. To keep up with the latest advancements in transportation technology, UTA seeks grants and other funding from various public and private programs. UTA and Rocky Mountain Power have some overlapping research interests, therefore, a partnership in this area could help both parties secure research funding. Currently, UTA and RMP in cooperation with Utah State University have a project underway to evaluate and mitigate the grid impacts of adding battery electric buses to the Salt Lake Central Station. This work is under way and will be completed by the end of 2021.

a. **Vehicle Drive System:** Since diesel and gasoline engines have historically been the primary sources of vehicle propulsion, drive system technology for these engines has been developed to achieve

maximum efficiency. Until recently, however, vehicle drive systems using alternative fuels have not had the same level of research investment. UTA is branching out to explore new technologies and alternative fuels to help Utah grow sustainably into the future. To that end, UTA hopes to research better vehicle drive systems for alternative fuels such as electric batteries and CNG. Researching more efficient electric drive systems and battery technology could result in an increase of electric vehicles on the road, resulting in expanded revenue opportunities for RMP and improved air quality for the region.

b. **Batteries and Peak Demand Management:** UTA is interested in partnering with Rocky Mountain Power to research the use of batteries and supercapacitors to manage peak energy demand. Storing energy in batteries during non-peak times to be used during peak times could result in a more even distribution of energy usage throughout the day. On-board supercapacitors could lessen the energy surges of accelerating TRAX vehicles, and regenerative braking could charge the supercapacitors as the vehicles decelerate. UTA and Rocky Mountain Power would benefit from a joint research effort to explore these and other peak management solutions.
c. **Other Research:** There are several other areas of research that UTA and Rocky Mountain Power could collaborate on. Without going into too much detail, a few examples are listed below. UTA, Rocky Mountain Power, and Salt Lake City could conduct a land use study around the North Temple Station to find ways to enhance public space and transit accessibility. Another research focus could be power usage and grid optimization. To maximize the efficient use of energy resources, additional studies could be done to target areas in UTA's systems that use excess power or put excessive strain on the grid. Finally, more research can be done on the effects of current technological developments such as autonomous vehicles and TNCs. Keeping up to date on the latest developments in science and technology can enable UTA and Rocky Mountain Power to provide their customers with the best services available.
d. **Grant Initiatives:** UTA seeks funding from various public and private entities that support sustainable growth and the use of advanced technologies to improve the quality of life in cities. Rocky Mountain Power partners with UTA to provide supporting funds for projects funded through Federal Transit Administration (FTA) grant programs (i.e. the Low or No Emission Vehicle Program (Low-No)). Additional funding programs are available through the U.S. Department of

Transportation, U.S. Department of Energy and other federal agencies. More locally, the Utah Clean Cities Coalition and the Utah Clean Air Partnership (UCAIR) offer grant programs to support emission reductions. Partnered together, UTA and Rocky Mountain Power will be eligible for more grant funding and will be more effective in identifying new funding opportunities.

3. MILESTONE SCHEDULE

On or before June 1, 2020, the Parties shall meet and agree to a schedule for joint evaluation of the above described initiatives. An order of priority shall be established. A milestone schedule tracking progress from initiation to conclusion for each of the initiatives shall be developed.

4. LEAD CHAMPION

The Parties shall designate either UTA or RMP as the "lead champion" for each of the above described initiatives. This "lead champion" shall be responsible for developing status reports, milestone charts, and generally managing and encouraging progress on the specific initiative.

5. FINANCES

Neither Party makes any type of financial commitment to the other under the terms of this MOU. Activities taken in furtherance of this Memorandum are voluntary and each Party shall be responsible for its own costs and expenses. Each Party shall, to the extent needed, supply at its own cost all personnel, equipment, supplies, and materials necessary to perform it obligations and intended actions as set forth in this agreement.

6. LEVEL OF EFFORT

Each Party to this MOU commits to exert good faith and timely efforts to fulfill the intent of this Memorandum.

7. INTELLECTUAL PROPERTY

Neither Party shall obtain or be provided with any type of license or right in the other Party's intellectual property while collaborating under this MOU unless a separate license agreement is negotiated for that purpose.

8. CONFIDENTIALITY

Each Party shall protect any confidential information received from the other Party under this MOU. Such information shall be protected from disclosure with the same degree of care the Party uses to protect its own confidential or proprietary information.

9. DURATION/TERMINATION

This MOU shall continue in force until all of the collaborative initiatives described herein have been evaluated to the satisfaction of each Party but in no event longer than 5 years from the date of execution. Nevertheless either Party may terminate this Memorandum without cause upon 30 days written notice.

10. LIABILITY

Neither Party shall be liable to the other for any type of damages or injury except those proximately caused by willful misconduct or gross negligence. However, nothing in this Agreement shall be construed as a waiver of any rights or defenses applicable to UTA under the Utah Governmental Immunity Act (the “Act”), including without limitation the provision of Section 63G-7-604 regarding limitation of judgments.

11. INDEMNINFICATION.

Each party agrees to indemnify and hold the other Parties and their respective officers, trustees, agents, employees, and permitted assigns harmless against any claims, losses, liabilities, damages, costs, deficiencies, or expenses affecting any persons or property as a result of the indemnifying Party's actions or from any misrepresentation, material omission, or non-fulfillment of any covenant or agreement on the part of the indemnifying Party under or relating to this MOU, and any and all actions, suits, proceedings, demands, assessments, judgments, costs, and other expenses incident to any of the foregoing.

12. NO JOINT VENTURE

This agreement shall not constitute a joint venture of the Parties. No Party is or shall be the legal representative or agent of any other Party for any purpose. A Party shall have no power to assume or create, in writing or otherwise, any obligation or responsibility of any kind, express or implied, in the name of or on behalf of any other Party. No Party shall have any obligation with respect to any other Party's debts or other liabilities.

11. Contact Information.

The designated primary contacts for the Parties are:

For Rocky Mountain Power

Name (s) _____
Address _____
Phone _____
Fax _____
Email _____

For Utah Transit Authority

Names (s) _____
Address _____
Phone _____
Fax _____
Email _____

DRAFT REV. 2 4-18-2020

Executed this _____ day of _____2020 by the duly authorized representatives who signatures appear below:

_____ Date: _____
UTA

AATF: _____

_____ Date: _____
RMP

MEMORANDUM TO THE BOARD

TO: Utah Transit Authority Board of Trustees
THROUGH: Carolyn Gonot, Executive Director
FROM: Bob Biles, Chief Financial Officer
PRESENTER(S): Bob Biles, Chief Financial Officer

BOARD MEETING DATE: May 6, 2020

SUBJECT:	**Proposed 2020 Budget Amendment Number 2**
AGENDA ITEM TYPE:	**Discussion**
RECOMMENDATION:	Informational Item for Discussion
BACKGROUND:	In accordance with Board of Trustee Policy Number 2.1, Financial Management, the Board of Trustees may amend or supplement the budget at any time after its adoption.
DISCUSSION:	Since the adoption of the 2020 operating and capital budgets, and 2020 budget amendment number one, changes have occurred which necessitate additional amendments to these budgets. **Operating budget:** **UDOT Pass Through Grant ($250,000 from UDOT grant**) - In the 2019 State of Utah Legislative session, S.B. 3 Item 142 appropriated $492,200 of one-time general funds in FY 2020. UTA was appropriated $250,000 of those funds to develop a comprehensive plan to address the problem of limited transportation options for seniors, persons with disabilities, and other transportation disadvantaged groups. Based on this appropriation, the UTA Coordinated Mobility Department developed a project scope, issued an RFP, and selected RLS and Associates as the contractor. The project is underway and scheduled for completion in early Q4 2020. **Park & Ride Maintenance ($22,000 from Operating Contingency**) - This expense is related to an interlocal cooperation agreement with Salt Lake County; Utah Department of Transportation; City of Cottonwood Heights; Solitude Mountain Ski Area, LLC; Boyne USA, Inc.; Brighton Ski Resort; Snowbird Resort, LLC; and Alta Ski lifts Company. This agreement ensures continued maintenance and upkeep of the park and ride lots with emphasis on safety, improved canyon transportation and aesthetic quality of the area. These park and ride lots are critical to the continued success of the ski bus service UTA provides to the Cottonwood Canyons. **Reallocation of Operating Contingency to Capital Contingency ($638,000)** - This transfer from the Operating Budget to the Capital Budget recognizes a declining need for

contingency in the Operating Budget (lower fuel, traveling, and other costs) and an increasing need in the Capital Budget for grant match funds.

Changes to the Operating Budget are summarized below:

	2020 Budget after Budget Amendment #1	Operating Budget Changes	2020 Budget after Budget Amendment #2
Other Revenues	$3,640,000	$250,000	$3,890,000
Total Revenues	492,354,000	250,000	492,604,000
Paratransit Service	24,637,000	250,000	24,887,000
Operations Support	50,331,000	22,000	50,353,000
Contingency	1,660,000	(660,000)	1,000,000
Transfer to Capital	18,427,000	638,000	19,065,000
Total Expense	$492,354,000	$250,000	$492,604,000

Capital budget:

There are five reasons for capital adjustments in amendment number 2. A summary of these changes is provided below. More details are provided in the 2020 Capital Budget Detail – Amendment #2 and 2020 Budget Amendment #2 Information documents.

2020 Budget After Amendment #1	**$196,034,000**
2019 Capital Carryforward Projects	49,398,300
Project Reductions	(36,196,800)
FrontRunner & Light Rail SOGR Projects	4,250,000
New Projects	9,086,900
Reallocations	638,000
2020 Budget After Proposed Amendment #2	**$223,210,400**

2019 Capital Projects Carryforward - Approximately 100 capital projects have some remaining 2019 funds that will be carried over into the 2020 budget. Many of these projects are ongoing efforts and the carryover funding will be added to the 2020 budgets. Some are one-time projects that are still in process or had obligations that

carried over into 2020 and carryover funding is required for them to be completed/paid. Several others are multi-year projects that initially included multi-year funding requirements in the 2019 budget.

Project Reductions – Project costs and associated revenues for six projects (Depot District, Ogden/Weber State University BRT, Airport Station Relocation, Light Rail Vehicle Accident Repair, TIGER Program of Projects, and Meadowbrook Expansion) are being moved to 2021 in the capital plan to reflect changes in the projects' work schedules.

FrontRunner and Light Rail State of Good Repair Projects – This includes seven projects to address state of good repair needs which need to be made to improve rail operations reliability during winter weather.

New Projects – These projects include a new security vehicle ($34,000), FTA pass-through grants ($2,209,900); the FrontRunner Business Plan ($1,900,000); FLHQ Space Planning ($75,000); Bus Shields ($714,000); and Light Rail Seat Replacement ($4,154,000).

Reallocation of Project Funds – The Transit Management System ($655,000) is a reallocation from four IT projects to this new, but related, project. The Jordan River Service Center Restroom ($135,000) is a reallocation from the University Medical EOL project. The Salt Lake Metro Settlement ($585,000) and FLHQ Gender Neutral Bathroom ($25,000) are reallocations from capital contingency funds. In addition, there is a reallocation from the Operating Budget to the Capital Budget of $638,000.

Changes to the capital expense budget are summarized in the following table.

	2020 Budget after Budget Amendment #1	Proposed Amendment #2	2020 Budget after Proposed Budget Amendment #2
Depot District	$40,937,000	$(15,937,000)	$25,000,000
Ogden/Weber BRT	28,197,000	(12,947,000)	15,250,000
Airport Station Relocation	13,000,000	(2,000,000)	11,000,000
Provo-Orem TRIP		5,211,000	5,211,000
State of Good Repair	59,898,000	15,069,500	74,967,500
Other Capital Projects	53,062,000	37,751,900	90,813,900
Contingency	940,000	28,000	968,000
Totals	**$196,034,000**	**$27,176,400**	**$223,210,400**

	Changes to the capital revenue budget are summarized in the table below. **2020 Budget after Budget Amendment #1** / **Proposed Amendment #2** / **2020 Budget after Proposed Budget Amendment #2** **UTA Current Year Funding** $24,732,000 / $18,200,000 / $42,932,000 Transfer from Operations 18,427,000 / 638,000 / 19,065,000 2018/2019 Bond Proceeds 61,611,000 / (28,751,500) / 32,859,500 Grants 39,787,030 / 25,254,600 / 65,041,630 Local Partner Contributions 13,936,970 / 7,199,900 / 21,136,870 State Contribution 7,200,000 / 1,850,000 / 9,050,000 Leasing 30,340,000 / 2,785,400 / 33,125,400 **Totals** **$196,034,000** / **$27,176,400** / **$223,210,400** Budget amendment number 2 incorporates all of these operating and capital budget changes. After presentation to the Local Advisory Council at their May 27 meeting, a resolution to adopt the amendment will be presented to the Board of Trustees at their June 3, 2020 meeting.
ALTERNATIVES:	The Board of Trustees may choose not to proceed with Budget Amendment Number 2.
FISCAL IMPACT:	Operating Budget – This amendment shifts $22,000 from the operating contingency to operating expense and $638,000 to Capital Budget contingency. Capital Budget – This amendment anticipates the use of $610,000 from the capital contingency for two projects, with $638,000 being transferred in from the Operating Budget for capital contingency and the use of $18,200,000 of UTA funding, mainly due to the carryover of capital projects from the 2019 budget.
ATTACHMENTS:	• Exhibit A – 2020 Operating and Capital Budgets • Exhibit B – 2020 Operating Budget by Chief Officer • 2020 Budget Amendment #2 Information • 2020 Capital Budget Detail – Amendment #2

UTAH TRANSIT AUTHORITY
2020 Operating Budget - Budget Amendment #2
May 6, 2020

Exhibit A

		2020 Budget After Amendment 1	Budget Amendment: Park & Ride Maintenance	Budget Amendment: UDOT Pass Through Grant - 2/12/20	Budget Amendment	Budget Amendment	Reallocations	2020 Budget After Amendment 2
	Revenue							
1	Sales Tax	$ 348,046,000						$ 348,046,000
2	Federal Prevent. Maint	67,911,000						67,911,000
3	Passenger Revenue	55,182,000						55,182,000
4	Advertising	2,517,000						2,517,000
5	Investment Income	7,577,000						7,577,000
6	Other Revenues	3,640,000		250,000				3,890,000
7	Salt Lake City	4,310,000						4,310,000
8	Salt Lake County (S-line support)	500,000						500,000
9	UDOT - Sales Tax	2,671,000						2,671,000
10	Total Revenue	492,354,000	-	250,000	-	-	-	492,604,000
	Operating Expense							
11	Bus	108,889,000						108,889,000
12	Commuter Rail	30,711,000						30,711,000
13	Light Rail	52,209,000						52,209,000
14	Paratransit Service	24,637,000		250,000				24,887,000
15	Rideshare/Vanpool	3,298,000						3,298,000
16	Operations Support	50,331,000	22,000					50,353,000
17	General & Administrative	38,695,000						38,695,000
18	Salt Lake County service	3,453,000						3,453,000
19	Contingency	1,660,000	(22,000)				(638,000)	1,000,000
20	Total Operating Expense	313,883,000	-	250,000	-	-	(638,000)	313,495,000
	Non-Operating Expense							
21	Planning/Real Estate/TOD/Major Program Development	6,444,000						6,444,000
22	Total Non-operating Expense	6,444,000	-	-	-	-	-	6,444,000
	Debt Service							
23	Principal and Interest	135,915,000						135,915,000
24	Contribution to Early Debt Retirement Reserve	16,077,000						16,077,000
25	Contribution to Reserves	1,608,000						1,608,000
26	Transfer to Capital	18,427,000					638,000	19,065,000
27	Total Debt Service and Reserves	172,027,000	-	-	-	-	638,000	172,665,000
28	Total Expense	$ 492,354,000	$ -	$ 250,000	$ -	$ -	$ -	$ 492,604,000

UTAH TRANSIT AUTHORITY
2020 Capital Budget - Budget Amendment #2
May 6, 2020

			Budget Amendment				
Funding Sources	2020 Budget After Amendment 1	2019 Capital Projects Carryforward	Project Reductions	FR & LR SGR Projects	New Projects	Reallocations	2020 Budget After Amendment 2
29 UTA Current Year Funding	$ 24,732,000	$ 18,905,500	$ (5,579,900)	$ 4,250,000	$ 624,400		$ 42,932,000
30 Transfer from Operations	18,427,000					638,000	19,065,000
31 2018 and 2019 Bond Proceeds	61,611,000	8,649,000	(37,400,500)				32,859,500
32 Grants	39,787,030	12,284,700	6,709,400		6,260,500		65,041,630
33 Local Partner Contributions	13,936,970	6,523,700	74,200		602,000		21,136,870
34 State Contribution	7,200,000	250,000			1,600,000		9,050,000
35 Leasing	30,340,000	2,785,400					33,125,400
36 Total Funding Sources	196,034,000	49,398,300	(36,196,800)	4,250,000	9,086,900	638,000	223,210,400
Expense							
37 Depot District	40,937,000	-	(15,937,000)				25,000,000
38 Ogden/Weber BRT	28,197,000	2,459,400	(15,406,400)				15,250,000
39 Airport Station Relocation	13,000,000	-	(2,000,000)				11,000,000
40 Provo-Orem TRIP		5,211,000					5,211,000
41 State of Good Repair	59,898,000	13,285,500	(1,200,000)	2,950,000	34,000		74,967,500
42 Other Capital Projects	53,062,000	28,442,400	(1,653,400)	1,300,000	9,662,900		90,813,900
43 Other Capital Projects - Contingency	940,000				(610,000)	638,000	968,000
44 Total Expense	$ 196,034,000	$ 49,398,300	$ (36,196,800)	$ 4,250,000	$ 9,086,900	$ 638,000	$ 223,210,400

UTAH TRANSIT AUTHORITY

Exhibit B

2020 OPERATING BUDGET - Budget Amendment #2

May 6, 2020

		2020 Budget After Amendment #1	Budget Amendment #1	2020 Budget After Amendment #2	
	Revenue				
1	Sales Tax	$ 348,046,000		$ 348,046,000	
2	Federal Preventative Maintenance	67,911,000		67,911,000	
3	Passenger Revenue	55,182,000		55,182,000	
4	Advertising	2,517,000		2,517,000	
5	Investment Income	7,577,000		7,577,000	
6	Other Revenues	3,640,000	250,000	3,890,000	
7	Salt Lake City	4,310,000		4,310,000	
8	Salt Lake County (S-Line)	500,000		500,000	
9	Motor Vehicle Registration to UDOT	2,671,000		2,671,000	
10	Total Revenue	$ 492,354,000	$ 250,000	$ 492,604,000	
11	**Operating Expense**				FTE
12	Board of Trustees	$ 2,787,000		$ 2,787,000	14.0
13	Executive Director	25,058,000	(660,000)	24,398,000	130.0
14	Chief Operations Officer	252,981,000	272,000	253,253,000	2,258.7
15	Chief Financial Officer	13,270,000		13,270,000	109.2
16	Chief People Officer	8,075,000		8,075,000	74.7
17	Chief Communications and Marketing Officer	10,644,000		10,644,000	69.0
18	Chief Service Development Officer	7,512,000		7,512,000	45.5
19	Total Operations	320,327,000	(388,000)	319,939,000	2,701.1
20	Debt Service	135,915,000		135,915,000	
21	Contribution to Reserves	17,685,000		17,685,000	
22	Transfer to Capital Budget	18,427,000	638,000	19,065,000	
23	Total Tentative 2020 Operating Budget	$ 492,354,000	$ 250,000	$ 492,604,000	2,701.1

2020 Budget Amendment #2
Detail Information
Operating Budget

1. **Park & Ride Maintenance ($22,000 from Operating Contingency):** This expense is related to an interlocal cooperation agreement with Salt Lake County; Utah Department of Transportation; City of Cottonwood Heights; Solitude Mountain Ski Area, LLC; Boyne USA, Inc.; Brighton Ski Resort; Snowbird Resort, LLC; and Alta Ski lifts Company. This agreement ensures continued maintenance and upkeep of the park and ride lots with emphasis on safety, improved canyon transportation and aesthetic quality of the area. These park and ride lots are critical to the continued success of the ski bus service UTA provides to the Cottonwood Canyons.

2. **UDOT Pass Through Grant ($250,000 from UDOT grant):** In the 2019 State of Utah Legislative session, S.B. 3 Item 142 appropriated $492,200 of one-time general funds in FY 2020. UTA was appropriated $250,000 of those funds to develop a comprehensive plan to address the problem of limited transportation options for seniors, persons with disabilities, and other transportation disadvantaged groups. Based on this appropriation, the UTA Coordinated Mobility Department developed a project scope, issued an RFP, and selected RLS and Associates as the contractor. The project is underway and scheduled for completion in early Q4 2020.

2020 Budget Amendment #2
Detail Project Information
Capital Budget

1. **Carryforward of 2019 Capital Projects to 2020 Capital Budget ($49,398,300. Funding sources are cash carry forward - $18,905,500; 2018 and 2019 Bond Proceeds - $8,649,000; Grants - $12,284,700; Local Partner Contributions - $6,523,700; State of Utah Contribution - $250,000; and 2019 Leasing - $2,785,400):** Approximately 100 capital projects have some remaining 2019 funds that will be carried over into the 2020 budget. Many of these projects are ongoing efforts and the carryover funding will be added to the 2020 budgets. Some are one-time projects that are still in process or had obligations that carried over into 2020 and carryover funding is required for them to be completed/paid. Several others are multi-year projects that initially included the multi-year funding needs in the 2019 budget. With the implementation of the 5-year capital budget plan in 2020, going forward, budget requests for multi-year projects should better match anticipated annual spending. Please see the 2020 Capital Budget Detail – Amendment #2 for a complete listing of the projects and amounts being carried forward.

2. **Project Reductions ($36,196,800. Funding sources changes are: Decrease in UTA funding - $5,579,900; decrease in 2018 and 2019 Bond Proceeds - $37,400,500; Increase in Grants - $6,709,400; and Increase in Local Partner Contributions - $74,200):** The specific projects are given below.

    a. **Depot District ($15,937,000):** Project costs and associated revenues are being moved to 2021 in the capital plan to reflect changes in the project work schedule.

    b. **Ogden/Weber State University BRT ($15,406,400):** Project costs and associated revenues are being moved to 2021 in the capital plan to reflect changes in the project work schedule.

    c. **Airport Station Relocation ($2,000,000):** Project costs and associated revenues are being moved to 2021 in the capital plan to better reflect the project work schedule.

    d. **LRV Accident Repair ($1,200,000):** Due to extended contract negotiations, as well as production facility closures from the pandemic response, less work will be completed than initially anticipated this year. Project costs will be moved to 2021 in the capital plan to reflect changes in the project work schedule.

    e. **TIGER Program of Projects ($53,390):** Project costs and associated revenues are being moved to 2021 in the capital plan to reflect changes in the project work schedule.

    f. **Meadowbrook Expansion ($1,600,000):** Project costs and associated revenues are being moved to 2021 in the capital plan to better reflect the project work schedule

3. **Rail system State of Good Repair Additions ($4,250,000 total from UTA current funding).**

    a. **Mandatory Directives Upgrades ($1,300,000):** In order to reduce the time FrontRunner trains need to travel at restricted speed due to a crossing restriction, this project will aim to make use of the crossing circuits so trains can receive an upgraded speed signal when they are through the crossing. Crossings will be determined strategically with Rail Operations.

    b. **Grade Crossings ($1,500,000):** Replacement of the Grade Crossing Panels at our Light Rail Crossings and tamping at our Commuter Rail Crossings. Light Rail crossings only have an expected life span of 10 years and they need to be addressed annually to keep up on the replacement frequency. Following crossings will be completed; 9000 South (Red Line), 4000 West (Red Line), 114th South Blue Line, 9400 South FrontRunner, 10000 South FrontRunner, and 300 North FrontRunner.

c. **Baselining of TRAX Crossings ($500,000):** Due to recent derails, loss of shunting, and Grade Crossing Activation failures, it has become necessary to review and verify the setup of all AFTAC track circuits and readjust as necessary to ensure the safer operation of train movements. UTA has coordinated with the vendor of the AFTACS and they have developed an updated procedure specific to UTA that will aid in the baselining activities. Due to the number of AFTACS that UTA has, UTA MOW does not have the manpower to complete this task in a timely manner.

d. **Switch Covers and New Switch Heaters ($500,000):** Purchase covers for our switches on FrontRunner and TRAX in the high priority areas to help reduce the switch issues from winter weather. This is a good start and will help with reliability during winter storms. This amount is for this year and we are assuming an equal amount for next year after we see how these perform.

e. **Rice Interlocking ($200,000)**: Finish off emergency repair work that was started on Rice Interlocking 2-3 years ago due to a burned signal house. We need to pour back concrete and add a coupler case and install new track circuits.

f. **Long Warning Times in Sandy ($100,000):** Purchase and install new Siemens PSO signal equipment that will allow us more control over crossing timing due to the more precise nature of the equipment.

g. **New Air Conditioners in Traction Power Supply Substations ($150,000):** UTA's substations are aging and these need to be replaced. There are two air conditioning units for every Traction Power Supply Substation. We spent over $60,000 on air conditioner repairs last year.

4. **New Projects ($4,218,900. Funding Sources are: State of Utah Contribution - $1,600,000; Grants - $1,571,000; Local Partner Contributions - $602,000; and UTA Funding - $445,900). Details of the new projects are provided below.**

a. **Security Vehicle ($34,000):** This request is for a new facility security vehicle for UTA's security guards to better patrol UTA sites. This will allow us to increase a security presence to help deter would be trespassers at Jordan River, Meadowbrook, Riverside and Warm Springs. This includes LED light bar, associated mounting equipment, spotlight and decals.

b. **2018 FTA 5310 Grants; MSP 220, MSP 221, MSP 222 ($969,233, $670,813, and $569,859):** UTA administers the FTA 5310 grant program for the urbanized areas of Utah. The projects include accessible vehicle purchases, operations and transportation support for agencies supporting seniors and people with disabilities. Funding is primarily federal grant funds and local match from these agencies. UTA

receives administration funds and was awarded mobility management funds in this grant cycle.

c. **FrontRunner Business Plan ($1,900,000):** The State legislative leaders have identified the need to increase FrontRunner service to help improve regional mobility and economic competitiveness, and to help reduce congestion on the I-15 corridor. Toward that end, they appropriated $1,600,000 in the 2020 legislative session to fund preparation of a strategic business plan for FrontRunner. UTA would contribute an additional $300,000. The plan will provide a roadmap that determines what capital investments and on what schedule we need to meet our short- and long-term service visions for FrontRunner.

d. **UTA-HQ Space Planning ($75,000):** This project is to determine UTA's office space requirements and optimal configuration for an anticipated new office facility. UTA's administrative facilities will be incorporated into a shared office building, contemplated in the adopted Salt Lake Central Station Area Plan. Space planning is a necessary step to implement the plan and accelerate this phase of development. It will also optimize workflow, communication, and collaboration between UTA departments.

e. **Bus Shields ($714,000):** In order to better protect operators, staff recommends installation of bus shields around the operator compartment. The Plexiglas barrier safeguards Operators from direct customer contact when social distancing is not an option. When combined with the metal railing around the farebox, the barrier also provides a level of protection for Operators.

f. **Light Rail Seat Replacement ($4,154,000):** To enhance light rail vehicle interior cleanliness and combat the COVID-19 pandemic, staff recommends replacing the fabric covered foam cushion seats with composite units. The current seats soil easily and require extensive cleaning on a regular basis. Replacing current seats with molded composite units will enable UTA to quickly clean and sanitize the interior of light rail vehicles.

5. **Reallocations between Capital Projects ($1,400,000):** Staff is recommending reallocation of capital project funds from five current projects and capital contingency to fund the four projects listed below.

   a. **Transit Management System ($655,000 reallocation between projects)**: This effort will support the 2025 Transit Management System program initiative that was approved last fall. This program is being funded from multiple IT capital projects. In order to consolidate the accounting, procurement, and tracking of this program

initiative, staff is requesting that funds be consolidated into one capital account. Transfers from the In-House Applications Development & Enhancement project ($225,000 decrease), the Passenger Information project ($100,000), the Rail Communications On-Board Technology project ($130,000 decrease), and the Bus Communications On-Board Technology project ($200,000 decrease) would be placed into the Bus Communications On-Board Technology project ($655,000 increase).

b. **Jordan River Service Center Restroom ($135,000):** This funding is for the purchase and installation of a prefabricated restroom to be placed outside of the maintenance building at the Jordan River Service Center. Currently there is no restroom in the yard so maintenance workers need to take additional time to walk to the building when the facilities are needed.

c. **Salt Lake Metro Settlement ($585,000 from Capital Contingency):** On March 5, 2020, UTA settled a boundary dispute with Salt Lake City Metro, LLC ("SLCM") on land located between 600 and 800 North in SLC adjacent to the Commuter Rail North Line. UTA agreed to pay SLCM $585,000 in exchange for a quitclaim deed from SLCM for 17,658 SF of land and a waiver of all claims against UTA including, but not limited to, severance damages, trespass and inverse condemnation.

d. **FLHQ Gender Neutral Bathroom ($25,000 from Capital Contingency):** This project will provide for construction of a unisex bathroom at FLHQ.

e. **Capital Contingency ($638,000 from Operating Contingency):** This transfer from the Operating Budget to the Capital Budget recognizes a declining need for contingency in the Operating Budget (lower fuel, traveling, and other costs) and an increasing need in the Capital Budget for grant match funds.

2020 Budget After Amendment #1

	Project Name	2020 Budget	Bonds	Grants	Lease	State Funding	Local Partners	UTA Funded
1	**Major Capital Projects**							
2	Depot District Maintenance Facility	$ 40,936,916	$ 31,850,000	$ 3,736,916	$ -	$ 2,500,000	$ -	$ 2,850,000
3	Ogden/Weber State University BRT	28,197,076	6,591,076	18,706,000	-	-	2,900,000	-
4	Airport Station Relocation	13,000,000	13,000,000	-	-	-	-	-
5	Provo-Orem TRIP							
6	Total Major Capital Projects	82,133,992	51,441,076	22,442,916	-	2,500,000	2,900,000	2,850,000
7								
8								
9	**Revenue / Service Vehicles**							
10	Non-Rev Service Vehicle Replacement	200,000	-	-	-	-	-	200,000
11	Replacement Paratransit	2,982,120	-	-	2,949,120	-	-	33,000
12	Bus Replacement	27,566,971	-	2,775,830	23,598,570	-	-	1,192,571
13	Salt Lake City Buses							
14	Van pool Van replacement	1,292,780	-	-	1,292,780	-	-	-
15	Total Revenue/Service Vehicles	32,041,871	-	2,775,830	27,840,470	-	-	1,425,571
16								
17	**Information Technology**							
18	Rail Passenger Info							
19	Electronic Fare Collection Maintenance & Replacement	2,500,000	-	-	2,500,000	-	-	-
20	FrontRunner WiFi Enhancements	50,000	-	-	-	-	-	50,000
21	IVR Passenger Callout							
22	Network & Infrastructure Equipment	500,000	-	-	-	-	-	500,000
23	CoordM-04 ITS Development							
24	Legal SW							
25	AppDev JDE 9.2 System Upgrade							
26	WFRC Grant Passenger Info Improvements							
27	In-house Application Development & Enhancements	400,000	-	-	-	-	-	400,000
28	Vanpool-02 Driver Tracking andDatabase System							
29	IT Managed Reserved (formerly IT Pool)	290,000	-	-	-	-	-	290,000
30	WiFi Towers							
31	Bus Communication On-Board Technology	300,000	-	-	-	-	-	300,000
32	Info Security Equip & SW (PCI Compliance & Cyber Security)	274,000	-	-	-	-	-	274,000
33	Rail Communication On-Board Technology	230,000	-	-	-	-	-	230,000
34	Server, Storage Infrastructure Equipment and Software	400,000	-	-	-	-	-	400,000
35	Radio Communication Infrastructure	150,000	-	-	-	-	-	150,000
36	New MS SQL Server Licenses	145,000	-	-	-	-	-	145,000
37	Central Div Fluid Mgmnt System							
38	TC-1 Timekeeping System							

2020 Budget After Amendment #1

	Project Name	2020 Budget	Bonds	Grants	Lease	State Funding	Local Partners	UTA Funded
39	E Voucher Software Development (pending grant)	757,838	-	757,838	-	-	-	-
40	Init APC Upgrade	200,000	-	-	-	-	-	200,000
41	SSBU Mobility Eligibility Center Trapeze Software	165,000	-	-	-	-	-	165,000
42	SSBU Radio System Install/subcontract fleet only	170,000	-	-	-	-	-	170,000
43	Transit Management System							
44	Total Information Technology	6,531,838	-	757,838	2,500,000	-	-	3,274,000
45								
46	**Facilities**							
47	Oil/Water Separator at Riverside							
48	Equipment Managed Reserve	250,000	-	-	-	-	-	250,000
49	Facilities Managed Reserve	1,000,000	-	-	-	-	-	1,000,000
50	Concrete/Asphalt Repair & Replacement							
51	Park and Ride Rehab and Replacement	500,000	-	-	-	-	-	500,000
52	Stations and Platforms Rehab and Replacement	125,000	-	-	-	-	-	125,000
53								
54	**Safety/Security/Police**							
55	Public Safety		-	-	-	-	-	
56	Tasers							-
57	Corridor Fencing	50,000						50,000
58	Ballistic Vests	15,000						15,000
59	Police Replacement Vehicles	240,000						240,000
60	Body Cameras							
61	Bus Safety and Security	30,000						30,000
62	Laptop Replacement							
63	Emergency Management Items							-
64	Safety Projects	100,000						100,000
65	Camera Coverage on Platforms							
66	Access Control for Data Rooms	10,000						10,000
67	Camera Sustainability	50,000						50,000
68	Mini Robot							
69	Camera Coverage on PCC Cabinets							
70	Facility Security SGR	50,000						50,000
71	Bus Camera Overhaul/Replacement	240,000						240,000
72	Emergency Operations Training	15,000						15,000
73	Camera, door locks, badge scanners	15,000						15,000
74	Security General Projects	20,000						20,000
75	Security Vehicle							

2020 Budget After Amendment #1

	Project Name	2020 Budget	Bonds	Grants	Lease	State Funding	Local Partners	UTA Funded
76	Next Crossing Cameras	40,000						40,000
77	Total Facilities, Safety, & Admin Equip.	2,750,000	-	-	-	-	-	2,750,000
78								
79	**Infrastructure State of Good Repair Projects**							
80	C-Car Tires							
81	Bus Engine/Transmission/Component Rehab/Replacement	1,500,000	-	-	-	-	-	1,500,000
82	Light Rail Vehicle Rehab	9,760,415	-	-	-	-	-	9,760,415
83	Stray Current Mitigation	300,000	-	-	-	-	-	300,000
84	Asset Management SW							
85	RFID Tracking							
86	Commuter Rail Engine Rehab	2,763,779	-	786,684	-	-	-	1,977,095
87	Bridge Rehabilitation & Maintenance	300,000	-	-	-	-	-	300,000
88	Paint Room Bldg 8							
89	Roof Replacements							
90	Rail Rehab and Replacement	250,000	-	-	-	-	-	250,000
91	LRV Accident Repair	1,500,000	-	-	-	-	-	1,500,000
92	Commuter Rail Cab/Coach overhaul							
93	FR Platform Snow Melt							
94	Grade Crossings Rehab and Replacement	500,000	-	-	-	-	-	500,000
95	Signal & Grade Crossing Bungalow Batteries							
96	Traction Power Rehab and Replacement	550,000	550,000	-	-	-	-	-
97	OCS Rehab and Replacement	500,000	-	-	-	-	-	500,000
98	Grounding for SoJo CR Signal House							
99	TRAX Curve Repl S. Temple/Main							
100	Ballast and Ties Rehab and Replacement	250,000	-	-	-	-	-	250,000
101	Train Control Rehab and Replacement	250,000	-	-	-	-	-	250,000
102	Rail Switches & Trackwork Controls - Rehab/Replacement	150,000	-	-	-	-	-	150,000
103	OK Building Repairs							
104	Total State of Good Repair	18,574,194	550,000	786,684	-	-	-	17,237,510
105	Total State of Good Repair	59,897,903	550,000	4,320,352	30,340,470	-	-	24,687,081
106								
107	**Capital Projects**							
108	Office Equipment Reserve	100,000	-	-	-	-	-	100,000
109	Tooele Bus Facility							
110	Positive Train Control w/MD Upgrades	900,000	-	-	-	-	-	900,000
111	Box Elder Right of Way Preservation	1,000,000	-	-	-	-	-	1,000,000
112	FTA 5310 Funds as designated rec							

2020 Budget After Amendment #1

	Project Name	2020 Budget	Bonds	Grants	Lease	State Funding	Local Partners	UTA Funded
113	Prop #1 Weber County Improvemens							
114	Prop #1 Davis County Improvemens							
115	Electric Bus Lo/No Grant							
116	Downtown TRAX Signal Imp							
117	Prop #1 Tooele County Improvements							
118	5310 Grant UT-2016-013 Salt Lake							
119	5310 Grant UT-2016-013 Davis/Web							
120	20-1717 - 5310 Prog - Ogd/Lay							
121	20-1717 - 5310 Prog - Pro/Orem							
122	20-1717 - 5310 Prog - SLC/WV							
123	Sandy Parking Structure							
124	Sugar House Double Tracking							
125	Signal Pre-emption Projects w/UDOT	500,000	-	-	-	-	500,000	-
126	UDOT I-15 Widening/7200 S Bridge							
127	MOW Bulding Clearfield							
128	Weber Cnty CR ROW Preservation	1,500,000	-	-	-	-	1,500,000	-
129	650 South Station	220,000	-	-	-	-	200,000	20,000
130	Bus Stop Imp - System-Wide ADA	1,000,000	-	800,000	-	-	-	200,000
131	Wayfinding Signage Plan - S-line and TRAX	475,000	-	-	-	-	-	475,000
132	South Davis BRT							
133	TIGER Program of Projects	11,169,660	-	4,836,435	-	-	6,314,294	18,931
134	UVU Ped Bridge	2,000,000	-	-	-	-	-	2,000,000
135	3300/3500 South MAX Expansion & Optimization	2,735,172	-	2,550,000	-	-	-	185,172
136	Clearfield FR Station Trail	1,501,663	-	1,400,000	-	-	101,663	-
137	Update Bike Cars on FrontRunner							
138	Stairs to Heated Apron/Track 15							
139	U of U Union Building Hub							
140	Sharp-Tintic Railroad Connection	700,000	-	424,030	-	-	235,970	40,000
141	Point of Mountain AA/EIS	1,500,000	-	-	-	1,200,000	200,000	100,000
142	MSP220 - 5310							-
143	MSP221 - 5310							-
144	MSP222 - 5310							-
145	Vanpool Vineyard Expansion							
146	UTA ADA Bus Stop Imp - Utah Cnty							
147	Police Substation Provo IMC							
148	Meadowbrook Expansion	2,900,000	-	-	-	-	-	2,900,000
149	Operator Restrooms- Salt Lake County	400,000	-	-	-	-	-	400,000

2020 Budget After Amendment #1

	Project Name	2020 Budget	Bonds	Grants	Lease	State Funding	Local Partners	UTA Funded
150	Bus Stop Imp and signage - SL County	2,500,000	-	-	-	-	-	2,500,000
151	SL UZA Bus Bike Rack Expansion	35,609	-	33,198	-	-	-	2,411
152	Operator Restrooms throughout system	600,000	120,000	480,000	-	-	-	-
153	Operator Shack at University Medical EOL	350,000	-	-	-	-	-	350,000
154	Northern Utah County Double Track	13,500,000	9,500,000	-	-	3,500,000	500,000	-
155	North Temple EOL	3,400,000	-	-	-	-	1,400,000	2,000,000
156	U of U EOL	2,950,000	-	2,500,000	-	-	-	450,000
157	Fort Union EOL	500,000	-	-	-	-	-	500,000
158	5600 W/4500 S EOL	500,000	-	-	-	-	-	500,000
159	Reconfigure Meadowbrook Gate	40,000	-	-	-	-	-	40,000
160	Paxton Avenue TRAX Crossing	85,000	-	-	-	-	85,000	-
161	JRSC Restroom	-	-	-	-	-	-	-
162	FR Business Plan	-	-	-	-	-	-	-
163	New FLHQ Space Planning	-	-	-	-	-	-	-
164	Property Settlement	-	-	-	-	-	-	-
165	Unisex Restroom at FLHQ	-	-	-	-	-	-	-
166	Park City Electric Bus	-	-	-	-	-	-	-
167	Paint Booth at Warm Springs	-	-	-	-	-	-	-
168	Bus Shields	-	-	-	-	-	-	-
169	Light Rail Seat Replacement	-	-	-	-	-	-	-
170	Capital Contingency	940,000	-	-	-	-	-	940,000
171	Total Capital Projects	54,002,104	9,620,000	13,023,663	-	4,700,000	11,036,927	15,621,514
172								
173	Total Capital Budget	$ 196,033,999	$ 61,611,076	$ 39,786,931	$ 30,340,470	$ 7,200,000	$ 13,936,927	$ 43,158,595

Proposed Budget Amendment #2

	Project Name	Amendment #2	Bonds	Grants	Lease	State Funding	Local Partners	UTA Funded
1	**Major Capital Projects**							
2	Depot District Maintenance Facility	$ (15,936,916)	(29,350,000)	16,263,084	-	-	-	$ (2,850,000)
3	Ogden/Weber State University BRT	(12,947,076)	(3,591,076)	(11,706,000)	-	-	2,350,000	-
4	Airport Station Relocation	(2,000,000)	(2,000,000)	-	-	-	-	-
5	Provo-Orem TRIP	5,210,967	3,355,027	1,855,940	-	-	-	-
6	Total Major Capital Projects	(25,673,025)	(31,586,049)	6,413,024	-	-	2,350,000	(2,850,000)
7								
8								
9	**Revenue / Service Vehicles**							
10	Non-Rev Service Vehicle Replacement	-	-	-	-	-	-	-
11	Replacement Paratransit	2,550,158	-	-	2,550,158	-	-	-
12	Bus Replacement	-	-	-	-	-	-	-
13	Salt Lake City Buses	235,231		-	235,231	-	-	-
14	Van pool Van replacement	-	-	-	-	-	-	-
15	Total Revenue/Service Vehicles	2,785,389	-	-	2,785,389	-	-	-
16								
17	**Information Technology**							
18	Rail Passenger Info	276,570	-	-	-	-	-	276,570
19	Electronic Fare Collection Maintenance & Replacement	214,187	-	-	-	-	-	214,187
20	FrontRunner WiFi Enhancements	23,320	-	-	-	-	-	23,320
21	IVR Passenger Callout	64,779	-	-	-	-	-	64,779
22	Network & Infrastructure Equipment	5,324	-	-	-	-	-	5,324
23	CoordM-04 ITS Development	200,855	-	144,748	-	-	-	56,107
24	Legal SW	139,258	-	-	-	-	-	139,258
25	AppDev JDE 9.2 System Upgrade	30,134	-	-	-	-	-	30,134
26	WFRC Grant Passenger Info Improvements	1,459,743	-	1,361,000	-	-	-	98,743
27	In-house Application Development & Enhancements	(37,384)	-	-	-	-	-	(37,384)
28	Vanpool-02 Driver Tracking andDatabase System	55,000	-	-	-	-	-	55,000
29	IT Managed Reserved (formerly IT Pool)	17,986	-	-	-	-	-	17,986
30	WiFi Towers	12,866	-	-	-	-	-	12,866
31	Bus Communication On-Board Technology	(137,771)	-	-	-	-	-	(137,771)
32	Info Security Equip & SW (PCI Compliance & Cyber Security)	79,882	-	-	-	-	-	79,882
33	Rail Communication On-Board Technology	(17,425)	-	-	-	-	-	(17,425)
34	Server, Storage Infrastructure Equipment and Software	10,965	-	-	-	-	-	10,965
35	Radio Communication Infrastructure	69,333	-	-	-	-	-	69,333
36	New MS SQL Server Licenses	-	-	-	-	-	-	-
37	Central Div Fluid Mgmnt System	33,000	-	-	-	-	-	33,000
38	TC-1 Timekeeping System	480,000	-	-	-	-	-	480,000

Proposed Budget Amendment #2

	Project Name	Amendment #2	Bonds	Grants	Lease	State Funding	Local Partners	UTA Funded
39	E Voucher Software Development (pending grant)	243,352	-	80,178	-	-	-	163,174
40	Init APC Upgrade	-	-	-	-	-	-	-
41	SSBU Mobility Eligibility Center Trapeze Software	-	-	-	-	-	-	-
42	SSBU Radio System Install/subcontract fleet only	-	-	-	-	-	-	-
43	Transit Management System	655,000	-	-	-	-	-	655,000
44	Total Information Technology	3,878,974	-	1,585,926	-	-	-	2,293,048
45								
46	**Facilities**							
47	Oil/Water Separator at Riverside	100,000	-	-	-	-	-	100,000
48	Equipment Managed Reserve	267,109	-	-	-	-	-	267,109
49	Facilities Managed Reserve	48,450	-	-	-	-	-	48,450
50	Concrete/Asphalt Repair & Replacement	30,000	-	-	-	-	-	30,000
51	Park and Ride Rehab and Replacement	-	-	-	-	-	-	-
52	Stations and Platforms Rehab and Replacement	-	-	-	-	-	-	-
53								
54	**Safety/Security/Police**							
55	Public Safety							
56	Tasers	12,052	-	-	-	-	-	12,052
57	Corridor Fencing	24,689	-	-	-	-	-	24,689
58	Ballistic Vests	5,722	-	-	-	-	-	5,722
59	Police Replacement Vehicles	21,388	-	-	-	-	-	21,388
60	Body Cameras	100,000	-	-	-	-	-	100,000
61	Bus Safety and Security	36,724	-	-	-	-	-	36,724
62	Laptop Replacement	33,349	-	-	-	-	-	33,349
63	Emergency Management Items	2,160	-	-	-	-	-	2,160
64	Safety Projects	20,081	-	-	-	-	-	20,081
65	Camera Coverage on Platforms	483	-	-	-	-	-	483
66	Access Control for Data Rooms	17,893	-	-	-	-	-	17,893
67	Camera Sustainability	2,410	-	-	-	-	-	2,410
68	Mini Robot	12,000	-	-	-	-	-	12,000
69	Camera Coverage on PCC Cabinets	35,000	-	-	-	-	-	35,000
70	Facility Security SGR		-	-	-	-	-	-
71	Bus Camera Overhaul/Replacement	31,486	-	-	-	-	-	31,486
72	Emergency Operations Training	9,933	-	-	-	-	-	9,933
73	Camera, door locks, badge scanners		-	-	-	-	-	-
74	Security General Projects		-	-	-	-	-	-
75	Security Vehicle	34,000	-	-	-	-	-	34,000

Proposed Budget Amendment #2

	Project Name	Amendment #2	Bonds	Grants	Lease	State Funding	Local Partners	UTA Funded
76	Next Crossing Cameras	22,112	-	-	-	-	-	22,112
77	Total Facilities, Safety, & Admin Equip.	867,041	-	-	-	-	-	867,041
78								
79	**Infrastructure State of Good Repair Projects**							
80	C-Car Tires	79,740	-	-	-	-	-	79,740
81	Bus Engine/Transmission/Component Rehab/Replacement	24,152	-	-	-	-	-	24,152
82	Light Rail Vehicle Rehab	850,150	-	-	-	-	-	850,150
83	Stray Current Mitigation	78,371	-	-	-	-	-	78,371
84	Asset Management SW	11,212	-	-	-	-	-	11,212
85	RFID Tracking	5,157	-	-	-	-	-	5,157
86	Commuter Rail Engine Rehab	1,779,047	-	-	-	-	-	1,779,047
87	Bridge Rehabilitation & Maintenance	165,003	-	-	-	-	-	165,003
88	Paint Room Bldg 8	133,591	-	-	-	-	-	133,591
89	Roof Replacements	51,826	-	-	-	-	-	51,826
90	Rail Rehab and Replacement	209,353	209,353	-	-	-	-	-
91	LRV Accident Repair	(1,200,000)	-	-	-	-	-	(1,200,000)
92	Commuter Rail Cab/Coach overhaul	-	-	-	-	-	-	-
93	FR Platform Snow Melt	24,249	-	-	-	-	-	24,249
94	Grade Crossings Rehab and Replacement	1,865,519	-	-	-	-	-	1,865,519
95	Signal & Grade Crossing Bungalow Batteries	70,000	-	-	-	-	-	70,000
96	Traction Power Rehab and Replacement	544,044	-	-	-	-	-	544,044
97	OCS Rehab and Replacement	23,510	-	-	-	-	-	23,510
98	Grounding for SoJo CR Signal House	70,399		-	-	-	-	70,399
99	TRAX Curve Repl S. Temple/Main	1,302,877	-	-	-	-	-	1,302,877
100	Ballast and Ties Rehab and Replacement	-	-	-	-	-	-	-
101	Train Control Rehab and Replacement	600,000	-	-	-	-	-	600,000
102	Rail Switches & Trackwork Controls - Rehab/Replacement	700,000	-	-	-	-	-	700,000
103	OK Building Repairs	150,000	-	-	-	-	-	150,000
104	Total State of Good Repair	7,538,200	209,353	-	-	-	-	7,328,847
105	Total State of Good Repair	15,069,604	209,353	1,585,926	2,785,389	-	-	10,488,936
106								
107	**Capital Projects**							
108	Office Equipment Reserve	-	-	-	-	-	-	-
109	Tooele Bus Facility	1,267,751	1,267,751					-
110	Positive Train Control w/MD Upgrades	2,916,641	1,276,951	339,690	-	-	-	1,300,000
111	Box Elder Right of Way Preservation	3,497,553	-	-	-	-	-	3,497,553
112	FTA 5310 Funds as designated rec	90,336		72,269				18,067

Proposed Budget Amendment #2

	Project Name	Amendment #2	Bonds	Grants	Lease	State Funding	Local Partners	UTA Funded
113	Prop #1 Weber County Improvemens	287,313	-	-	-	-	-	287,313
114	Prop #1 Davis County Improvemens	1,490,580	-	-	-	-	-	1,490,580
115	Electric Bus Lo/No Grant	170,792	-	170,792	-	-	-	-
116	Downtown TRAX Signal Imp	11,000	-	-	-	-	-	11,000
117	Prop #1 Tooele County Improvements	13,316	-	-	-	-	-	13,316
118	5310 Grant UT-2016-013 Salt Lake	89,828	-	63,530	-	-	20,428	5,870
119	5310 Grant UT-2016-013 Davis/Web	121,374	-	94,542	-	-	26,832	-
120	20-1717 - 5310 Prog - Ogd/Lay	600,748	-	475,766	-	-	105,941	19,041
121	20-1717 - 5310 Prog - Pro/Orem	529,592	-	429,475	-	-	70,205	29,912
122	20-1717 - 5310 Prog - SLC/WV	1,412,686	-	991,222	-	-	353,202	68,262
123	Sandy Parking Structure	5,904,174	-	2,000,000	-	-	2,484,253	1,419,921
124	Sugar House Double Tracking	43,900	-	43,900	-	-		-
125	Signal Pre-emption Projects w/UDOT	888,711	-	-	-	-	888,711	-
126	UDOT I-15 Widening/7200 S Bridge	73,000	-	-	-	-	73,000	-
127	MOW Bulding Clearfield	350,000	-	-	-	-	-	350,000
128	Weber Cnty CR ROW Preservation	500,000	-	-	-	-	500,000	-
129	650 South Station	-	-	-	-	-	-	-
130	Bus Stop Imp - System-Wide ADA	82,402	-	-	-	-	-	82,402
131	Wayfinding Signage Plan - S-line and TRAX	917,950	-	-	-	-	-	917,950
132	South Davis BRT	1,101,153	-	-	-	-	1,101,153	-
133	TIGER Program of Projects	(53,390)	-	2,152,360	-	-	(2,275,835)	70,085
134	UVU Ped Bridge	-	-	-	-	-	-	-
135	3300/3500 South MAX Expansion & Optimization	268,154	-	250,000	-	-	-	18,154
136	Clearfield FR Station Trail	268,154	-	250,000	-	-	-	18,154
137	Update Bike Cars on FrontRunner	296,699	-	276,612	-	-	-	20,087
138	Stairs to Heated Apron/Track 15	9,296	-	-	-	-	-	9,296
139	U of U Union Building Hub	85,635	-	-	-	-	-	85,635
140	Sharp-Tintic Railroad Connection	-	-	-	-	-	-	-
141	Point of Mountain AA/EIS	655,107	-	-	-	250,000	400,000	5,107
142	MSP220 - 5310	969,233	-	652,383	-	-	297,496	19,354
143	MSP221 - 5310	670,813	-	488,754	-	-	171,576	10,483
144	MSP222 - 5310	569,859	-	429,841	-	-	132,950	7,068
145	Vanpool Vineyard Expansion	135,000	-	125,860	-	-	-	9,140
146	UTA ADA Bus Stop Imp - Utah Cnty	672,234	-	629,302	-	-	-	42,932
147	Police Substation Provo IMC	694,875	80,448	339,900	-	-	-	274,527
148	Meadowbrook Expansion	(1,600,000)	-	-	-	-	-	(1,600,000)
149	Operator Restrooms- Salt Lake County	200,000	-	-	-	-	-	200,000

Proposed Budget Amendment #2

	Project Name	Amendment #2	Bonds	Grants	Lease	State Funding	Local Partners	UTA Funded
150	Bus Stop Imp and signage - SL County	-	-	-	-	-	-	-
151	SL UZA Bus Bike Rack Expansion	-	-	-	-	-	-	-
152	Operator Restrooms throughout system	-	-	-	-	-	-	-
153	Operator Shack at University Medical EOL	(135,000)	-	-	-	-	-	(135,000)
154	Northern Utah County Double Track	-	-	-	-	-	-	-
155	North Temple EOL	-	-	-	-	-	-	-
156	U of U EOL	-	-	-	-	-	-	-
157	Fort Union EOL	-	-	-	-	-	-	-
158	5600 W/4500 S EOL	-	-	-	-	-	-	-
159	Reconfigure Meadowbrook Gate	$ -	-	-	-	-	-	-
160	Paxton Avenue TRAX Crossing	-	-	-	-	-	-	-
161	JRSC Restroom	135,000	-	-	-	-	-	135,000
162	FR Business Plan	1,900,000	-	-	-	1,600,000	-	300,000
163	New FLHQ Space Planning	75,000		-	-	-	-	75,000
164	Property Settlement	585,000	-	-	-	-	-	585,000
165	Unisex Restroom at FLHQ	25,000		-	-	-	-	25,000
166	Park City Electric Bus	2,952,159	-	2,290,000	-	-	500,000	162,159
167	Paint Booth at Warm Springs	1,144,206	-	-	-	-	-	1,144,206
168	Bus Shields	714,000	-	535,500	-	-	-	178,500
169	Light Rail Seat Replacement	4,154,000		4,154,000	-	-	-	-
170	Capital Contingency	28,000	-	-	-	-	-	28,000
171	Total Capital Projects	37,779,834	2,625,150	17,255,698	-	1,850,000	4,849,912	11,199,074
172								
173	Total Capital Budget	$ 27,176,413	$ (28,751,546)	$ 25,254,648	$2,785,389	$ 1,850,000	$ 7,199,912	$ 18,838,010

2020 Budget After Amendment #2

	Project Name	Amended 2020 Budget	Bonds	Grants	Lease	State Funding	Local Partners	UTA Funded
1	**Major Capital Projects**							
2	Depot District Maintenance Facility	$ 25,000,000	$ 2,500,000	$ 20,000,000	$ -	$ 2,500,000	$ -	$ -
3	Ogden/Weber State University BRT	15,250,000	3,000,000	7,000,000	-	-	5,250,000	-
4	Airport Station Relocation	11,000,000	11,000,000	-	-	-	-	-
5	Provo-Orem TRIP	5,210,967	3,355,027	1,855,940	-	-	-	-
6	Total Major Capital Projects	56,460,967	19,855,027	28,855,940	-	2,500,000	5,250,000	-
7								
8								
9	**Revenue / Service Vehicles**							
10	Non-Rev Service Vehicle Replacement	200,000	-	-	-	-	-	200,000
11	Replacement Paratransit	5,532,278	-	-	5,499,278	-	-	33,000
12	Bus Replacement	27,566,971	-	2,775,830	23,598,570	-	-	1,192,571
13	Salt Lake City Buses	235,231	-	-	235,231	-	-	-
14	Van pool Van replacement	1,292,780	-	-	1,292,780	-	-	-
15	Total Revenue/Service Vehicles	34,827,260	-	2,775,830	30,625,859	-	-	1,425,571
16								-
17	**Information Technology**							-
18	Rail Passenger Info	276,570	-	-	-	-	-	276,570
19	Electronic Fare Collection Maintenance & Replacement	2,714,187	-	-	2,500,000	-	-	214,187
20	FrontRunner WiFi Enhancements	73,320	-	-	-	-	-	73,320
21	IVR Passenger Callout	64,779	-	-	-	-	-	64,779
22	Network & Infrastructure Equipment	505,324	-	-	-	-	-	505,324
23	CoordM-04 ITS Development	200,855	-	144,748	-	-	-	56,107
24	Legal SW	139,258	-	-	-	-	-	139,258
25	AppDev JDE 9.2 System Upgrade	30,134	-	-	-	-	-	30,134
26	WFRC Grant Passenger Info Improvements	1,459,743	-	1,361,000	-	-	-	98,743
27	In-house Application Development & Enhancements	362,616	-	-	-	-	-	362,616
28	Vanpool-02 Driver Tracking andDatabase System	55,000	-	-	-	-	-	55,000
29	IT Managed Reserved (formerly IT Pool)	307,986	-	-	-	-	-	307,986
30	WiFi Towers	12,866	-	-	-	-	-	12,866
31	Bus Communication On-Board Technology	162,229	-	-	-	-	-	162,229
32	Info Security Equip & SW (PCI Compliance & Cyber Security)	353,882	-	-	-	-	-	353,882
33	Rail Communication On-Board Technology	212,575	-	-	-	-	-	212,575
34	Server, Storage Infrastructure Equipment and Software	410,965	-	-	-	-	-	410,965
35	Radio Communication Infrastructure	219,333	-	-	-	-	-	219,333
36	New MS SQL Server Licenses	145,000	-	-	-	-	-	145,000
37	Central Div Fluid Mgmnt System	33,000	-	-	-	-	-	33,000
38	TC-1 Timekeeping System	480,000	-	-	-	-	-	480,000

2020 Budget After Amendment #2

	Project Name	Amended 2020 Budget	Bonds	Grants	Lease	State Funding	Local Partners	UTA Funded
39	E Voucher Software Development (pending grant)	1,001,190	-	838,016	-	-	-	163,174
40	Init APC Upgrade	200,000	-	-	-	-	-	200,000
41	SSBU Mobility Eligibility Center Trapeze Software	165,000	-	-	-	-	-	165,000
42	SSBU Radio System Install/subcontract fleet only	170,000	-	-	-	-	-	170,000
43	Transit Management System	655,000	-	-	-	-	-	655,000
44	Total Information Technology	10,410,812	-	2,343,764	2,500,000	-	-	5,567,048
45								
46	**Facilities**							
47	Oil/Water Separator at Riverside	100,000	-	-	-	-	-	100,000
48	Equipment Managed Reserve	517,109	-	-	-	-	-	517,109
49	Facilities Managed Reserve	1,048,450	-	-	-	-	-	1,048,450
50	Concrete/Asphalt Repair & Replacement	30,000	-	-	-	-	-	30,000
51	Park and Ride Rehab and Replacement	500,000	-	-	-	-	-	500,000
52	Stations and Platforms Rehab and Replacement	125,000	-	-	-	-	-	125,000
53								
54	**Safety/Security/Police**							
55	Public Safety	-	-	-	-	-	-	-
56	Tasers	12,052	-	-	-	-	-	12,052
57	Corridor Fencing	74,689	-	-	-	-	-	74,689
58	Ballistic Vests	20,722	-	-	-	-	-	20,722
59	Police Replacement Vehicles	261,388	-	-	-	-	-	261,388
60	Body Cameras	100,000	-	-	-	-	-	100,000
61	Bus Safety and Security	66,724	-	-	-	-	-	66,724
62	Laptop Replacement	33,349	-	-	-	-	-	33,349
63	Emergency Management Items	2,160	-	-	-	-	-	2,160
64	Safety Projects	120,081	-	-	-	-	-	120,081
65	Camera Coverage on Platforms	483	-	-	-	-	-	483
66	Access Control for Data Rooms	27,893	-	-	-	-	-	27,893
67	Camera Sustainability	52,410	-	-	-	-	-	52,410
68	Mini Robot	12,000	-	-	-	-	-	12,000
69	Camera Coverage on PCC Cabinets	35,000	-	-	-	-	-	35,000
70	Facility Security SGR	50,000	-	-	-	-	-	50,000
71	Bus Camera Overhaul/Replacement	271,486	-	-	-	-	-	271,486
72	Emergency Operations Training	24,933	-	-	-	-	-	24,933
73	Camera, door locks, badge scanners	15,000	-	-	-	-	-	15,000
74	Security General Projects	20,000	-	-	-	-	-	20,000
75	Security Vehicle	34,000						34,000

2020 Budget After Amendment #2

	Project Name	Amended 2020 Budget	Bonds	Grants	Lease	State Funding	Local Partners	UTA Funded
76	Next Crossing Cameras	62,112	-	-	-	-	-	62,112
77	Total Facilities, Safety, & Admin Equip.	3,617,041	-	-	-	-	-	3,617,041
78								
79	**Infrastructure State of Good Repair Projects**							
80	C-Car Tires	79,740	-	-	-	-	-	79,740
81	Bus Engine/Transmission/Component Rehab/Replacement	1,524,152	-	-	-	-	-	1,524,152
82	Light Rail Vehicle Rehab	10,610,565	-	-	-	-	-	10,610,565
83	Stray Current Mitigation	378,371	-	-	-	-	-	378,371
84	Asset Management SW	11,212	-	-	-	-	-	11,212
85	RFID Tracking	5,157	-	-	-	-	-	5,157
86	Commuter Rail Engine Rehab	4,542,826	-	786,684	-	-	-	3,756,142
87	Bridge Rehabilitation & Maintenance	465,003	-	-	-	-	-	465,003
88	Paint Room Bldg 8	133,591	-	-	-	-	-	133,591
89	Roof Replacements	51,826	-	-	-	-	-	51,826
90	Rail Rehab and Replacement	459,353	209,353	-	-	-	-	250,000
91	LRV Accident Repair	300,000	-	-	-	-	-	300,000
92	Commuter Rail Cab/Coach overhaul							-
93	FR Platform Snow Melt	24,249	-	-	-	-	-	24,249
94	Grade Crossings Rehab and Replacement	2,365,519	-	-	-	-	-	2,365,519
95	Signal & Grade Crossing Bungalow Batteries	70,000	-	-	-	-	-	70,000
96	Traction Power Rehab and Replacement	1,094,044	550,000	-	-	-	-	544,044
97	OCS Rehab and Replacement	523,510	-	-	-	-	-	523,510
98	Grounding for SoJo CR Signal House	70,399	-	-	-	-	-	70,399
99	TRAX Curve Repl S. Temple/Main	1,302,877	-	-	-	-	-	1,302,877
100	Ballast and Ties Rehab and Replacement	250,000	-	-	-	-	-	250,000
101	Train Control Rehab and Replacement	850,000	-	-	-	-	-	850,000
102	Rail Switches & Trackwork Controls - Rehab/Replacement	850,000	-	-	-	-	-	850,000
103	OK Building Repairs	150,000	-	-	-	-	-	150,000
104	Total State of Good Repair	26,112,394	759,353	786,684	-	-	-	24,566,357
105	Total State of Good Repair	74,967,507	759,353	5,906,278	33,125,859	-	-	35,176,017
106								
107	**Capital Projects**							
108	Office Equipment Reserve	100,000	-	-	-	-	-	100,000
109	Tooele Bus Facility	1,267,751	1,267,751	-	-	-	-	-
110	Positive Train Control w/MD Upgrades	3,816,641	1,276,951	339,690	-	-	-	2,200,000
111	Box Elder Right of Way Preservation	4,497,553	-	-	-	-	-	4,497,553
112	FTA 5310 Funds as designated rec	90,336	-	72,269	-	-	-	18,067

2020 Budget After Amendment #2

	Project Name	Amended 2020 Budget	Bonds	Grants	Lease	State Funding	Local Partners	UTA Funded
113	Prop #1 Weber County Improvemens	287,313	-	-	-	-	-	287,313
114	Prop #1 Davis County Improvemens	1,490,580	-	-	-	-	-	1,490,580
115	Electric Bus Lo/No Grant	170,792	-	170,792	-	-	-	-
116	Downtown TRAX Signal Imp	11,000	-	-	-	-	-	11,000
117	Prop #1 Tooele County Improvements	13,316	-	-	-	-	-	13,316
118	5310 Grant UT-2016-013 Salt Lake	89,828	-	63,530	-	-	20,428	5,870
119	5310 Grant UT-2016-013 Davis/Web	121,374	-	94,542	-	-	26,832	-
120	20-1717 - 5310 Prog - Ogd/Lay	600,748	-	475,766	-	-	105,941	19,041
121	20-1717 - 5310 Prog - Pro/Orem	529,592	-	429,475	-	-	70,205	29,912
122	20-1717 - 5310 Prog - SLC/WV	1,412,686	-	991,222	-	-	353,202	68,262
123	Sandy Parking Structure	5,904,174	-	2,000,000	-	-	2,484,253	1,419,921
124	Sugar House Double Tracking	43,900	-	43,900	-	-	-	-
125	Signal Pre-emption Projects w/UDOT	1,388,711	-	-	-	-	1,388,711	-
126	UDOT I-15 Widening/7200 S Bridge	73,000	-	-	-	-	73,000	-
127	MOW Bulding Clearfield	350,000	-	-	-	-	-	350,000
128	Weber Cnty CR ROW Preservation	2,000,000	-	-	-	-	2,000,000	-
129	650 South Station	220,000	-	-	-	-	200,000	20,000
130	Bus Stop Imp - System-Wide ADA	1,082,402	-	800,000	-	-	-	282,402
131	Wayfinding Signage Plan - S-line and TRAX	1,392,950	-	-	-	-	-	1,392,950
132	South Davis BRT	1,101,153	-	-	-	-	1,101,153	-
133	TIGER Program of Projects	11,116,270	-	6,988,795	-	-	4,038,459	89,016
134	UVU Ped Bridge	2,000,000	-	-	-	-	-	2,000,000
135	3300/3500 South MAX Expansion & Optimization	3,003,326	-	2,800,000	-	-	-	203,326
136	Clearfield FR Station Trail	1,769,817	-	1,650,000	-	-	101,663	18,154
137	Update Bike Cars on FrontRunner	296,699	-	276,612	-	-	-	20,087
138	Stairs to Heated Apron/Track 15	9,296	-	-	-	-	-	9,296
139	U of U Union Building Hub	85,635	-	-	-	-	-	85,635
140	Sharp-Tintic Railroad Connection	700,000	-	424,030	-	-	235,970	40,000
141	Point of Mountain AA/EIS	2,155,107	-	-	-	1,450,000	600,000	105,107
142	MSP220 - 5310	969,233	-	652,383	-	-	297,496	19,354
143	MSP221 - 5310	670,813	-	488,754	-	-	171,576	10,483
144	MSP222 - 5310	569,859	-	429,841	-	-	132,950	7,068
145	Vanpool Vineyard Expansion	135,000	-	125,860	-	-	-	9,140
146	UTA ADA Bus Stop Imp - Utah Cnty	672,234	-	629,302	-	-	-	42,932
147	Police Substation Provo IMC	694,875	80,448	339,900	-	-	-	274,527
148	Meadowbrook Expansion	1,300,000	-	-	-	-	-	1,300,000
149	Operator Restrooms- Salt Lake County	600,000	-	-	-	-	-	600,000

2020 Budget After Amendment #2

	Project Name	Amended 2020 Budget	Bonds	Grants	Lease	State Funding	Local Partners	UTA Funded
150	Bus Stop Imp and signage - SL County	2,500,000	-	-	-	-	-	2,500,000
151	SL UZA Bus Bike Rack Expansion	35,609	-	33,198	-	-	-	2,411
152	Operator Restrooms throughout system	600,000	120,000	480,000	-	-	-	-
153	Operator Shack at University Medical EOL	215,000	-	-	-	-	-	215,000
154	Northern Utah County Double Track	13,500,000	9,500,000	-	-	3,500,000	500,000	-
155	North Temple EOL	3,400,000	-	-	-	-	1,400,000	2,000,000
156	U of U EOL	2,950,000	-	2,500,000	-	-	-	450,000
157	Fort Union EOL	500,000	-	-	-	-	-	500,000
158	5600 W/4500 S EOL	500,000	-	-	-	-	-	500,000
159	Reconfigure Meadowbrook Gate	40,000	-	-	-	-	-	40,000
160	Paxton Avenue TRAX Crossing	85,000	-	-	-	-	85,000	-
161	JRSC Restroom	135,000	-	-	-	-	-	135,000
162	FR Business Plan	1,900,000	-	-	-	1,600,000	-	300,000
163	New FLHQ Space Planning	75,000	-	-	-	-	-	75,000
164	Property Settlement	585,000						585,000
165	Unisex Restroom at FLHQ	25,000						25,000
166	Park City Electric Bus	2,952,159	-	2,290,000	-	-	500,000	162,159
167	Paint Booth at Warm Springs	1,144,206	-	-	-	-	-	1,144,206
168	Bus Shields	714,000	-	535,500	-	-	-	178,500
169	Light Rail Seat Replacement	4,154,000		4,154,000	-	-	-	-
168	Capital Contingency	968,000	-	-	-	-	-	968,000
169	Total Capital Projects	91,781,938	12,245,150	30,279,361	-	6,550,000	15,886,839	26,820,588
170								
171	Total Capital Budget	$ 223,210,412	$ 32,859,530	$ 65,041,579	$ 33,125,859	$ 9,050,000	$ 21,136,839	$ 61,996,605

Proposed Budget Amendment #2 By Type

	Project Name	2019 Capital Carry Forward	Project Reductions	FR & LR SGR Projects	New Projects	Reallocation of Projects	Totals Amendment #2
1	**Major Capital Projects**						
2	Depot District Maintenance Facility	$ -	$ (15,936,916)	$ -	$ -	$ -	$ (15,936,916)
3	Ogden/Weber State University BRT	2,459,437	(15,406,513)	-	-	-	(12,947,076)
4	Airport Station Relocation	-	(2,000,000)	-	-	-	(2,000,000)
5	Provo-Orem TRIP	5,210,967	-	-	-	-	5,210,967
6	Total Major Capital Projects	7,670,404	(33,343,429)	-	-	-	(25,673,025)
7							
8							
9	**Revenue / Service Vehicles**						
10	Non-Rev Service Vehicle Replacement	-	-	-	-	-	-
11	Replacement Paratransit	2,550,158	-	-	-	-	2,550,158
12	Bus Replacement	-	-	-	-	-	-
13	Salt Lake City Buses	235,231	-	-	-	-	235,231
14	Van pool Van replacement	-	-	-	-	-	-
15	Total Revenue/Service Vehicles	2,785,389	-	-	-	-	2,785,389
16							
17	**Information Technology**						
18	Rail Passenger Info	376,570	-	-	-	(100,000)	276,570
19	Electronic Fare Collection Maintenance & Replacement	214,187	-	-	-	-	214,187
20	FrontRunner WiFi Enhancements	23,320	-	-	-	-	23,320
21	IVR Passenger Callout	64,779	-	-	-	-	64,779
22	Network & Infrastructure Equipment	5,324	-	-	-	-	5,324
23	CoordM-04 ITS Development	200,855	-	-	-	-	200,855
24	Legal SW	139,258	-	-	-	-	139,258
25	AppDev JDE 9.2 System Upgrade	30,134	-	-	-	-	30,134
26	WFRC Grant Passenger Info Improvements	1,459,743	-	-	-	-	1,459,743
27	In-house Application Development & Enhancements	187,616	-	-	-	(225,000)	(37,384)
28	Vanpool-02 Driver Tracking andDatabase System	55,000	-	-	-	-	55,000
29	IT Managed Reserved (formerly IT Pool)	17,986	-	-	-	-	17,986
30	WiFi Towers	12,866	-	-	-	-	12,866
31	Bus Communication On-Board Technology	62,229	-	-	-	(200,000)	(137,771)
32	Info Security Equip & SW (PCI Compliance & Cyber Security)	79,882	-	-	-	-	79,882
33	Rail Communication On-Board Technology	112,575	-	-	-	(130,000)	(17,425)
34	Server, Storage Infrastructure Equipment and Software	10,965	-	-	-	-	10,965
35	Radio Communication Infrastructure	69,333	-	-	-	-	69,333
36	New MS SQL Server Licenses	-	-	-	-	-	-
37	Central Div Fluid Mgmnt System	33,000	-	-	-	-	33,000
38	TC-1 Timekeeping System	480,000	-	-	-	-	480,000

Proposed Budget Amendment #2 By Type

	Project Name	2019 Capital Carry Forward	Project Reductions	FR & LR SGR Projects	New Projects	Reallocation of Projects	Totals Amendment #2
39	E Voucher Software Development (pending grant)	243,352	-	-	-	-	243,352
40	Init APC Upgrade	-	-	-	-	-	-
41	SSBU Mobility Eligibility Center Trapeze Software	-	-	-	-	-	-
42	SSBU Radio System Install/subcontract fleet only	-	-	-	-	-	-
43	Transit Management System	-	-	-	-	655,000	655,000
44	Total Information Technology	3,878,974	-	-	-	-	3,878,974
45							
46	**Facilities**						
47	Oil/Water Separator at Riverside	100,000	-	-	-	-	100,000
48	Equipment Managed Reserve	267,109	-	-	-	-	267,109
49	Facilities Managed Reserve	48,450	-	-	-	-	48,450
50	Concrete/Asphalt Repair & Replacement	30,000	-	-	-	-	30,000
51	Park and Ride Rehab and Replacement	-	-	-	-	-	-
52	Stations and Platforms Rehab and Replacement	-	-	-	-	-	-
53							-
54	**Safety/Security/Police**						-
55	Public Safety						-
56	Tasers	12,052	-	-	-	-	12,052
57	Corridor Fencing	24,689	-	-	-	-	24,689
58	Ballistic Vests	5,722	-	-	-	-	5,722
59	Police Replacement Vehicles	21,388	-	-	-	-	21,388
60	Body Cameras	100,000	-	-	-	-	100,000
61	Bus Safety and Security	36,724	-	-	-	-	36,724
62	Laptop Replacement	33,349	-	-	-	-	33,349
63	Emergency Management Items	2,160	-	-	-	-	2,160
64	Safety Projects	20,081	-	-	-	-	20,081
65	Camera Coverage on Platforms	483	-	-	-	-	483
66	Access Control for Data Rooms	17,893	-	-	-	-	17,893
67	Camera Sustainability	2,410	-	-	-	-	2,410
68	Mini Robot	12,000	-	-	-	-	12,000
69	Camera Coverage on PCC Cabinets	35,000	-	-	-	-	35,000
70	Facility Security SGR	-	-	-	-	-	-
71	Bus Camera Overhaul/Replacement	31,486	-	-	-	-	31,486
72	Emergency Operations Training	9,933	-	-	-	-	9,933
73	Camera, door locks, badge scanners	-	-	-	-	-	-
74	Security General Projects	-	-	-	-	-	-
75	Security Vehicle	-	-	-	34,000	-	34,000

Proposed Budget Amendment #2 By Type

	Project Name	2019 Capital Carry Forward	Project Reductions	FR & LR SGR Projects	New Projects	Reallocation of Projects	Totals Amendment #2
76	Next Crossing Cameras	22,112	-	-	-	-	22,112
77	Total Facilities, Safety, & Admin Equip.	833,041	-	-	34,000	-	867,041
78							
79	**Infrastructure State of Good Repair Projects**						
80	C-Car Tires	79,740	-	-	-	-	79,740
81	Bus Engine/Transmission/Component Rehab/Replacement	24,152	-	-	-	-	24,152
82	Light Rail Vehicle Rehab	850,150	-	-	-	-	850,150
83	Stray Current Mitigation	78,371	-	-	-	-	78,371
84	Asset Management SW	11,212	-	-	-	-	11,212
85	RFID Tracking	5,157	-	-	-	-	5,157
86	Commuter Rail Engine Rehab	1,779,047	-	-	-	-	1,779,047
87	Bridge Rehabilitation & Maintenance	165,003	-	-	-	-	165,003
88	Paint Room Bldg 8	133,591	-	-	-	-	133,591
89	Roof Replacements	51,826	-	-	-	-	51,826
90	Rail Rehab and Replacement	209,353	-	-	-	-	209,353
91	LRV Accident Repair	-	(1,200,000)	-	-	-	(1,200,000)
92	Commuter Rail Cab/Coach overhaul	-	-	-	-	-	-
93	FR Platform Snow Melt	24,249	-	-	-	-	24,249
94	Grade Crossings Rehab and Replacement	365,519	-	1,500,000	-	-	1,865,519
95	Signal & Grade Crossing Bungalow Batteries	70,000	-		-	-	70,000
96	Traction Power Rehab and Replacement	394,044	-	150,000	-	-	544,044
97	OCS Rehab and Replacement	23,510	-	-	-	-	23,510
98	Grounding for SoJo CR Signal House	70,399	-	-	-	-	70,399
99	TRAX Curve Repl S. Temple/Main	1,302,877	-	-	-	-	1,302,877
100	Ballast and Ties Rehab and Replacement	-	-	-	-	-	-
101	Train Control Rehab and Replacement	-	-	600,000	-	-	600,000
102	Rail Switches & Trackwork Controls - Rehab/Replacement	-	-	700,000	-	-	700,000
103	OK Building Repairs	150,000	-	-	-	-	150,000
104	Total State of Good Repair	5,788,200	(1,200,000)	2,950,000	-	-	7,538,200
105	Total State of Good Repair	13,285,604	(1,200,000)	2,950,000	34,000	-	15,069,604
106							
107	**Capital Projects**						
108	Office Equipment Reserve	-	-	-	-	-	-
109	Tooele Bus Facility	1,267,751	-	-	-	-	1,267,751
110	Positive Train Control w/MD Upgrades	1,616,641	-	1,300,000	-	-	2,916,641
111	Box Elder Right of Way Preservation	3,497,553	-	-	-	-	3,497,553
112	FTA 5310 Funds as designated rec	90,336	-	-	-	-	90,336

Proposed Budget Amendment #2 By Type

	Project Name	2019 Capital Carry Forward	Project Reductions	FR & LR SGR Projects	New Projects	Reallocation of Projects	Totals Amendment #2
113	Prop #1 Weber County Improvemens	287,313	-	-	-	-	287,313
114	Prop #1 Davis County Improvemens	1,490,580	-	-	-	-	1,490,580
115	Electric Bus Lo/No Grant	170,792	-	-	-	-	170,792
116	Downtown TRAX Signal Imp	11,000	-	-	-	-	11,000
117	Prop #1 Tooele County Improvements	13,316	-	-	-	-	13,316
118	5310 Grant UT-2016-013 Salt Lake	89,828	-	-	-	-	89,828
119	5310 Grant UT-2016-013 Davis/Web	121,374	-	-	-	-	121,374
120	20-1717 - 5310 Prog - Ogd/Lay	600,748	-	-	-	-	600,748
121	20-1717 - 5310 Prog - Pro/Orem	529,592	-	-	-	-	529,592
122	20-1717 - 5310 Prog - SLC/WV	1,412,686	-	-	-	-	1,412,686
123	Sandy Parking Structure	5,904,174	-	-	-	-	5,904,174
124	Sugar House Double Tracking	43,900	-	-	-	-	43,900
125	Signal Pre-emption Projects w/UDOT	888,711	-	-	-	-	888,711
126	UDOT I-15 Widening/7200 S Bridge	73,000	-	-	-	-	73,000
127	MOW Bulding Clearfield	350,000	-	-	-	-	350,000
128	Weber Cnty CR ROW Preservation	500,000	-	-	-	-	500,000
129	650 South Station	-	-	-	-	-	-
130	Bus Stop Imp - System-Wide ADA	82,402	-	-	-	-	82,402
131	Wayfinding Signage Plan - S-line and TRAX	917,950	-	-	-	-	917,950
132	South Davis BRT	1,101,153	-	-	-	-	1,101,153
133	TIGER Program of Projects	-	(53,390)	-	-	-	(53,390)
134	UVU Ped Bridge	-	-	-	-	-	-
135	3300/3500 South MAX Expansion & Optimization	268,154	-	-	-	-	268,154
136	Clearfield FR Station Trail	268,154	-	-	-	-	268,154
137	Update Bike Cars on FrontRunner	296,699	-	-	-	-	296,699
138	Stairs to Heated Apron/Track 15	9,296	-	-	-	-	9,296
139	U of U Union Building Hub	85,635	-	-	-	-	85,635
140	Sharp-Tintic Railroad Connection	-	-	-	-	-	-
141	Point of Mountain AA/EIS	655,107	-	-	-	-	655,107
142	MSP220 - 5310	-	-	-	969,233	-	969,233
143	MSP221 - 5310	-	-	-	670,813	-	670,813
144	MSP222 - 5310	-	-	-	569,859	-	569,859
145	Vanpool Vineyard Expansion	135,000	-	-	-	-	135,000
146	UTA ADA Bus Stop Imp - Utah Cnty	672,234	-	-	-	-	672,234
147	Police Substation Provo IMC	694,875	-	-	-	-	694,875
148	Meadowbrook Expansion	-	(1,600,000)	-	-	-	(1,600,000)
149	Operator Restrooms- Salt Lake County	200,000	-	-	-	-	200,000

Proposed Budget Amendment #2 By Type

	Project Name	2019 Capital Carry Forward	Project Reductions	FR & LR SGR Projects	New Projects	Reallocation of Projects	Totals Amendment #2
150	Bus Stop Imp and signage - SL County	-	-	-	-	-	-
151	SL UZA Bus Bike Rack Expansion	-	-	-	-	-	-
152	Operator Restrooms throughout system	-	-	-	-	-	-
153	Operator Shack at University Medical EOL	-	-	-	-	(135,000)	(135,000)
154	Northern Utah County Double Track	-	-	-	-	-	-
155	North Temple EOL	-	-	-	-	-	-
156	U of U EOL	-	-	-	-	-	-
157	Fort Union EOL	-	-	-	-	-	-
158	5600 W/4500 S EOL	-	-	-	-	-	-
159	Reconfigure Meadowbrook Gate	-	-	-	-	-	-
160	Paxton Avenue TRAX Crossing	-	-	-	-	-	-
161	JRSC Restroom	-	-	-	-	135,000	135,000
162	FR Business Plan	-	-	-	1,900,000	-	1,900,000
163	New FLHQ Space Planning	-	-	-	75,000	-	75,000
164	Property Settlement	-	-	-	-	585,000	585,000
165	Unisex Restroom at FLHQ	-	-	-	-	25,000	25,000
166	Park City Electric Bus	2,952,159	-	-	-	-	2,952,159
167	Paint Booth at Warm Springs	1,144,206	-	-	-	-	1,144,206
168	Bus Shields	-	-	-	714,000	-	714,000
169	Light Rail Seat Replacement	-	-	-	4,154,000	-	4,154,000
170	Capital Contingency	-	-	-	-	28,000	28,000
171	Total Capital Projects	28,442,319	(1,653,390)	1,300,000	9,052,905	638,000	37,779,834
172							
173	Total Capital Budget	49,398,327	(36,196,819)	4,250,000	9,086,905	638,000	27,176,413