
**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR**

**SAN LUIS VALLEY COMBINED EDUCATORS
HEALTH PLAN**

TABLE OF CONTENTS

INTRODUCTION	1
ELIGIBILITY, FUNDING, EFFECTIVE DATE AND PRE-EXISTING CONDITIONS	3
TERMINATION PROVISIONS	13
HEALTH CARE PRIVACY NOTICE.....	17
OPEN ENROLLMENT	23
SCHEDULE OF BENEFITS	24
MEDICAL BENEFITS.....	30
COST MANAGEMENT SERVICES.....	42
DEFINED TERMS	47
PLAN EXCLUSIONS	58
PRESCRIPTION DRUG BENEFITS	64
HOW TO SUBMIT A CLAIM.....	67
COORDINATION OF BENEFITS	70
THIRD PARTY RECOVERY PROVISION	74
CONTINUATION OF COVERAGE-PUBLIC HEALTH SERVICES ACT.....	76
RESPONSIBILITIES FOR PLAN ADMINISTRATION	79
GENERAL PLAN INFORMATION	85

INTRODUCTION

This document is a description of the San Luis Valley Combined Educators Health Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses. References within the document specific to the male gender also include the female gender.

The purpose of the Plan Document is to set forth the provisions of the Plan in accordance with the Intergovernment Agreement adopted by the participating district school boards, which provide for the payment or reimbursement of all or a portion of eligible medical expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and

excessive charges.

This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation of Coverage-Public Health Services Act. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND PRE-EXISTING CONDITIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active and Retired Employees of the Employer. The following Classes of Employees:

- (1) Non-teaching employees.
- (2) Full-time teachers or school employees who work at least 50% of normal work hours for their position and are on the regular payroll of the Employer for that work.
- (3) Employees retired on or before September 30, 2000. Coverage will terminate on the date the retired employee is age sixty-five (65), is eligible for Medicare or is covered under another group health plan.
- (4) A consultant to the Board who is a retired member of the Plan will be eligible to continue single coverage only, as requested by the Board. Such coverage for this person shall end at age 65. This eligibility provision is effective March 1, 2005.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day of the month following the employee's first payroll deduction/payment that he:

- (1) is a Full-Time, Active Non-Teaching Employee of the Employer. A Non-Teaching Employee is considered to be Full-Time if he normally works at least 50% of normal work hours for his position and is on the regular payroll of the Employer for that work.
- (2) is a Full-Time, Active Teaching or School Employee of the Employer. A Teaching or School Employee is considered to be Full-Time if he normally works at least 50% of normal work hours for his position and is on the regular payroll of the Employer for that work.
- (3) is in a class eligible for coverage.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

- (1) A covered Employee's Spouse and unmarried children from birth to the limiting age of nineteen (19) years. The Dependent children must be primarily dependent upon the covered Employee for support and maintenance. However, a Dependent child will continue to be covered after age nineteen (19), provided the child is a

Full-Time Student at an accredited school or on an approved church mission, and is primarily dependent upon the covered Employee for support and maintenance, is unmarried and under the limiting age of twenty-five (25). When the child reaches either limiting age, coverage will end on the last day of the child's birthday month. If the child does not maintain full-time status or graduates, coverage closes independent of limiting age.

Full-Time Student coverage continues between semester/quarters only if the student is enrolled as a Full-Time Student in the next regular semester/quarter. If the student is not enrolled as a Full-Time Student, coverage will be terminated as of the last day of the month in which classes were attended.

Coverage for an enrolled Dependent child who is a Full-time Student at a post-secondary school and who needs a medically necessary leave of absence will be extended until the earlier of the following:

- one year after the medically necessary leave of absence begins; or
- the date coverage would otherwise terminate under the Plan.

Coverage will be extended only when the enrolled Dependent is covered under the Plan because of Full-time Student status at a post-secondary school immediately before the medically necessary leave of absence begins.

Coverage will be extended only when the enrolled Dependent's change in Full-time Student status meets all of the following requirements:

- the enrolled Dependent is suffering from a serious sickness or injury;
- the leave of absence from the post-secondary school is medically necessary, as determined by the enrolled Dependent's treating Physician; and;
- the medically necessary leave of absence causes the enrolled Dependent to lose Full-time Student status for purposes of coverage under the Plan.

A written certification by the treating Physician is required. The certification must state that the enrolled Dependent child is suffering from a serious sickness or injury and the leave of absence is medically necessary.

For purposes of this extended provision, the term "leave of absence" shall include any change in enrollment at the post-secondary school that causes the loss of Full-time Student status.

A previously ineligible dependent child who becomes an attending full-time student at a recognized educational institution at a later date may be enrolled under the Plan as a new dependent within thirty (30) days of the date the semester begins for which the dependent is attending. Proof of attendance as a full-time student from the registrar of the educational institution must be provided to the

employer within the 30-day period for coverage to become effective on the first day of the month in which classes start.

The term "Spouse" shall mean the covered Employee's legally recognized husband or wife, unless legally separated, or husband or wife by common law agreement, under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship. A Domestic Partnership is not recognized by the Plan.

The term "children" shall include natural children, adopted children or Legally Dependent Children (living in the same household as the Employee) for whom the employee has legal guardianship. Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee.

An unmarried child for whom the covered Employee is the Legal Guardian and who meets the following criteria may be enrolled in this Plan as a covered Dependent:

- child must reside in the Employee's or covered spouse's home and be in a parent-child relationship; or
- the Employee or covered spouse of the Employee claim an income tax deduction for the child; or
- the Employee or covered spouse of the Employee is legally responsible through a divorce decree or other court order, for the medical care of the child.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

In all cases, to qualify as an eligible Dependent under the Plan, the child must be dependent upon the covered Employee for over one-half of his support during the Plan Year. A special rule applies in the case of a child of divorced parents, legally separated parents or parents who lived apart at all times of the year or during the last six months of the calendar year. The child will be considered dependent upon

the Employee for over one-half of his support if the child is in the custody of the Employee and/or the other parent for more than one-half of the year and the child is dependent upon one and/or both parents for more than one-half of his support for the year. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

- (2) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; Domestic Partners or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. San Luis Valley Combined Educators Health Plan shares the cost of Employee and Dependent coverage under this Plan with the covered Employees.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

PRE-EXISTING CONDITIONS

NOTE: The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan even if that coverage is still in effect. The Plan will reduce the length of the Pre-Existing Condition Limitation period by each day of Creditable Coverage under this or a prior plan; however, if there was a significant break in the Creditable Coverage of 63 days or more, then only the coverage in effect after the break will be counted.

Pre-existing condition limitations do not apply to covered dependent children under the age of 19.

An eligible person may request a certificate of Creditable Coverage from his prior plan within twenty-four (24) months after losing coverage and the Employer will assist any eligible person in obtaining a certificate of Creditable Coverage from a prior plan.

A Covered Person will be provided a certificate of creditable coverage from this Plan upon termination of coverage by this Plan. A Covered Person will also be provided a certificate of Creditable Coverage from this Plan upon request either before losing coverage or within 24 months of coverage ceasing.

If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

All questions about the Pre-Existing Condition Limitation and Creditable Coverage should be directed to the Claims Administrator, San Luis Valley HMO, 700 Main Street, Suite 100, Alamosa, CO 81101, (719) 589.3696.

Covered charges incurred under Medical Benefits for Pre-Existing Conditions are not payable unless incurred twelve (12) consecutive months after the person's Enrollment Date. This time, known as the Pre-Existing Conditions Limitation period, may be offset if the person has Creditable Coverage from his previous plan.

Pre-Existing Condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six (6) months prior to the person's Enrollment Date under this Plan. Genetic Information is not, by itself, a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to Pregnancy, or to any dependent child under age 19, including an adopted child or a child placed for adoption.

In addition, pre-existing limitations and exclusions do not apply to conditions discovered during the waiting period or prescriptions purchased using the Prescription Drug Card Program.

Expenses resulting from pre-existing conditions will be considered for payment to a maximum

paid of \$1,000 for all conditions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application which also acts as a payroll deduction authorization. If the covered Employee already has Dependent coverage, a newborn child will be automatically enrolled for thirty (30) days from birth; otherwise, separate enrollment for a newborn child is required.

Enrollment Requirements for Newborn Children. A newborn child of a covered Employee who has Dependent coverage is automatically enrolled in this Plan for thirty (30) days. Charges for covered nursery care will be applied toward the Plan of the covered parent.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent. If the newborn child is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the child is not enrolled within thirty (30) days of birth, the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

- (1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than thirty (30) days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

- (2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on October 1.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within thirty (30) days after the coverage ends (or after the employer stops contributing towards the other coverage). In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within thirty (30) days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Claims Administrator, San Luis Valley HMO, 700 Main Street, Suite 100, Alamosa, CO 81101, (719) 589-3696.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. This means that any Pre-Existing Condition will be determined on the basis of the look back period prior to the Enrollment Date, and the period of the Pre-Existing Conditions Limitation will start on the Enrollment Date.

- (1) Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to each of the following conditions:
 - (a)** The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
 - (b)** If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
 - (c)** The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.
 - (d)** The Employee or Dependent requests enrollment in this Plan not later than thirty (30) days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
 - (e)** The Employee or Dependent was covered under a Medicaid plan or under a State child health plan (SCHIP) and coverage of the employee or dependent is terminated as a result of loss of eligibility.
 - (f)** The Employee or Dependent becomes eligible for premium assistance under Medicaid or SCHIP, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than direct enrollment in a state Medicaid program.
 - (g)** The Employee or Dependent requests enrollment in this Plan not later than sixty (60) days after the date the employee or dependent become eligible

for premium assistance under Medicaid or SCHIP or the date Medicaid or state-sponsored CHIP coverage ends. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

- (h) For purposes of these rules, a loss of eligibility occurs if:
 - (i) The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.
 - (ii) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e. part-time employees).
 - (iii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
 - (iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
 - (v) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) Dependent beneficiaries. If:

- (a) The Employee is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- (b) A person becomes a Dependent of the Employee through marriage, birth,

adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of thirty (30) days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this thirty (30)-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

- (a) in the case of marriage, on the date of marriage or the first day of the first month beginning after the date of the completed request for enrollment is received;
- (b) in the case of a Dependent's birth, as of the date of birth; or
- (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

- (1) The Eligibility Requirement.
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Claims Administrator for a copy of these procedures and further details.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for continuation of coverage through the Public Health Services Act). For a complete explanation of when continuation of coverage through the Public Health Services Act is available, what conditions apply and how to select it, see the section entitled Continuation of Coverage-Public Health Services Act):

- (1) The date the Plan is terminated.
- (2) The date the covered Employee's Eligible Class is eliminated.
- (3) The last day of the calendar month following the date in which the covered Employee ceases to be in one of the Eligible Classes and for which premium deduction/payment has occurred. This includes death or termination of Active Employment of the covered Employee. (See the Continuation of Coverage-Public Health Services Act.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.
- (4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due, unless due to a clerical error whereby past contributions may be paid to bring coverage current.
- (5) On the date the eligible retired employee reaches age sixty-five (65) and is eligible for Medicare; or the date the eligible retired employee is covered under another group health plan.
- (6) On the date the eligible retired employee reaches age sixty-five (65) ; is eligible for Medicare; or the date the eligible retire employee is covered under another group health plan including but not limited to P.E.R.A.

Continuation During Periods of Employer-Certified Leave of Absence, Disability or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to leave of absence. This continuance will end as follows:

For leave of absence only: The end of the ninety (90) days or with approval by the San Luis Valley Combined Educators Health Plan Board of Directors, up to a nine (9) calendar month period that next follows the month in which the person last worked as an Active Employee provided that the employee pays any contribution toward the cost of

coverage as normally required when not on a leave of absence.

For layoff only: If coverage terminates due to a district layoff, there is no continuation of coverage except what is chosen through the Public Health Services Act coverage election.

All Plan provisions will continue as though there were no lapse of coverage status if Public Health Services Act continuation of coverage was elected during this termination period and coverage was uninterrupted to the date of rehire.

For layoff only: If coverage terminates due to total disability, there is no extension of benefits except what is chosen through the Public Health Services Act continuation of coverage election.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993, as amended by the National Defense Authorization Acts of 2008 and 2010; and as promulgated in regulations issued by the Department of Labor. The 2008 and 2010 amendments add and expand upon new military family leave entitlements.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Employee and/or his Dependents when Plan coverage terminated.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

- (1) The maximum period of coverage of a person under such an election shall be the lesser of:
 - (a) The twenty-four (24) month period beginning on the date on which the person's absence begins; or

- (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for thirty (30) days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for continuation of coverage. For a complete explanation of when continuation coverage through the Public Health Services Act is available, what conditions apply and how to select it, see the section entitled Continuation of Coverage- Public Health Services Act):

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the Continuation of Coverage - Public Health Services Act)
- (3) The date a covered Spouse loses coverage due to loss of dependency status. (See the Continuation of Coverage - Public Health Services Act.)
- (4) On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan. (See the Continuation of Coverage - Public Health Services Act)
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due, unless due to a clerical error whereby past contributions may be paid to bring coverage current.
- (6) The earliest date the Dependent has a claim that is denied in whole or in part because it meets or exceeds a lifetime limit on all benefits.

Transfer Between School Districts. An employee who is covered under the Plan and transfers employment from one participating member district of the San Luis Valley Combined Educators Health Plan to another may do so, providing any required contributions are made and there is no lapse in coverage. All Plan provisions will continue as though there was no lapse of active coverage status.

If any required contribution is not made and/or there is a lapse in coverage, the employee must meet the same eligibility and waiting period requirements as that of a new hire, with the waiting period starting on the effective date of the transfer.

Participation Of A New District - When Coverage Begins. When enrollment requirements are met, coverage for eligible employees, and their eligible dependents, who are employed by the newly participating district will be effective as of the date of the participation, or the date of termination of the prior district's coverage, whichever is later, if they were covered under a plan offered by the prior district on the day before the date of the participation. The waiting period will be waived.

If a bodily injury or sickness is a pre-existing condition, but would not have been a pre-existing condition under the prior plan had it remained in force, it will not be a pre-existing condition under this Plan. Credit will be given for any pre-existing period satisfied under the prior plan. A certificate of prior health coverage may be required to substantiate the creditable period of coverage.

The employee and his eligible dependents will be given credit for deductibles and coinsurance provided they submit evidence of amounts satisfied under the prior plan.

New hires will be subject to the waiting period, pre-existing condition restrictions, and all other Plan provisions.

HEALTH CARE PLAN PRIVACY NOTICE

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

The **San Luis Valley Combined Educators Health Plan**, (the Plan) is required by law to maintain the privacy of "protected health information."

"Protected health information" includes any individually identifiable information that the Plan collects from you or creates or receives by a health care provider, a healthcare clearing house, a health plan or your employer on behalf of a group health plan and that relates to 1) your past, present or future physical or mental health or condition; 2) the provision of health care to you; or 3) past, present or future payment for the provision of health care to you.

As required by law, this notice provides you with information about your rights and the Plan's legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures the Plan will make of your protected health information.

The Plan reserves the right to change the terms of this notice from time-to-time and to make the revised notice effective for all protected health information the Plan maintains. You can always request a copy of our most current privacy notice from our office.

Permitted Uses and Disclosures. The Plan can use or disclose your protected health information for purposes of **treatment, payment and health care operations**. In some cases, we have outsourced certain functions to business associates. To the extent that we share your information with a business associate, we require the business associate to protect and maintain the confidentiality of your information in the same manner as we protect and maintain its confidentiality.

Treatment means the provision, coordination or management of your health care, including any referrals for health care from one health care provider to another. For example, a provider under the Plan may need to know health care information in Plan files that might assist in treatment.

Payment means activities to obtain and provide reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, the information on or accompanying health care bills sent to the Plan may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

As another example, prior to providing health care services, the Plan may need information from a provider about your Medical Condition to determine whether the proposed course of treatment will be covered. When the Plan receives a bill from the provider, the Plan can obtain information regarding your care if necessary to provide payment.

Health care operations means the support function related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, Physician reviews, compliance programs, audits, business planning, development, management

and administrative activities. For example, the Plan may use your medical information to evaluate the performance of providers used in the Plan. The Plan may also combine medical information about many patients to decide how to better provide needed benefits under the Plan.

Other Uses and Disclosures of Protected Health Information. The Plan may contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you.

The Plan may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care.

The Plan will only disclose the protected health information directly relevant to their involvement in your care or payment. The Plan may also use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition, or death. If you are available, the Plan will give you an opportunity to object to these disclosures, and the Plan will not make these disclosures if you object. If you are not available, the Plan will determine whether a disclosure to your family or friends is in your best interest, and the Plan will disclose only the protected health information that is directly relevant to their involvement in your care. When permitted by law, the Plan may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.

For purposes of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

When your Authorization is Required. Except as explained above for treatment, payment and health operations and except for circumstances in which use or disclosure is required or permitted by law:

- We will not disclose your health information to persons outside the Plan without your authorization.
- We will not seek or accept payment or other remuneration in exchange for your health information from third parties without your permission.
- We will not use your health information for marketing purposes without your authorization.

If you give us authorization and then change your mind, **you may revoke your authorization at any time in writing.**

The following uses and disclosures are required or permitted by law without your authorization. In most cases, we will limit the information given to the minimum amount necessary to meet state or federal law:

- **Coroners, Medical Examiners and Funeral Directors.** The Plan may release medical information to the coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release medical information about patients to funeral directors as necessary to carry out their duties.
- **Health Oversight Activities.** The Plan may disclose medical information to federal or state agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. The Plan may disclose protected health information to persons under the Food and Drug Administration's jurisdiction to track products or to conduct post-marketing surveillance.
- **Inmates.** If you become an inmate of a correctional institution or fall under the custody of a law enforcement official, the Plan may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.
- **Law Enforcement.** The Plan may release medical information in these situations: if asked to do so by law enforcement official in response to a court order, subpoena, warrant, summons, or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances and are unable to obtain the person's agreement; about a death believed may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime; the location of the crime or victims or the identity, description or location of the person who committed the crime.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or dispute, the Plan may disclose medical information about you in response to a court or administrative order. The Plan may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Military and Veterans.** If you are a member of the armed forces, the Plan may release medical information about you as required by military command authorities. The Plan may also release medical information about foreign military personnel to the appropriate foreign military authority.
- **National Security and Intelligence Activities.** The Plan may release medical information about you to authorized federal officials for intelligence, counterintelligence,

or other national security activities authorized by law.

- **Organ and Tissue Donation.** If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Protective Services for the President and Others.** The Plan may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
- **Public Health Risks.** The Plan may disclose medical information about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of product recalls, repairs or replacements; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if believed a patient has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.
- **Research Purposes.** We may share information on a limited basis for research purposes; we will not seek payment for any information we furnish for research, except for a reasonable amount to pay for our preparation of your information for such research purposes.
- **Serious Threats.** As permitted by applicable law and standards of ethical conduct, the Plan may use and disclose protected health information if, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Workers' Compensation.** The Plan may release medical information about you for programs that provide benefits for work-related injuries or illness.

Our uses and disclosures of information may be prohibited or materially limited by other applicable federal or state law.

Your Rights

- **You have the right to request restrictions** on the Plan's uses and disclosures of protected health information for treatment, payment and health care operations. *Please note that while we will try to honor your request, the Plan is not required to agree to these restrictions.*
- **You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations.** Subject to payment of a reasonable copying charge (if you cannot afford to pay for copies, you will not be denied access), you have the right to inspect and copy the protected health information contained in the Plan's records, except for psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed.
- **You have the right to request a correction** to your protected health information, but the Plan may deny your request for correction.

Any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.

- **You have the right to receive an accounting of disclosures** of protected health information made by the Plan to individuals or entities other than to you, except for disclosures to carry out treatment, payment and health care operations as provided above; to persons involved in your care or for other notification purposes as provided by law; for national security or intelligence purposes as provided by law; to correctional institutions or law enforcement officials as provided by law.
- **You have the right to request and receive a paper copy of this notice from us.**
- **You have the right to notification of any unauthorized use or disclosure of your information that compromises the security or privacy of the information.** We will provide written notice to you as soon as reasonably possible but no later than 60 days after our discovery of a breach of security or privacy of your information.

Filing a Complaint. If you believe that your privacy rights have been violated, you should immediately contact your Privacy Officer, as designated by each individual school district/BOCES. **The Plan will not take action against you for filing a complaint.** You also may file a complaint with the Secretary of Health and Human Services, Region VIII, Office for Civil Rights, U.S. Department of Health and Human Services, 1961 Stout Street-Room 1185 FOB, Denver, CO 80294-3538. Voice phone (303) 844-2024. Fax (303) 844-2025. TDD (303) 844-3439

Contact Person. If you have any questions or would like further information about this notice, please contact the San Luis Valley Combined Educators Health Plan c/o Gallagher Benefit Services, Inc., 6399 S. Fiddlers Green Circle, Suite 200, Greenwood Village, CO 80111-4949, (303) 220-7575.

OPEN ENROLLMENT

OPEN ENROLLMENT

Every August and September, the annual open enrollment period, Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective October 1.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

SCHEDULE OF BENEFITS

Verification of Eligibility (719) 589-3696 or (800) 475-8466

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Note: The following services must be precertified or reimbursement from the Plan may be reduced. For precertification call San Luis Valley HMO, (719) 589-3696 or (800) 475-8466.

- **All inpatient hospitalizations**
- **Home Health Care**
- **Maternity stays extending beyond forty-eight (48) hours for a normal delivery or ninety-six (96) hours for a Cesarean delivery (c-section) and Newborns that must remain in the hospital after the Mother has been discharged.**
- **MRI/CT/PET Scans**
- **Durable Medical Equipment, excluding oxygen related equipment and supplies**
- **Physical, Occupational, and Cardiac Rehabilitation Therapies**
- **Outpatient Transplant Procedures**

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Please see the Cost Management section in this booklet for details.

The Plan is a plan which contains a Network Provider Organization.

PPO name: Colorado Choice Health Plans dba San Luis Valley HMO/Cofinity
Telephone: (719) 589-3696 or (800) 475-8466
E-mail: www.coloradochoicehp.com

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a Non-Network Provider is used. It is the Covered

Person's choice as to which Provider to use.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area.

If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.

Additional information about this option, as well as a list of Network Providers, will be given to Plan Participants, at no cost, and updated as needed.

Deductibles and Coinsurance payable by Plan Participants

Deductibles are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required.

Coinsurance means that in each Calendar Year, the eligible expenses incurred by a covered person are shared by the Plan and the covered person in the amounts shown in the Schedule of Benefits. All Coinsurance, except for the pharmacy benefit, accrues toward the 100% Maximum Out of Pocket amount.

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Maximum Lifetime Benefit Amount	\$2,000,000	
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	\$350	\$500
Per Family Unit	\$1,050	\$1,500
COPAYMENTS		
Hospital services	N/A	\$250*
*The Non-Network Hospital per confinement Copayment applies to elective admissions only. It does not apply to newborns before initial discharge from the hospital. It does not apply toward the deductible or out-of-pocket maximums.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (In-Network and Out-Of-Network Combined)		
Per Covered Person	\$1,850	\$6,500
Per Family Unit	\$4,050	\$13,500
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Cost containment penalties Pharmacy coinsurance Non Covered Expenses		
COVERED CHARGES		
Ambulance Service	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Home Health Care	80% after deductible 100 visit Calendar Year maximum	60% after deductible 100 visit Calendar Year maximum

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Hospice Care	80% after deductible 180 day inpatient and outpatient Lifetime maximum	80% after deductible 180 day inpatient and outpatient Lifetime maximum
Bereavement Counseling (within 3 months of death)	80% after deductible	80% after deductible
Hospital Services		
Room and Board the semiprivate room rate	80% after deductible	60% after copayment and deductible;
Intensive Care Unit Hospital's ICU Charge	80% after deductible	60% after copayment and deductible
Outpatient/Ambulatory Surgery Center	80% after deductible	60% after deductible
Emergency Room	80% after deductible	60% after deductible
Birthing Center	80% after deductible	60% after deductible
Newborn Care in Hospital or Birthing Center Nursery	80%	60%
Infertility Benefits	80% after deductible	60% after deductible
Includes: services for the initial diagnosis and initial testing of infertility.		
Marital Counseling Benefit (all covered expenses)	50% after deductible \$1,500 Lifetime maximum	50% after deductible \$1,500 Lifetime maximum
Mental Health and Substance Abuse Treatment		
Mental Disorders		
Inpatient	80% after deductible	60% after copayment and deductible
Outpatient	80% after deductible	60% after deductible
Substance Abuse		
Inpatient	80% after deductible	60% after copayment and deductible
Outpatient	80% after deductible	60% after deductible

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Morbid Obesity	50% up to a \$500 Calendar Year Maximum \$2,000 Lifetime Maximum	50% up to a \$500 Calendar Year Maximum \$2,000 Lifetime Maximum
Includes: Initial workup, hospital room and board, intensive care, miscellaneous charges, charges relating to surgery, assistant surgeon or anesthesiology and complications and/or reversal of bypass surgery.		
Occupational Therapy	80% after deductible	60% after deductible
Organ Transplants	As any other illness See Medical Benefits Section	As any other illness See Medical Benefits Section
Outpatient Private Duty Nursing	80% after deductible \$2,000 Calendar Year maximum \$5,000 Lifetime maximum	60% after deductible \$2,000 Calendar Year max. \$5,000 Lifetime maximum
Pain Clinics, Facilities, Centers	As any other illness	As any other illness
Physical Therapy	80% after deductible	60% after deductible
Preadmission Testing (within 7 days of hospitalization)	80% after deductible	60% after deductible
Physician Services		
Inpatient visits	80% after deductible	60% after deductible
Office visits	80% after deductible	60% after deductible
Surgery	80% after deductible	60% after deductible
Physician Emergency Room Visit	80% after deductible	60% after deductible
Allergy testing	80% after deductible	60% after deductible
Allergy serum and injections	80% after deductible	60% after deductible
Pregnancy	As any other illness	As any other illness
Preventive Care		
Routine Well Adult Care	80% after deductible \$200 Calendar Year maximum	60% after deductible \$200 Calendar Year maximum
Includes: office visits, pap smear, mammogram, prostate screening, routine physical examination, x-rays, laboratory blood tests, immunizations/flu shots and well-baby care.		
Frequency limits for mammogram Ages 40 and over annually		
Routine Well Baby Care	80% after deductible \$200 Calendar Year maximum	60% after deductible \$200 Calendar Year maximum
Prosthetics	80% after deductible	60% after deductible
Sleep Apnea	50% after deductible	50% after deductible
Skilled Nursing Facility one-half Hospital average semiprivate room and board rate	80% after deductible within 7 days of a 3 day stay; 60 day Calendar Year maximum	60% after deductible within 7 days of a 3 day stay; 60 day Calendar Year maximum
Speech Therapy	80% after deductible	60% after deductible

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Acupuncture and Spinal Manipulation / Chiropractic	50% after deductible \$500 Calendar Year maximum \$2,500 Lifetime maximum	50% after deductible \$500 Calendar Year maximum \$2,500 Lifetime maximum
Urgent Care Facility/Extended Hour/Walk-in Facility (not ER of hospital)		
Emergency or illness care	80% after deductible	60% after deductible
All Other Eligible Expenses	80% after deductible	60% after deductible
The term "as any other illness" means covered expenses will be paid based on the type of service rendered.		

PRESCRIPTION DRUG BENEFIT

	Prescription Solution Pharmacies	All Other Pharmacies
DEDUCTIBLE	\$75/ 3x family	
RETAIL	(34 day supply or 100 units)	(34 day supply or 100 units)
Tier 1: Generic Drugs	100% after 10% Coinsurance, (does not apply to out of pocket maximum)	60% after Deductible (does not apply to out of pocket maximum)
Tier 2: Preferred Brand Name Drugs	100% after 20% Coinsurance, (does not apply to out of pocket maximum)	60% after Deductible (does not apply to out of pocket maximum)
Tier 3: Other Brand Name Drugs	100% after 30% Coinsurance, (does not apply to out of pocket maximum)	60% after Deductible (does not apply to out of pocket maximum)
Tier 4: Specialty Drugs*	100% after 40% coinsurance to a maximum of \$250 per prescription (does not apply to out of pocket maximum)	N/A
* Specialty Drugs are not available via Mail Order		
MAIL ORDER	(90-day supply)	
Tier 1: Generic Drugs	100% after 10% Coinsurance, (does not apply to out of pocket maximum)	N/A
Tier 2: Preferred Brand Name Drugs	100% after 20% Coinsurance, (does not apply to out of pocket maximum)	N/A
Tier 3: Other Brand Name Drugs	100% after 30% Coinsurance, (does not apply to out of pocket maximum)	N/A

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

Deductible Three Month Carryover. Covered Charges incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next Calendar Year.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person.

COVERED CHARGES

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

- (1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

- (2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness. Charges for any services or supplies provided to a person not covered by the Plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple) are not covered charges.

Group health plans 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).

Expenses for **amniocentesis testing and/or genetic counseling**, when recommended by a Physician for a Covered Person who is thirty-five (35) years of age or older at the time of delivery, or for a documented high-risk pregnancy, or family history of genetic disorder. Any procedure intended solely for sex determination is not covered.

Fetal surgery will be considered as part of the mother's care.

Birthing centers.

- (3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:
 - (a) the patient is confined as a bed patient in the facility;
 - (b) the confinement starts within seven (7) days of a Hospital confinement of

at least three (3) days;

- (c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
- (d) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered charges for a Covered Person's care in these facilities is limited to the covered daily maximum shown in the Schedule of Benefits.

- (4) **Physician Care.** The professional services of a Physician for surgical or medical services.
 - (a) Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:
 - (i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
 - (ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and
 - (iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20%, or a physician's assistant 15% of the surgeon's Usual and Reasonable allowance.
- (5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:

- (a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
- (b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

- (6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

- (7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or covered Dependent Children). Bereavement services must be furnished within six months after the patient's death.

- (8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

- (a) **Acupuncture** performed by a physician or licensed acupuncturist when medically necessary to treat a covered illness or injury.

- (b) **Allergy testing, treatment and injections.** RAST (radioallergosorbent test) allergy testing will be allowed only when Medically Necessary as the only alternative to traditional allergy testing.
- (c) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.
- (d) **Anesthetic;** oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
- (e) **Assistant Surgeon's** fee when the procedure requires an assistant surgeon due to medical necessity.
- (f) **Blood transfusions,** blood processing costs, blood transport charges, blood handling charges, administration charges, the cost of blood, plasma and blood derivatives and pre-surgical autologous storage of blood. Any credit allowable for replacement of blood plasma by donor or blood insurance will be deducted from the total of eligible covered expenses.
- (g) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.
- (h) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.
- (i) Accredited facilities, clinics, or centers involved in the testing and treatment of **chronic pain** for a covered illness or injury.
- (j) **Cleft Palate and Cleft Lip.** The Plan will provide benefits for cleft palate and cleft lip. Cleft palate is defined as a birth deformity in which the palate (the roof of the mouth) fails to close, and cleft lip is defined as a birth deformity in which the lip fails to close.

The Plan will cover expenses incurred for the following services when provided by a Physician, other professional provider, and facilities necessary for treatment.

- (i) Oral and facial surgery, surgical management and follow-up care by plastic surgeons and oral surgeons.
 - (ii) Habilitative speech therapy.
 - (iii) Otolaryngology treatment.
 - (iv) Audiological assessments and treatment.
 - (v) Orthodontic treatment.
 - (vi) Prosthodontic treatment.
 - (vii) Prosthetic treatment such as obturators, speech appliances and feeding appliances.
- (k) Initial **contact lenses** or glasses required following cataract surgery.
 - (l) Injuries resulting from an act of **domestic violence**.
 - (m) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.
 - (n) Expenses for treatment of kidney disorder by **hemodialysis or peritoneal dialysis** as an inpatient in a hospital or other facility, or for expenses in an outpatient facility or in your home, including the training of one (1) attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces inpatient or outpatient dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in your home.
 - (o) Expenses incurred for the initial diagnosis and testing to determine **infertility and impotency**, whether a medical problem exists or not is covered; expenses incurred in connection with the treatment of infertility, impotency or promotion of conception, including drug therapy, are not covered. However, drug therapy for erectile dysfunction shall be covered per FDA prescribing guidelines.
 - (p) **Laboratory studies.**
 - (q) Treatment of **Mental Disorders and Substance Abuse**, Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse are covered as any other illness, as shown on the Schedule of Benefits.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

- (r) **Morbid Obesity.** Charges for surgical treatment of morbid obesity will be covered if :
 - (i) The condition of morbid obesity exists for at least 5 years
 - (ii) Nonsurgical methods of accomplishing with reduction have been tried under physician supervision for at least 3 years; and
 - (iii) Conditions such as high blood pressure, pulmonary insufficiency (lung disease) arteriosclerosis (hardening of the arteries), diabetes, coronary artery disease, and the like indicate a need for surgery.

Benefits will not be provided for subsequent procedures to correct further injury or illness resulting from the covered person's non-compliance with prescribed medical treatment.

Expenses which are medically necessary in connection with services or supplies and surgical procedures performed in conjunction with morbid obesity will be limited to 50% of reasonable and customary charges up to a maximum of \$500 per calendar year (including initial work-up) with a lifetime maximum of \$2,000. This includes hospital room and board, intensive care, miscellaneous charges, charges relating to surgery, assistant surgeon or anesthesiology and complications and/or reversal of bypass surgery as described in the schedule of benefits.

- (s) Injury to or care of **mouth, teeth and gums.** Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

- (t) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.
- (u) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

Benefit payments for donor charges are subject to the separate Donor Maximum Benefit limit as shown in the Schedule of Benefits.

If the organ or tissue donor is a Covered Person and the recipient is not, then, the Plan will cover donor organ or tissue charges for:

evaluating the organ or tissue;

removing the organ or tissue from the donor.

No transportation charges will be considered. The Plan will always pay secondary to any other coverage.

Special Transplant Program

In addition to any standard transplant set forth in this booklet, a Special Transplant Benefit may be available when a Covered Person participates in the Special Transplant Program. The Special Transplant Benefit provides enhanced transplant benefits and participation in the Program is voluntary. Additional information regarding the Special Transplant Program may be obtained through San Luis Valley HMO.

The Special Transplant Benefit provides the following benefits in addition to any transplant benefits available under this plan:

- (i) Access to Centers of Excellence Transplant Facilities throughout the United States;

- (ii) Reimbursement, up to a total of \$5,000, for expenses incurred by the Covered Person and one companion, or both parents if the Covered Person is a minor child;
 - 1) For travel to and from the Centers of Excellence facility when the travel is related to the actual transplant occurrence; and
 - 2) For lodging expenses related to such travel and occurring prior to and following the actual transplant occurrence; and
- (iii) Waiver of the Covered Person's deductible and copayments up to \$1,500 during the year in which the transplant occurs.

The Special Transplant Benefit is only available when a Covered Person participates in the Special Transplant Program and satisfies all of the following requirements:

- (i) Notification of the transplant procedure must be provided to San Luis Valley HMO in accordance with its guidelines.
 - (ii) The Covered Person must call the Special Transplant Program at 1-888-ORGANS is identified as a potential transplant candidate to notify the Special Transplant Program of the impending transplant; and
 - (iii) All transplant services must be rendered at a Centers of Excellence Transplant Facility which participates in this Program for the specific organ or tissue transplant required. A current list of participating Centers of Excellence facilities for each type of transplant is available from San Luis Valley HMO
- (v) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.
 - (w) **Physician's assistant** fee when the procedure requires a Physician's assistant due to medical necessity, in lieu of the service of an assistant surgeon.
 - (x) **Prescription** Drugs (as defined)
 - (y) **Routine Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule

of Benefits.

Charges for **Routine Well Adult Care**. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

- (z) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.
- (aa) **Reconstructive Surgery**. Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

- (i) reconstruction of the breast on which a mastectomy has been performed,
 - (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and
 - (iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.
- (bb) **Sleep Apnea**. Charges in connection with testing or treatment of sleep apnea. Expenses incurred for all other conditions of sleep disorders are not covered.
 - (cc) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.
 - (dd) **Spinal Manipulation/Chiropractic** services by a licensed M.D., D.O. or D.C.
 - (ee) **Sterilization** procedures.
 - (ff) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
 - (gg) **Urgent and emergency medical care incurred while outside the United States**. Urgent and emergency medical care incurred outside the United States must be provided under the order and direction of a physician. Urgent care is covered when obtained from a provider other than a hospital or emergency room. When a Member receives urgent care, claims

must be submitted to the Plan within sixty (60) days from the date the care was rendered. The claims must contain an itemized statement, physician notes, records, etc. and any other sufficient information to establish the Medically Necessary and urgent nature of the care.

A medical emergency continues as long as the transfer of the Member to an appropriate Plan provider of services or alternate designated by Plan is precluded because of grave risk to the Member's health or when Plan has determined that the distance and the nature of illness involved would make such a transfer unreasonable. When a Member is admitted to a hospital for emergency care, notice of the admission must be provided to the Plan the first business day after admission or as soon as medically possible.

(hh) Coverage of Well Newborn Nursery/Physician Care.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Usual and Reasonable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

Group health plans 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).

Charges for Routine Physician Care. The benefit is limited to the Usual and Reasonable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent.

- (ii) Diagnostic **x-rays**.

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

San Luis Valley HMO
(719) 589-3696 or (800) 475-8466

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least ten (10) days in advance of services being rendered or within forty-eight (48) hours after an emergency.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

- **All inpatient hospitalizations**
- **Home Health Care**
- **Maternity stays extending beyond forty-eight (48) hours for a normal delivery of ninety-six (96) hours for a Cesarean delivery (c-section) and Newborns that must remain in the hospital after the Mother has been discharged.**

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.
- **MRI/CT/PET scans**
- **Durable Medical equipment, excluding oxygen related equipment and supplies**
- **Physical, Occupational and Cardiac therapies**
- **Outpatient transplant procedures**

- (b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;
- (c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- (d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator San Luis Valley HMO at (719) 589-3696 or (800) 475-8466 **at least ten (10) days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family

member, Medical Care Facility or attending Physician must contact San Luis Valley HMO **within forty-eight (48) hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by \$250.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

A second (or third) surgical opinion for an elective surgical procedure, that may be required by the utilization review administrator will be provided at the Plan's expense. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

The patient **may contact San Luis Valley HMO for a referral** or choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty. **San Luis Valley HMO may at any time require a second or third opinion.**

PREAMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

- (1) performed on an outpatient basis within seven days before a Hospital confinement;

- (2) related to the condition which causes the confinement; and
- (3) performed in place of tests while Hospital confined.

Covered charges for this testing will be payable at 80% for In-Network services and 60% for Out-of-Network services even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

CENTERS OF EXCELLENCE PROGRAM

Please note that as part of the Employee Benefit Plan, Covered Persons have access to a Centers of Excellence Program. This is a voluntary program which allows the Covered Person to use one (1) of several facilities throughout the country that offer the highest quality care at a discounted rate for major procedures such as transplants, heart surgery, etc. For more information, contact the Precertification Department at San Luis Valley HMO at (719) 589-3696 or (800) 475-8466.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally

would not be paid by the Plan.

The Plan reserves the right to allow for care at home or other alternative methods of treatment or medical care not otherwise covered under the Plan. In cases where the patient's condition is expected to be or is of a serious nature, the Plan Administrator may arrange for review and/or case management services from a professional qualified to perform such services. The Plan Administrator shall have the right to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost effective result without a sacrifice to the quality of patient care, provided such care is approved by the Plan's case management organization, the patient (or patient's legal representative), the attending Physician, the Plan Administrator, and the Plan's reinsurance carrier.

Benefits provided under this section are subject to all other Plan provisions. Alternative care will be determined on the merits of each individual case and any care or treatment provided will not be considered as setting any precedent or creating any future liability, with respect to that Covered Person or any other Covered Person.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his job with the Employer on a full-time basis.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

Common-Law Marriage means a marriage recognized by the state in which the Covered Person resides as common-law and files both federal and state taxes as married, provides evidence of cohabitation as husband and wife, and by general reputation the two (2) individuals are living together as husband and wife and claiming to be such, and submits a notarized affidavit verifying Common-Law Marriage status. By general reputation is meant the understanding among the neighbors and acquaintances with whom the parties associate in their daily lives, that they are living together as husband and wife, and not that they are merely living together.

Cosmetic Procedure/Surgery means a procedure performed solely for the improvement of a Covered Person's appearance rather than for the improvement or restoration of bodily function. Cosmetic procedures performed for psychiatric or psychological reasons or to change family characteristics or conditions due to aging are not covered under the Plan.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee, Retiree or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including continuation of coverage through the Public Health Service Act), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of more than 63 days. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of special second COBRA election period under the Trade Act, does not count.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Services means treatment for an Illness or Injury which develops suddenly and unexpectedly and which in the absence of immediate medical treatment would result in the condition becoming significantly worse, or result in the death of the Covered Person.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is a school district participating in the San Luis Valley Combined Educators Health Plan.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Claims Administrator shall make the initial determination of experimental and/or investigational. However, if the initial decision is appealed, the Plan Administrator must make an independent evaluation of the experimental/ non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment, which may or may not utilize the services of an independent agency to aid in their understanding of the technical aspects of each individual situation. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Full-Time Student is an Employee's Dependent child who is enrolled in and regularly attending an accredited college or university, high school or vocational school for the minimum number of credit hours required by that school, college or university in order to maintain Full-Time Student status.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets

these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Laboratory, Pathology Services, X-ray and Radiology Services means: Laboratory and pathology services - testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material which has been removed from the body. Diagnostic medical procedures requiring the use of technical equipment for evaluation of body systems are also considered laboratory services. Examples: electrocardiograms (EKGs) and electroencephalograms (EEGs). X-ray and radiology services - services including the use of radiology, nuclear medicine, and ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Legally Dependant Child means an unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Employee's; the child depends on the covered Employee for primary support; the child lives in the home of the covered Employee; and the covered Employee may legally claim the child as a federal income tax deduction.

A covered Legally Dependent Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the

current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Network Provider means a legally licensed health care provider which provides services and supplies within the scope of its authority, but which has not entered into a contract with the Preferred Provider Organization.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Partial Hospitalization is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours, a day and no charge is made for room and board.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his license.

Plan means the San Luis Valley Combined Educators Health Plan, which is a benefits plan for certain Employees of the San Luis Valley Combined Educators Health Plan and is described in this document.

Plan Participant means "any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or member of such organization, or whose beneficiaries may be eligible to receive any such benefit.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the person's Enrollment Date under this Plan (e.g. the six month look back period for an Enrollment Date of August 15 is February 15 through August 14). Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to Pregnancy or to a covered dependent child under the age of 19, including an adopted child or a child placed for adoption.

Preferred Provider Organization means an independent entity which has developed a network of quality health care providers who contractually provide services and supplies, within the scope of their authority, on a reduced fee basis, to the Employees and Dependents of Employer sponsored health plans.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Qualified Medical Child Support Order (QMCSO) means a judgment, decree or order issued by a court, domestic relations magistrate or administrator that provides for child support related to health benefits or enforces a state medical child support order under the Social Security Act (for Medicaid purposes). It requires that the child(ren) named in the order have the right to receive benefits from their parent through any group medical plan under which the parent is enrolled, whether or not the parent has family coverage. The required contribution for coverage will be that of family coverage. The QMCSO must contain:

- (1) the name and last known mailing address of the participant;
- (2) the name and mailing address of each child (alternate recipient) covered by the order;
- (3) a reasonable description of the type of coverage to be provided by the group health plan to each alternate recipient or the manner in which coverage will be determined;
- (4) the period of time to which the order applies; and
- (5) the identification of each plan to which the order applies.

Qualifying Beneficiary (under COBRA) is a covered Employee and/or the Spouse and/or child of a covered Employee who, on the date before a qualifying event occurred, was eligible for benefits under this group health plan. Effective January 1, 1997, a Qualified Beneficiary includes a child who is born to or placed for adoption with the covered Employee during the period of COBRA coverage.

Restorative or Reconstructive Surgery means surgery to restore or improve bodily function to the level experienced before the event which necessitated the surgery or, in the case of a congenital defect, to a level considered normal. Such surgery may have a coincidental cosmetic effect.

Retired Employee is a former Active Employee of the Employer, who was retired on or before September 30, 2000, and while employed by the Employer under the formal written plan of the Employer, elected to contribute to the Plan the contribution required from the Retired Employee.

Schedule of Benefits means the outline of benefits.

Second Surgical Opinion means expenses incurred for examinations, x-rays, and lab performed by a qualified physician in the approved specialty to substantiate medical necessity of the procedure to be performed. A third opinion will be paid in case of a conflict between the first two (2) opinions.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (RN.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Sound Natural Teeth means teeth which are whole or properly restored, are without impairment or periodontal disease, and are not in need of the treatment provided for reasons other than dental injury.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Total Disability (Totally Disabled) means the physical state of a Covered Person resulting from an Illness or Injury which wholly prevents that individual from performing the duties pertaining to his customary employment. That individual must be under the continuous care of a Physician. All determinations of a final definition of a disability are the decision of the Plan Administrator. In the case of a Dependent, Total Disability (Totally Disabled) means unable to perform the normal activities of a person of same age and sex in good health. The Dependent must be under the continuous care of a Physician.

Urgent Care/Extended Care Facility means a freestanding facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A Physician and registered nurse (RN) must be in attendance at all times. The facility may or may not have an x-ray technician and x-ray and laboratory equipment. The facility must have a life support system available.

Usual, Customary and Reasonable. The “usual” fee is that fee usually charged, for a given service, by an individual Physician to his private patients (i.e., his own usual fee). A fee is “customary” when it is within the range of the usual fees charged by Physicians of similar training and experience, for the same service within the same specific and limited geographic area (socio-economic area of a metropolitan area or socio-economic area of a county) as determined by the Plan. The fee is “reasonable” when it meets the above two criteria or is justifiable as determined by the Plan in consideration of the special circumstances of the particular case in question. In no event shall a fee exceeding 130% of the Medicare allowable based on resource based relative value scale (RBRVS) or diagnostic related group (DRG) methodology be considered “reasonable” for purposes of this Plan.

Waiting Period means the period of time that must pass before an Employee or Dependant is eligible to enroll under the terms of a group health plan. If an Employee or Dependent enrolls as a Late Enrollee or on a special enrollment date, any period before such late or special enrollment

is not a Waiting Period.

Well Baby Care means medical treatment, services or supplies rendered to a child or newborn solely for the purpose of health maintenance and not for the treatment of an Illness or Injury.

You, Your means any Covered Person, unless the language specifically refers only to the Employee or only to the Dependents.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

- (1) **Ambulance for convenience.** Any expense for commercial transport, private aviation, or air taxi services are not covered regardless of the circumstances or their FAA certification. Any expenses for transportation by private automobile, commercial or public transportation are not covered. The Plan will not pay for any of these services even if other means of transportation were not available.
- (2) **Artificial insemination,** including but not limited to invitro fertilization, GIFT procedure, surrogate parents, or expenses related to other direct attempts to induce pregnancy including drug and hormone therapy.
- (3) **Biochemical analysis of hair.**
- (4) **Biofeedback, biofeedback equipment** and related services or supplies.
- (5) **Birthing classes.** Expenses for birthing classes.
- (6) **Breast pumps and infant formula.**
- (7) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.
- (8) **Convenience.** Expenses required only for the convenience of the Covered Person or the Covered Person's Physician are not covered.

- (9) **Cosmetic surgery.** Any expenses for cosmetic services or the revision of a previous procedure performed for cosmetic purposes, including but not limited to, breast augmentation unless due to symmetrical reconstruction as provided under the reconstructive surgery benefit, are not covered. Benefits for cosmetic surgery and related expenses are allowed only when such surgery is required as the result of a congenital anomaly or an accidental injury.
- (10) **Court order.** Any expenses incurred as a result of a court order, unless the expenses for the Illness or Injury would be covered under the Plan in the absence of a court order.
- (11) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
- (12) **Deluxe or luxury items** are not covered. Examples are motorized equipment when manually operated equipment can be used, wheelchair sidecars. The Plan will cover deluxe equipment only when additional features are required for effective medical treatment, or to allow the covered person to operate the equipment without assistance. Air conditioners, purifiers, humidifiers, corrective shoes, heating pads, hot water bottles, exercise equipment, whirlpools, waterbeds or other floatation mattresses, self-help devices and other clothing and equipment which is not medical in nature are not covered, regardless of the relief they provide for a Medical Condition.
- (13) **Dental Services or Dental Supplies.** Except where specifically indicated as a covered expense.
- (14) **Domiciliary care.** Care provided in a residential institution, treatment center, half-way house or school because the Covered Person's own home arrangements are not appropriate, and consisting chiefly of room and board is not covered, even if therapy is included.
- (15) **Educational or vocational testing.** Services for educational or vocational testing or training.
- (16) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.
- (17) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (18) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

- (19) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult section of this Plan.
- (20) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).
- (21) **Foreign travel.** Care, treatment or supplies out of the U.S. unless the care is urgent or emergency medical care as outlined in the Medical Benefits section of this Plan document.
- (22) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- (23) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician or a medical reason for the hair loss.
- (24) **Health club membership.**
- (25) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult section of this Plan.
- (26) **Homeopathic or naturopathic physicians** are not covered regardless of the relief they may provide.
- (27) **Hypnosis** whether for medical or anesthesia purposes.
- (28) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

- (29) **Infertility.** Care, supplies, services and treatment for infertility, except for diagnostic services rendered for infertility evaluation.
- (30) **Late claims filing.** Expenses submitted for coverage more than twelve (12) months after the date of service are not covered.
- (31) **Lifestyle and personal growth counseling.**
- (32) **Mailing or sales tax.**
- (33) **Massage therapist,** physical culturist or physical education instructor are not covered.
- (34) **Missed appointments.**
- (35) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (36) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (37) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (38) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- (39) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
- (40) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.
- (41) **Occupational, physical or speech therapy** services to maintain function at a level to which it has been restored, or when no further significant practical improvement can be expected. In addition, The Plan will not pay for **speech therapy** or diagnostic testing related learning disorders which accompany mental retardation or stuttering, at any age.
- (42) **Orthotics.** Orthotics will be covered only to the extent of medical necessity as set forth in the *Defined Terms* section of this Plan Document.

- (43) **Orthognathic (Jaw) Surgery.** The only circumstance under which benefits will be allowed for upper or lower jaw augmentation or reduction procedures is when restoration is required as the result of an accidental injury or due to a congenital defect.
- (44) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
- (45) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
- (46) **Post-mortem testing.**
- (47) Expenses that are subject to the **pre-existing condition restrictions provision**, except as specifically provided.
- (48) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (49) **Rhinoplasty, blepharoplasty or brow lift** except expenses for rhinoplasties and blepharoplasties to correct a functional condition, or expenses for rhinoplasty to correct a condition as a result of an accidental injury.
- (50) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- (51) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (52) **Surrogate pregnancy.** For any services or supplies provided to a person not covered by the Plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- (53) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung illness such as emphysema or asthma.
- (54) **Surgical sterilization reversal.** Care and treatment for reversal of surgical

sterilization.

- (55) **Temporomandibular Joint Syndrome.** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.
- (56) **Therapy and training and self-help programs** treatment, testing, procedures, devices and drugs, including but not limited to:
 - (a) Any type of goal-oriented or behavior modification therapy.
 - (b) Holistic medicine, environmental medicine and naturopathic medicine.
 - (c) Megavitamin therapy.
 - (d) Myotherapy or massage therapy.
 - (e) Recreational, sex addiction, primal scream and Z therapies.
 - (f) Religious counseling.
 - (g) Rolfing.
 - (h) Self-help, stress management and weight loss programs.
 - (i) Sensitivity or assertiveness training.
 - (j) Transactional analysis, encounter groups and transcendental mediation (TM).
- (57) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.
- (58) **War.** Any loss that is due to a declared or undeclared act of war.
- (59) **Weight Reduction.** Expenses for treatment, supplies, instruction or activities for weight reduction, weight control, weight loss programs or physical fitness even if the services are performed or prescribed by a physician. Obesity in itself is not considered an illness or disease and benefits are not allowed solely for its evaluation and treatment. Benefits will be allowed for services, supplies or surgery when required due to **morbid obesity**.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. RxPlus is the administrator of the pharmacy drug plan.

Coinsurance

The coinsurance is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. The coinsurance amount is not a covered charge under the medical Plan and does not accrue towards the out of pocket maximum. Any one pharmacy prescription is limited to a 34-day or 100 unit supply. Any one mail order prescription is limited to a 90-day supply.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, RxPlus, the mail order pharmacy, is able to offer Covered Persons significant savings on their prescriptions. You must obtain an order/enrollment form from your benefit office and complete the form; mail this form along with the physician's original prescription and payment to the mail order pharmacy.

Covered Prescription Drugs

- (1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, erectile dysfunction medications and drugs prescribed for the treatment of chemical dependency, but excludes any drugs stated as not covered under this Plan.
- (2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- (3) Insulin and other diabetic supplies when prescribed by a Physician. Injectables, except for those injectables covered as specialty drugs, are not covered under the pharmacy benefit, but are included in the Plan's medical benefit.
- (4) Immunosuppressants.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

- (1) Refills only up to the number of times specified by a Physician.
- (2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
- (3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- (5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.
- (6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
- (7) **FDA.** Any drug not approved by the Food and Drug Administration.
- (8) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.
- (9) **Immunization.** Immunization agents or biological sera.
- (10) **Infertility.** A charge for infertility medication.
- (11) **Injectable supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).
- (12) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined

in any institution that has a facility for the dispensing of drugs and medicines on its premises.

- (13) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- (14) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
- (15) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- (16) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- (17) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.
- (18) **Smoking cessation.** A charge for Prescription Drugs, such as nicotine gum or smoking deterrent patches, for smoking cessation.
- (19) **Tretinoin,** all dosage forms (e.g., Retin-A) except to treat a non-cosmetic condition for dependents to age nineteen (19) years.
- (20) **Anorexic medications.**
- (21) **Vitamins** except prescription prenatal vitamins to treat a covered pregnancy.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a claim to submit for payment that person must:

- (1) Either the Employee or Provider should submit bills for services rendered. ALL BILLS MUST SHOW:
 - Name of Plan
 - Employee's name
 - Name, address, telephone number and tax ID number of provider of care
 - Diagnosis
 - Type of services rendered, with diagnosis and/or procedure codes
 - Date of Services
 - Charges
 - Group # 7006
- (2) Send the above to the Claims Administrator at this address:

San Luis Valley HMO
700 Main Street, Suite 100
Alamosa, Colorado 81101
(719) 589-3696 or (800) 475-8466

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within ninety (90) days of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

- (a) it's not reasonably possible to submit the claim in that time; and
- (b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a written notice of this denial.

This written notice will be provided within 90 days after receipt of the claim. The written notice will contain the following information:

- (a) the specific reason or reasons for the denial;
- (b) specific reference to those Plan provisions on which the denial is based;
- (c) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and
- (d) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

A Plan Participant will be notified within 90 days of receipt of the claim as to the acceptance or denial of a claim and if not notified within 90 days, the claim shall be deemed denied.

If special circumstances require an extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

CLAIMS REVIEW PROCEDURE

In cases where a claim for benefits payment is denied in whole or in part, the Plan Participant may appeal the denial. This appeal provision will allow the Plan Participant to:

- (a) Request from the Plan Administrator a review of any claim for benefits. Such request must include: the name of the Employee, his Social Security number, the name of the patient and the Group Identification Number, if any.
- (b) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Plan Administrator or Claims Administrator within 60 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Plan Participant with a written response within 60 days of the date the Plan Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Plan

Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the Plan Participant of the delay within the 60 day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the Plan Participant's written request for review.

The Plan Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes Medicare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile Limitations. When medical payments are available under vehicle insurance, the Plan shall have no liability for expenses covered by any other available vehicle coverage, regardless of whether under a no-fault or tort-based system. The Plan shall **pay excess coverage only**, without reimbursement for vehicle plan deductibles. Please refer to the Schedule of

Benefits for specific coverage information. This Plan shall always be considered the secondary when other coverage is available.

For expenses resulting from an automobile accident such coverage carried through auto insurance carriers, which will be considered primary, includes but is not limited to:

- No-Fault Personal Injury Protection (PIP);
- Optional Medical Payments Coverage (MPC);
- Bodily injury liability coverage;
- Un-insured or under-insured motorist coverage; or
- Personal liability umbrella policies, which include excess benefits for medical expenses related to automobile accidents.

Auto related claims that are the responsibility of a third party are also subject to the Third Party Recovery Provision section of the Plan.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules.

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
 - (a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
 - (b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
 - (c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

- (d)** When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

 - (i)** The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - (ii)** If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

- (e)** When a child's parents are divorced or legally separated, these rules will apply:

 - (i)** This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - (ii)** This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - (iii)** This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
 - (iv)** If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
 - (v)** For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

- (f)** If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

- (3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.
- (4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

- (1) automatically assigns to the Plan his rights against any Third Party or insurer when this provision applies; and
- (2) must repay to the Plan the benefits paid on his behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its

rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION OF COVERAGE - PUBLIC HEALTH SERVICE ACT

A federal law (Public Law 99-272, Title X, commonly known as Public Health Services Act) requires that most Employers sponsoring group health plans offer employees the opportunity to temporarily continue their current coverage at group rates in certain instances where coverage under the Plan would otherwise terminate. Coverage for dependents may also be continued if they are already covered under this Plan.

The individual must elect continuation during the election period, and the individual's coverage must have ended for one (1) of the following Qualifying events:

- (1) End of employment with the Employer for any reason (this includes retirement and voluntary quitting) other than gross misconduct.
- (2) Reduction of hours.
- (3) Death of the employee.
- (4) Divorce or legal separation from the employee.
- (5) Attainment of the maximum eligible age by a dependent child.
- (6) Marriage of a dependent child.
- (7) Entitlement of the employee to Medicare benefits.
- (8) Commencement of a Chapter 11 Bankruptcy proceeding after June 1986 by the Employer (if the employee has retired).

The employer will notify the qualifying individual of continuation coverage rights within fourteen (14) days of the notice described above. The qualifying individual will then have sixty (60) days to elect continuation coverage. Failure to elect continuation coverage within sixty (60) days after notification by the employer will result in loss of continuation coverage rights.

The coverage continued will be the same as the individual had at the time coverage ended unless the coverage is subsequently modified for all Plan participants, and will be paid by you, the Covered Participant.

NOTIFICATION REQUIREMENTS AND ELECTION PERIOD

The employee or dependent must notify the Employer within sixty (60) days when coverage ceases because of divorce, legal separation, or when a dependent child ceases to be a dependent child under the requirements of the Plan.

In the case of an employee's reduction of hours, end of employment, death, or entitlement to Medicare the Employer will notify the eligible employee or dependent and the Plan Supervisor

of their right to elect continuation of coverage. When the Employer is notified by the employee of a divorce, legal separation or when a dependent child ceases to be a dependent child under the requirements of the Plan, the Employer will notify the eligible employee or dependent and the Plan Supervisor of their right to elect continuation of coverage. The employee or dependent must elect continuation by the later of:

- (1) Sixty (60) days after the individual's coverage ends; or
- (2) Sixty (60) days after the date shown on the notice of their continuation right from the Employer.

END OF CONTINUATION

Continuation will end on the earliest to the following dates:

- (1) Eighteen (18) months from the date continuation began for individuals whose coverage ended because of a reduction of hours or end of employment.
- (2) Thirty-six (36) months from the date continuation began for individuals whose coverage ended because of the death of the employee, divorce or legal separation from the employee, the marriage or attainment of the maximum age of eligibility by a dependent, or the employee's entitlement to Medicare.
- (3) Twenty-nine (29) months for any qualified beneficiary who is totally disabled within the meaning of either Title 2 (Old Age, Survivors, and Disability Insurance) or Title 16 (Supplemental Security Income) of the Social Security Act at the time of the employee's termination of employment or reduction of hours.
- (4) A qualified beneficiary may be able to extend existing coverage from eighteen (18) months to twenty-nine (29) months if the Social Security Administration determines that you, or a covered dependent, were or became totally disabled at any time during the first sixty (60) days of Continuation of Coverage - Public Health Services Act continuation coverage. To qualify for the extension, the qualified beneficiary must submit a copy of the Social Security disability determination notice within sixty (60) days of the date of such notice to the employer. This paragraph applies only if you have health coverage under the Continuation of Coverage - Public Health Services Act law on or after January 1, 1997.
- (5) The end of the period for which premium is paid if the individual fails to make a premium payment on the date specified by the Employer as governed by Public Health Services Act rules and regulations.
- (6) The date the individual becomes covered under any other group health plan unless said plan contains any exclusions or limitations with respect to any pre-existing condition.

- (7) The date the individual becomes entitled to Medicare; however, and qualified dependent (other than the employee) may continue to eighteen (18) or thirty-six (36) months as determined by the original qualifying event or Public Health Services Act rules and regulations.
- (8) The date the group health Plan ends.

If, before the end of eighteen (18) months of continuation, a continuing dependent becomes a surviving spouse, divorced or legally separated spouse, covered or married dependent, or dependent of any employee who becomes eligible for Medicare, such dependent may continue for the balance of thirty-six (36) months or, if sooner, the earliest of 5 through 7 above. Request for extended continuation must be sent to the Employer/administrator within sixty (60) days after the occurrence of any of the above described qualifying events or you will not receive extended continuation of coverage.

The above is only a summation of benefits and rights under the Public Health Services Act regulations. For additional information contact either the Plan Administrator or Plan Supervisor.

It is the intent of this Plan to comply with all existing Public Health Services Act regulations. If for some reason the information presented in the Plan differs from actual Public Health Services Act regulations, the Plan reserves the right to administer continuation coverage in accordance with such actual regulations.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. San Luis Valley Combined Educators Health Plan is the benefit plan of the Combined Educators Health Plan. The member school districts, in combination, form the Trust and are the Plan Administrator, also called the Plan Sponsor. An individual may be appointed by the San Luis Valley Combined Educators Health Plan to function as the Plan Administrator and serve at the convenience of the Employer (Trustees of the member school districts that comprise the Trust). If the designated Plan Administrator resigns, dies or is otherwise removed from the position, the San Luis Valley Combined Educators Health Plan shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access only if the Plan is amended in accordance with the Privacy Standards.

Therefore, the following provisions apply:

- (1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "*Protected Health Information*" means information that is created or received by the Plan and relates to the past, present or future physical or mental health or condition of a participant; the provision of healthcare to a participant; or the past, present or future payment for the provision of healthcare to a participant; and that identifies the participant or for which there is a reasonable basis to believe that information can be used to identify the participant. Protected health information includes information of persons living or deceased.
- (2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.
- (3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.
 - (a) **Updates Required.** The Employer shall amend this document promptly

with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

- (b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his duties with respect to the Plan.

- (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
 - (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

 - (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

 - (iii) Mitigating any harm caused by the breach, to the extent practicable; and

 - (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

 - (v) The Plan will comply with the requirements of the Health Information technology for Economic and Clinical Health Act (HITECH) and its implementing regulations to provide notification to affected individuals, the Department of Health and Human Services and the media (when required) if the Plan or one of its business associates discovers a breach of unsecured Protected Health Information.

- (4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:
 - (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

 - (b) Ensure that any business associate, to whom it provides Protected Health Information received from the Plan, agrees in writing, protect and maintain the confidentiality of the Protected Health Information with the

same restrictions and conditions that apply to the Employer with respect to such information;

- (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Amendment, or required by law;
- (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
- (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
- (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
- (j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of the Employer's workforce are designated as authorized to receive Protected Health Information from the San Luis Valley Combined Educators Health Plan ("the Plan") in order to perform their duties with respect to the Plan: Participating school districts' Personnel Directors.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Plan documents must be amended to reflect certain obligations required of the Employer.

Therefore, the following provisions apply:

- (1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (2) The Employer shall ensure that any business associate to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan

retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is provided through a combination of insured and partially self-funded benefits and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees.

PLAN NAME

San Luis Valley Combined Educators Health Plan

PLAN NUMBER: 501

TAX ID NUMBER: 84-1437900

PLAN EFFECTIVE DATE: June 1, 1994

PLAN RESTATEMENT DATE: June 1, 2010

PLAN YEAR ENDS: May 31

EMPLOYER INFORMATION

See Addendum A Schedule of Employers for a list of the individual school districts that participate in the San Luis Valley Combined Educators Health Plan

PLAN ADMINISTRATOR

San Luis Valley Combined Educators Health Plan
c/o Gallagher Benefit Services, Inc.
6399 S. Fiddler's Green Circle, Suite 200
Greenwood Village, Colorado 80111-4949
(303) 220-7575

CLAIMS ADMINISTRATOR

San Luis Valley HMO
700 Main Street, Suite 100
Alamosa, Colorado 81101
(719) 589-3696 or (800) 475-8466

BY THIS AGREEMENT, San Luis Valley Combined Educators Health Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for San Luis Valley Combined Educators Health Plan on or as of the day and year first below written.

By _____
San Luis Valley Combined Educators Health Plan

By _____
San Luis Valley Combined Educators Health Plan

Date _____

Date _____

Witness _____

Date _____

