PPO Plan Document for

San Luis Valley School District Members

Effective July 1, 2017

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STATEMENT OF PURPOSE

The purpose of this Medical Plan Document is to describe the Medical Plan and its provisions for the payment or reimbursement of all or a portion of certain medical expenses for enrolled Eligible Employees and Dependents, referred to as Members.

Changes and/or amendments to the Plan may occur in any or all parts of this Medical Plan Document including, but not limited to, covered services, benefit maximums, co-pay, co insurance, deductibles, definitions, limitations, exclusions and eligibility. Any such change or amendment will be binding on each Member. Any such action will be communicated to Members in writing as soon as reasonably possible. **(Please note any Riders to this Medical Plan Document as they may modify the terms and conditions of this Medical Plan Document.)**

If the Plan is terminated, amended, or benefits are eliminated, the benefits of Members are limited to Covered Expenses incurred prior to the termination, amendment or elimination.

This Medical Plan Document supersedes all other documents, previously issued amendments and schedules of benefits and together with the attached Riders shall be the sole document used in determining benefits to which Members are eligible. This Medical Plan is not in lieu of and does not affect any requirements for coverage by Worker's Compensation Insurance.

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

Covered Expenses will be payable, subject to the terms and conditions of this document, only for expenses incurred while coverage is in force and for which Notice of Proof of Claim has been timely submitted. The only exception to this is in the event of a Hospital Confinement of a Member on what would be the Effective Date of Coverage. Refer to the Effective Dates of Coverage Section of this Medical Plan Document for this exception.

No action at law or in equity shall be brought to recover benefits, damages or other losses or expenses under any section of this Plan until the Appeal rights, detailed in this document, have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

This Plan is not deemed to constitute a contract of employment or to give any Member the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge or otherwise terminate the employment of any Member.

Authority to Interpret Plan

The Employer has designated the Claims Administrator and the Boards of Education Self-Funded Trust ("BEST") to have complete authority to determine the standard of proof required in any case and to apply and interpret this Medical Plan Document.

All questions or appeals arising in any manner by and between any parties or persons in connection with this Plan or its operation, whether as to any claim for benefits, or as to the construction of language or meaning of the Medical Plan Document, or as to any writing, decision, instrument or account in connection with the operation of the Plan or otherwise, shall be submitted initially to the Claims Administrator and subsequently to BEST for decisions. Refer to Filing a Claim and an Appeal of a Denied Claim.

This document becomes effective on July 1, 2017.

Note: Pronouns: Whenever used in this Medical Plan Document, pronouns refer to either or both the masculine and feminine gender unless the context indicates otherwise.

If any provision of this Medical Plan Document is in violation of state or federal law, that provision shall be null and void, but only to the extent necessary to bring it within the requirements of the law and to carry out the purpose of this Document. If any provision of this Document is held to be null and void for any reason, its status shall not affect the remainder of this Document, which shall remain in full force and effect and enforceable according to its terms.

WELCOME AND INTRODUCTION

The Boards of Education Self-Funded Trust ("BEST") is a self-funded non-federal governmental health plan ("BEST Health Plan") sponsored through the Colorado Association of School Boards. Your Employer has become a Member Employer of BEST in order to offer this health plan to its Eligible Employees and qualified Dependents.

Your Employer may, from time to time, evaluate the costs of the Plan and determine the amount to be contributed by each Member. You will receive notification of any change in this amount.

You are encouraged to read this Medical Plan Document thoroughly and to become familiar with the provisions, terms, conditions, limitations and exclusions of the Plan. This material will answer most, if not all, of your questions and can serve as a valuable resource to Members and Member Employers regarding eligibility and coverage under this Plan.

As a Member in this Plan, you will receive a wallet-sized Identification Card which will include the necessary information that you will need in order to verify your coverage and telephone numbers to be used in the case of required pre-authorizations, emergency situations, and to assist you to identify participating physicians and other service providers.

When arranging medical services and treatments, discuss your care with your health care provider to become educated about the treatment that may be appropriate in your specific case. Actively participating in your health care decisions can enhance your comfort level with the treatment decisions and can ensure that appropriate options have been considered. This is one way for you to contribute to keeping Plan costs as low as possible while still receiving the level of care you need.

Please note: It is the Eligible Employee's and Member's responsibility to follow the eligibility and enrollment requirements of this Plan accurately and in a timely manner in accordance with the Plan requirements. Failure to do so may result in delay or denial of coverage. Reimbursement(s) from the Plan may be reduced or denied pursuant to certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, limitations, timeliness of Continuation Coverage elections, lack of medical necessity, or lack of coverage. All of these provisions are defined and explained in this document.

GENERAL PROVISIONS

ADMINISTRATION: The Board of Directors of BEST, or an entity so designated by BEST and the Claims Administrator shall be in charge of and responsible for the operation and administration of the Plan.

APPLICATIONS AND COVERAGE: The Employer shall forward Members' enrollment applications and notices of automatic enrollment, when applicable, to BEST or its designated Service Provider. Employer shall also provide notification of any new hires, status changes concerning Members and Dependents, and information concerning Members who are no longer eligible to participate in the Plan.

ASSIGNMENT: Benefits shall be directly assigned to a Preferred Provider. Urgent or Emergency Care benefits provided for by the Plan not received through a Preferred Provider shall not be assignable. However, in the case of an Emergency or in the event that the Claims Administrator has provided written approval for the use of non-participating providers, all or a portion of the benefits, if any, provided by this Plan for Hospital, nursing, medical or surgical service may be paid directly to the provider of such service.

NOTICE AND PROOF OF CLAIMS: In the instance of approved use of non-participating providers where the Member paid for the medical service or supply, written notice of a claimed expense must be given to the Claims Administrator within 180 days after the date of service when the expense is incurred. Failure to furnish such notice of claim together with proof of expenses incurred within the time specified will not invalidate or reduce any claimed expense if it was not reasonably possible to furnish such notice within the time specified. In no case may Claims or claimed expenses for payment filed later than 12 months after the date of service be paid.

The payment of any benefit set forth in this Medical Plan Document is subject to the provision by the Member of such proof and releases as the Claims Administrator may reasonably require before approving the payment of any such benefit.

LEGAL ACTIONS: No action at law or in equity arising under this Plan may be commenced later than two years after the time a Member received the service in question. Any action arising at law or in equity under this Plan shall take place in any court of competent jurisdiction located in Denver, Colorado. Colorado law governs the interpretation of this Medical Plan Document and any related documents.

RIGHT TO EXAMINE CLAIMANT: The Claims Administrator or the Board of Directors of BEST shall have the right and opportunity to have a Physician designated by it, examine a Member whose Injury, Illness or condition is the basis of a claim when and so often as reasonably may be required during the pendency of any such Claim.

FACILITY OF PAYMENT: If any Member in the opinion of the Employer, Claims Administrator, or BEST is legally incapable of executing a valid receipt for any payment due him and a guardian has not been appointed, the Claims Administrator may, at its option, authorize payment to those who, in the Claims Administrator's opinion, have assumed the care and principal support of such individual. If the individual should die before all amounts due and payable to him have been paid, the Claims Administrator in conjunction with the Employer, and/or BEST may, at their option, make such payment to the personal representative or administrator of the estate or to the surviving spouse/domestic partner, child or children, parent or to any other individual or individuals who are legally entitled thereto. Any payment authorized and made by the Claims Administrator in accordance with these provisions shall fully discharge the Plan to the extent of such payment.

BENEFIT CHANGE OR DISCONTINUANCE: The Board of Directors of BEST may change or discontinue any provision of the Medical Plan Document including any benefit or procedure, and such change shall apply to Employers and Members as of the effective date of the change or discontinuance. Subject to the terms and conditions of the Employer Participation Agreement, Employers may change their eligibility rules once annually and such change shall apply to such Eligible Employees and Members as of the effective date of the change. No change or discontinuance made may reduce the amount or restrict the terms of any benefits which become payable under the Plan prior to the effective date of the change or discontinuance. Any benefit change or discontinuance shall apply only at such time as the Employee is Actively at Work.

NONDISCRIMINATION: In the administration of this Plan, the Employer, Claims Administrator, and BEST will act so as not to discriminate unfairly between individuals in similar situations at the time of the action. The Claims Administrator will be entitled to rely on actions by the Plan, the Employer or BEST without being obliged to inquire into the circumstances. BEST will not discriminate in the delivery of health care services based on age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

STATEMENTS CONCERNING THE PLAN: Statements made by the Employer or its agents shall not be deemed representations or warranties binding on BEST.

DATA REQUIRED: Employers and Members shall furnish to the Claims Administrator and BEST all information pertaining to this Plan that reasonably may be required for purposes of Plan administration. In addition, and in accordance with any and all limitations set forth in HIPAA and the HITECH Act, all material that may have a bearing on a Member's coverage shall be open for inspection by the Claims Administrator or BEST at all reasonable times during the continuance of this Plan and until the final determination has been made of all rights and obligations under this Plan.

CLERICAL ERROR: Any clerical error in keeping pertinent records by the Employer, the Claims Administrator, or BEST or a delay in making any entry, will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. An equitable adjustment will be made when the error or delay is discovered.

NO LIABILITY FOR PRACTICE OF MEDICINE: The Plan, BEST, and Claims Administrator are not engaged in the practice of medicine, nor do any of them have any control over the diagnosis, treatment, care or lack thereof, or any health care service provided or delivered to a Member by any health care provider. Neither the Plan, BEST, nor the Claims Administrator will have any liability whatsoever for any loss or injury caused to a Member or other third party by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise, whether or not the health care provider states that his or her professional judgment was affected by the Plan.

APPLICABLE LAW: The parties acknowledge that as a Multiple Employer Health Trust operating a government-sponsored Health Benefit Plan, BEST is not subject to the regulatory authority of the Department of Labor under the Employee Retirement Income Security Act of 1974 ("ERISA"), nor is BEST subject to the jurisdiction of the Division of Insurance of the State of Colorado, Department of Regulatory Agencies. Nevertheless, the parties have determined that compliance with the scope of certain regulatory structures would assist in the orderly administration of the Plan. Where such compliance is intended by the parties, reference to the applicable statutory or regulatory provision will be stated herein. All subsequent amendments or regulatory enactments pursuant to such statute shall be incorporated into the interpretation of this Plan unless notice is given by BEST that such amendments or enactments shall not be applicable. The reference to any particular statutory provision is not intended to invoke the jurisdiction of the Department of Labor or the Division of Insurance over BEST, nor constitute any admission of such jurisdiction.

RIGHT TO RECOVERY: Whenever payments for Allowable Expenses have been made by this Plan in a total amount, at any time, in excess of the maximum amount of payment required, or to a party in error, the Plan shall have the right to recover such payments.

PROVIDER NETWORK

The word "Network" means an outside organization that has contracted with various providers to provide health care services to Members at a negotiated rate. Providers who participate in a network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Member must pay due to the Deductible, coinsurance amounts or other out-of-pocket expenses. Charges are subject to the negotiated fee arrangement in lieu of the Usual and Customary limitation. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the negotiated rates in the network contract. A provider who does not participate in a network may bill Members for additional fees over and above what the Plan pays which will be subject to the Plan's Usual and Customary limitations.

Knowing which network a provider belongs to will help a Member determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Members need to see an In-Network provider, however this Plan does not limit a Member's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a Covered Charge under this Plan, or is subject to a limitation or exclusion.

To find out which network a provider belongs to, please refer to the network website, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

If a provider belongs to the following network, claims for Covered Expenses will normally be processed in accordance with the In-Network benefit levels that are listed on the Schedule of Benefits:

- **Cofinity (www.cofinity.net)**
- **Colorado Choice Health Plans (www.cochoice.com)**

For transplants (other than cornea and kidney for which Cofinity is used), the network is through Optum Centers of Excellence transplant network. If you are a candidate for a transplant, in order to receive the highest level of coverage you must participate in this program. If you do not participate and receive a transplant outside of the Optum Centers of Excellence transplant network, reimbursement will be reduced to the amount that would have been paid under the Optum Centers of Excellence transplant network. See further details elsewhere in this Medical Plan Document under the Benefit Provisions section for *Organ and Marrow Transplant Benefits*.

For elective surgeries arranged through Apostrophe, the network is through a Special Bundled Payment Program with Apostrophe. If you are a candidate for an elective surgery, you must sign up with Apostrophe at my.apostrophehealth.com/best to receive the highest level of coverage. See further details elsewhere in this Medical Plan Document under the Benefit Provisions section for *Outpatient Surgery.*

EXCEPTIONS TO THE PROVIDER NETWORK RATES

Some benefits may be processed at In-Network benefit levels when provided by an Out-of-Network provider. When non-network charges are covered in accordance with network benefits, the charges are still subject to the Usual and Customary charge limitations. The following exceptions may apply:

- Covered Services provided by a radiologist, anesthesiologist, or pathologist when services are provided at a Network facility, even if the provider is an Out-of-Network Provider.
- Covered Services provided by a Physician during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital.
- Covered Services provided by an Emergency room Physician will be payable at the In-Network level of benefits when provided at an In-Network Hospital.

TRANSITIONAL CARE

Certain eligible expenses that would have been considered at the PPO benefit level by the prior Claims Administrator but which are not considered at the PPO benefit level by the current Claims Administrator may be paid at the applicable PPO benefit level if the Member is currently under a treatment plan by a Physician who was a member of this Plan's previous PPO but who is not a member of the Plan's current PPO in the Employee or Dependent's network area. In order to ensure continuity of care for certain medical conditions already under treatment, the PPO medical plan benefit level may continue for 90 days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

- Cancer if under active treatment with chemotherapy and/or radiation therapy.
- Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).
- If the Member is Inpatient in a Hospital on the effective date.
- Post acute Injury or Surgery within the past three months.
- Pregnancy in the second or third trimester and up to eight weeks postpartum.
- Behavioral Health – any previous treatment.

The Eligible Employee must call Colorado Choice Health Plans within 90 days prior to the effective date to see if you or your Dependents are eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, minor Illnesses and elective surgical procedures will not be covered by transitional level benefits.

SCHEDULE OF BENEFITS

*The following schedule summarizes the benefits payable as Covered Charges, subject to identified limitations, maximum payments and all other provisions of the Medical Plan Document. Benefits are subject to the scheduled limitations and in order to receive the highest level of benefits, care **must** be obtained from a Preferred Provider Organization (network vs. non-network) provider/facility.*

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
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.		
MEDICAL DEDUCTIBLE, PER CALENDAR YEAR		
Per Individual	$500	$1,000
Per Family Unit	$1,500	$3,000
COPAYMENTS		
Physician Office Visits - Primary Care	$30.00 co-pay per visit for office visit charge. Any additional services/charges subject to deductible, then 80/20 coinsurance	60% after deductible
Physician Office Visits - Specialty	$50.00 co-pay per visit for office visit charge. Any additional services/charges subject to deductible, then 80/20 coinsurance	60% after deductible
Hospital services	N/A	$250*
*The Non-Network Hospital per confinement Copayment applies to elective admissions only. It does not apply toward the deductible.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (In-Network and Out-Of-Network Combined)		
Per Individual	$2,000	$7,000
Per Family Unit	$4,500	$15,000
The Plan will pay the designated percentage of Covered Expenses until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Expenses 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 ▪ Non Covered Expenses		
COVERED MEDICAL EXPENSES		
	NETWORK PROVIDERS	**NON-NETWORK PROVIDERS**
Acupuncture and Spinal Manipulation / Chiropractic	50% after deductible 12 visits per year maximum 60 visits lifetime maximum	50% after deductible 12 visits per year maximum 60 visits lifetime maximum
Ambulance Service	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Hearing Aids - Minors (under age 18)	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
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	80%	60%

Center Nursery		
Infertility Benefits	80% after deductible	60% after deductible
Includes: services for the initial diagnosis and initial testing of infertility.		

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Laboratory Services	80% after deductible	60% after deductible
Marital Counseling Benefit (all covered expenses)	50% after deductible. 30 visits 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
Morbid Obesity	50% after deductible. One treatment 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.		
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 20 visits per year maximum 50 visits lifetime maximum	60% after deductible 20 visits per year maximum 50 visits lifetime maximum
Pain Clinics, Facilities, Centers	As any other illness	As any other illness
Physical, Speech and Occupational Therapy	80% after deductible (60 visits combined annual maximum)	60% after deductible (60 visits combined annual maximum)
Preadmission Testing (within 7 days of hospitalization)	80% after deductible	60% after deductible
Physician Services		
Inpatient 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 / Routine		
Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.	100% in compliance with the Patient Protection and Affordable Care Act	60% after deductible
Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	100% in compliance with the Patient Protection and Affordable Care Act	60% after deductible
With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	100% in compliance with the Patient Protection and Affordable Care Act	60% after deductible
With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration including well woman visits, gestational diabetes screening, Human Papillomavirus (HPV) testing, annual counseling for HIV and sexually transmitted infections plus annual HIV testing, contraceptives and contraceptive counseling, breastfeeding support, supplies and counseling and domestic violence screening and counseling as required under the Patient Protection and Affordable Care Act.	100% in compliance with the Patient Protection and Affordable Care Act	60% after deductible

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
Urgent Care Facility/Extended Hour/Walk-in Facility (not ER of hospital)		
Emergency or illness care	80% after deductible	80% 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.		
ADDITIONAL BENEFITS IF ENROLLED WITH APOSTROPHE*		
Telehealth visits	$0 copayment when arranged through Apostrophe	n/a
Select outpatient surgeries	$0 copayment when arranged through Apostrophe and received at a designated surgery center for a bundled price	n/a
Expert medical opinions for select surgeries/treatments	$0 copayment when arranged through Apostrophe	n/a
Cancer radiation therapy and imaging services	$0 copayment if arranged through Apostrophe and services received at Rocky Mountain Cancer Center	n/a
*To be eligible for additional benefits outlined above, each subscriber and adult dependent over 18 years of age must complete an online registration, health survey, and quiz through Apostrophe at my.apostrophehealth.com/best.		

PRESCRIPTION DRUG BENEFIT		
	Catamaran Pharmacies	**All Other Pharmacies**
RETAIL	**(30-day supply or 100 units)**	**N/A**
Tier 1: Generic Drugs	100% after l0% Coinsurance	N/A
Tier 2: Preferred Brand Name Drugs	100% after 20% Coinsurance	N/A
Tier 3: Other Brand Name Drugs	100% after 30% Coinsurance	N/A
Tier 4: Specialty Drugs	100% after 40% coinsurance to a maximum of $250 per prescription. Only available for 30-day supply through Briova Rx.	N/A
MAIL ORDER	**(90-day supply)**	
Tier 1: Generic Drugs	100% after 10% Coinsurance	N/A
Tier 2: Preferred Brand Name Drugs	100% after 20% Coinsurance	N/A
Tier 3: Other Brand Name Drugs	100% after 30% Coinsurance	N/A
Tier 4: Specialty Drugs	Not Available for 90-Day Supply	N/A

PREVENTIVE PRESCRIPTION DRUGS COVERED UNDER PATIENT PROTECTION AND AFFORDABLE CARE ACT		
Drug / Supplement	**Coverage**	**Benefit**
Oral Fluorides	Prescription (generic single ingredient only) oral fluoride supplement products for children ages 6 months to 6 years.	$0 copay / prescription
Folic Acid and Prenatal Vitamins	Over-the-counter folic acid supplements (with prescription) including prenatal vitamins for women < 55 years of age.	$0 copay / prescription
Iron Supplements	Prescription and over-the-counter (with prescription) iron supplements for children ages 6 months to 12 months. Intravenous and bulk iron products are excluded.	$0 copay / prescription
Vitamin D	Over-the-counter single ingredient Vitamin D supplements (with prescription) for adults 65 years of age and older.	$0 copay / prescription
Contraceptives	Prescription contraceptive drugs as follows: - Emergency contraceptives – Generic Only - Oral contraceptives – Generic Only	$0 copay / prescription
Smoking Cessation	Prescription and over-the-counter (with prescription) smoking cessation products. Quantity limit of 2 cycles per	$0 copay / prescription

	year applies to all products.	
Bowel Prep Agents	Prescription (generic only) bowel preparation agents for adults 50 years of age or older. Quantity limit of 1 bowel preparation product per year applies. Branded bowel preparation products are excluded.	$0 copay / prescription
Low-Dose Aspirin	Oral over-the-counter aspirin products > 81 mg (with prescription) only for adults 44 years of age and older. Oral over-the-counter aspirin products 81 mg (with prescription) with no age limit. Prescription aspirin products, non-oral aspirin products, combination aspirin products or aspirin strengths > 325 mg are excluded.	$0 copay / prescription

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

An eligible employee is responsible for enrolling in the manner and form prescribed by the employer. Each Employer establishes its own rules for eligibility and effective date of coverage under this Plan and such rules may vary by Employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with these rules. The Plan may request documentation from the eligible employee or eligible dependents in order to make these determinations.

ELIGIBLE CLASSES OF EMPLOYEES

An Eligible Employee is:

- one who is employed and regularly scheduled the minimum number of hours per week as defined by the Employer subject to the minimum requirements of BEST; or,
- An Employee on an Approved Leave of Absence; or,
- Grandfathered Employees; or,
- Qualified Beneficiaries as defined under Continuation Coverage.

Eligibility for coverage in the Plan begins on the day an Eligible Employee commences qualifying employment, in accordance with Eligibility policies set by the Employer.

Suspension or denial of eligibility, coverage, and benefits may occur should a Member fail to:

- pay a required contribution to the Plan, if any; or
- furnish any information, records or releases that the Claims Administrator or BEST may require in order to adjudicate a claim; or
- cooperate with the procedures and investigations of the Claims Administrator and BEST; or
- meet the requirements of the Medical Plan Document/Summary Plan Description; or
- meet the Eligibility requirements.

Members shall be entitled to benefits under the Plan during a Family and Medical Leave in accordance with the provisions of the Family and Medical Leave Act of 1993, as may be amended.

Members also may be entitled to benefits under the Plan during an Employer-approved leave of absence, including coverage of benefits for up to three months during school summer recess. Refer to the Employer policies for these details.

ELIGIBLE CLASSES OF DEPENDENTS

An eligible Dependent is:

- an Eligible Employee's spouse (unless legally separated) including common law spouse unless the Employer does not offer Dependent coverage; or
- an Eligible Employee's current same-gender domestic partner unless the Employer does not offer Dependent coverage; or
- an Eligible Employee's current opposite-gender domestic partner unless the Employer does not offer Dependent coverage; or
- an Eligible Employee's current partner in a civil union unless the Employer does not offer Dependent coverage; or
    - an Eligible Employee's child from birth to the end of the calendar month in which the child attains age 26 unless the Employer does not offer Dependent coverage. For Employers with Dependent coverage, an eligible Dependent child is the Eligible Employee's:
        - natural child; or
        - legally adopted child; or
        - stepchild as long as the employee and natural parent are married; or
        - child of a same or opposite-gender domestic partner as long as the employee and parent are in the committed relationship; or
        - a child for whom the Eligible Employee has been appointed by a court of competent jurisdiction as the child's permanent Legal Guardian and for whom the Eligible Employee is legally financially responsible regarding medical and other health care expenses; or
        - a child placed for adoption; or
        - a Foster Child; or
        - a child covered by a Qualified Medical Child Support Order (QMCSO).

- Coverage may be continued for any Dependent child incapable of self-support because of mental retardation or severe physical handicap, provided such Dependent child became so incapable prior to the end of the month in which the child attained the limiting age and is primarily dependent upon the Employee Member for care and support. Notification and a Physician's statement certifying such incapacity must be submitted to the Employer 31 days prior to the date the Dependent child's coverage would otherwise terminate.
- If both husband and wife are employed by the same Employer and are Eligible Employees, either may elect to cover the other spouse/domestic partner as a Dependent together with any eligible Dependent children.
- The Claims Administrator may request proof of dependency status and permanent legal guardianship from time to time. This proof may be requested in the form of marriage records, birth certificates, income tax returns and official court certified adoption, permanent legal guardianship, divorce decree and other documents determined to be necessary by the Claims Administrator. A Power of Attorney will not be accepted as proof of dependency.
- A Member must notify the Employer within thirty-one (31) days after any change in status affecting coverage resulting from marriage, birth, adoption, divorce, legal separation, death, a child reaching age 26 , or the entrance into or the return from military service.

WAITING PERIOD
A Waiting Period may be required by the Employer to be completed before coverage becomes effective. A Waiting Period is a period of time that must pass before an Employee or Dependent becomes eligible for coverage under the terms of this Plan.

A Waiting Period is not considered a break in coverage.

NON-DUPLICATION OF COVERAGE
Any person who is covered as an eligible Employee shall not also be considered an eligible Dependent under this Plan.

ELIGIBLE EMPLOYEE EFFECTIVE DATE OF COVERAGE

This Medical Plan Document became effective as of July 1, 2017. Benefits of this Plan shall be payable only for Covered Expenses incurred for a properly enrolled Member on or after the effective date of this Plan, and in accordance with the terms, conditions, limitations and exclusions and other requirements as are specified in the Plan.

The Effective Date of Coverage for an Eligible Employee shall be, unless otherwise requested, as of the first day of Active Work in a qualifying position, the date the Employer adopts the Plan or the date that coverage under the Plan begins for Members who are properly enrolled in the Plan.

Each Eligible Employee is required to complete the Medical Plan enrollment application process and elect to enroll in or decline coverage when initially eligible and during the initial enrollment period of 31 days.

Eligible Employees electing to enroll in the Plan must, if applicable, also authorize payroll deductions as of the Effective Date of Coverage to pay the required contributions.

NOTE: Services or treatment for Medical Conditions arising prior to the Effective Date of Coverage and resulting in Hospital confinement as of the Effective Date, are covered as of the Effective Date only if the Eligible Employee notifies the Claims Administrator of the confinement within 48 hours of the Effective Date, or as soon thereafter as is reasonably possible, and if health services are received in accordance with the terms, conditions, exclusions an limitations of this Plan, and are determined to be Medically Necessary and are provided by a Preferred Provider and Hospital. In this case, Plan benefits will be paid; however the Plan will coordinate with another health plan that may also be in effect at the time under the Coordination of Benefits provisions.

An Eligible Employee must begin employment for the Employer before eligibility for coverage under the Plan commences.

The Active Work Requirement shall be waived for Members covered under the prior Medical Plan Document but not Actively at Work on the Effective Date of this Medical Plan Document. For a Member under the prior Plan not Actively at Work because of Total Disability, coverage is effective on the effective date of this Plan for expenses other than those incurred for the Illness or Injury causing the Total Disability.

In the following situations, coverage will begin on the later of:

- If coverage is applied for within any applicable Waiting Period, coverage will become effective the first day of the month coinciding with or following the Waiting Period. If the Waiting Period ends on the first day of the month, coverage will begin on that day; or
- If coverage is applied for more than 30 days after the date of eligibility, you will be considered a Late Enrollee. Coverage for a Late Enrollee will become effective at the beginning of the next Plan Year immediately following the next Open Enrollment following application.
- If you are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 31 days of the event.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Dependent coverage is not available unless the Employer offers Dependent coverage and the Eligible Employee is enrolled in the Plan. This section is not applicable to Employers that do not offer Dependent coverage.

If an Eligible Employee has eligible Dependents on the Effective Date of his coverage and he has enrolled and authorized contributions for Dependent benefits, coverage for those Dependents will be the same as the Eligible Employee's Effective Date of Coverage.

If an Eligible Employee does not have eligible Dependents on the Effective Date of his coverage and later acquires eligible Dependent(s), Plan coverage may be available under Special Enrollment described below.

If the Eligible Employee does not want coverage for his eligible Dependents, he must decline coverage during the enrollment process.

Dependent coverage will be effective on the later of:

- The date of coverage for the Eligible Employee with the Plan begins if the Dependent is enrolled at that time; or
- The date the Dependent is acquired if application is made within 31 days of acquiring the Dependent; or
- The first of the month coinciding with or following the date an enrollment application is properly made if the Dependent is not a Late Enrollee. If coverage is applied for Your Dependent more than 31 days after the date they become eligible they will be considered a Late Enrollee. Coverage for a Late Enrollee will become effective at the beginning of the next Plan Year immediately following the next Open Enrollment following application; or
- If Your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision, if application is made within 31 days following the event; or
- The later of the date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

EFFECTIVE DATE OF COVERAGE FOR A NEWBORN CHILD

A newborn child will be covered from the date of birth only if the Member or Eligible Employee completes and submits the necessary enrollment forms / process and authorizes required payroll deductions to enroll the newborn in the Plan within 31 days of the birth. For Employers without Dependent coverage, the newborn child must be enrolled in another health plan within 60 days of birth to ensure coverage of health care expenses incurred from the date of birth.

Expenses for Covered Expenses will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, there will be no payments from the Plan and the Member or Eligible Employee will be responsible for all costs.

A contribution will be charged from the first day of coverage for the newborn child, if additional contribution is required. In no event will a Dependent be covered prior to the day coverage begins for the Eligible Employee.

ANNUAL OPEN ENROLLMENT PROVISION

On an annual basis the Employer conducts an Open Enrollment period. This is the one time during the year (except for Special Enrollment) that an Eligible Employee or Member may make changes to the benefit elections for the coming Plan year based on individual and/or family needs.

Each Employer establishes its own Open Enrollment period and this will be communicated to its Eligible Employees and Employee Members.

Benefit choices made during this period will be effective with the Employer's new Plan year and will remain in effect until the next Plan year, unless there are status changes during the year which qualify for Special Enrollment.

Coverage Waiting Periods are waived during the annual open enrollment period for covered Employees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If an Eligible Employee and/or Eligible Dependents become covered under this Plan as a result of electing coverage during the annual open enrollment period, the following shall apply:

- The annual open enrollment period shall typically be in the month prior to the commencement of a new Plan Year; and
- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Member's coverage; and
- The Effective Date of coverage shall be the first day of the Plan Year following the annual open enrollment period.

SPECIAL ENROLLMENT PROVISION

If an Eligible Employee or Dependent declined coverage under this Plan when initially eligible, they may enroll under this provision if there was a qualifying loss of other group coverage, including Continuation Coverage, or if there is a qualifying change in family status.

This Plan gives eligible persons special enrollment rights under this Plan if there is a loss of other health coverage or a change in family status as explained below.

LOSS OF HEALTH COVERAGE

Current Employees and their Dependents may have a special opportunity to enroll for coverage under this Plan if there is a loss of other health coverage, if the following conditions are met:

- An Eligible Employee and/or Eligible Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan is offered; and
- An Eligible Employee stated in writing that the reason for declining coverage was due to coverage under another group health plan or health insurance policy; and
- The coverage under the other group health plan or health insurance policy was:
    - COBRA continuation coverage and that coverage was exhausted; or
    - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
    - Terminated and no substitute coverage is offered; or
    - No longer receiving any monetary contribution toward the premium from the employer.

An Eligible Employee or Eligible Dependent(s) must request and apply for coverage under this Plan no later than 31 calendar days after the date the other coverage ended.

An Employee or Dependents may not enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact, or
- Coverage was voluntarily canceled, unless the current or former employer no longer contributed any money toward the premium for that coverage.

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries and other eligible persons have a special opportunity to enroll for coverage under this Plan if there is a change in family status.

If a person becomes an eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse/domestic partner and newly acquired Dependent(s) who are not already enrolled, may enroll for health coverage under this Plan during a special enrollment period. You must request and apply for coverage within 31 calendar days of marriage, birth, adoption or Placement for Adoption.

NEWLY ELIGIBLE FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

Current Employees and their Dependents may be eligible for a Special Enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependent is determined to be eligible for such assistance.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective:

- In the case of marriage, on the date of the marriage (Note: Eligible individuals must submit their enrollment forms/process prior to the Effective Date of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or
- In the case of a Dependent's birth, on the date of such birth; or
- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the date the approved request for coverage is received; or
- In the case of loss of coverage, on the date following loss of coverage.

Eligible Employees electing to enroll in the Plan must, if applicable, also authorize payroll deductions as of the Effective Date of Coverage to pay the required contributions.

TERMINATION

EFFECTIVE DATE OF TERMINATION OF COVERAGE

Except as otherwise provided in this Medical Plan Document, the coverage of any Employee Member under this Plan shall cease on the date coverage terminated under Continuation Coverage, or on the earliest of the following:

- the termination date of this Plan; or
- the ending of the period for which contributions, if required, have been paid; or
- the last day of the month in which the Employee Member ceases to be eligible; or;
- the Employee Member begins active duty in the Armed Forces of any country for longer than 31 days; or,
- the last day of the month in which coverage is discontinued with respect to an entire class of Employees to which such Employee Member belongs; or
- the death of the Employee Member; or
- the last day of the month in which the employment of the Employee Member terminates; or
- the last day of the month in which the Employee Member retires; or
- the filing of a Chapter 11 Bankruptcy proceeding by the Employer; or
- on the date coverage terminated under Continuation Coverage.

NOTE: The Employer must signify an Employee Member's termination of employment by notifying the Claims Administrator within 31 days. If subsequent to termination of service, an Employee is re-employed or reinstated as an Eligible Employee, he will be treated in the same manner as a new Eligible Employee at the date of such re-employment or reinstatement unless such Eligible Employee has been covered continuously since termination by electing Continuation Coverage under this Plan.

For information about continuing coverage, refer to the CONTINUATION OF BENEFITS section.

TERMINATION OF COVERAGE FOR DEPENDENT MEMBER

Coverage with respect to any Dependent Member shall cease on the last day of the month in which such individual ceases to be a Dependent as defined in this Medical Plan Document. Coverage with respect to all Dependents of an Employee Member shall cease on the date coverage terminates for the Employee Member, except as provided in "Continuation of Medical Coverage" section of this Medical Plan Document. An Employee Member's Dependents' coverage shall also terminate on the date the Employee Member requests such coverage be terminated upon acceptable proof of other coverage, but in no event prior to the date of such request. Any remaining premium balance for the current month will be due and payable by the Member.

HIPAA PORTABILITY RIGHTS

CERTIFICATES OF CREDITABLE COVERAGE

New Employees and covered Dependents are encouraged to get a Certificate of Creditable Coverage from the individual's prior employer or insurance company.

Members will receive a Certificate of Creditable Coverage from this Plan when the person loses coverage under this Plan, when the person loses COBRA coverage or upon a written request to this Plan if the individual is covered under this Plan or terminated from this Plan within the previous twenty four month period. The Certificate of Creditable Coverage is evidence of Your coverage under this Plan.

Please submit written requests for a Certificate of Creditable Coverage from this Plan to:

Colorado Choice Health Plans
700 Main Street – Suite 100
Alamosa, CO 81101

Keep these Certificates in a safe place in the event You or Your Dependents become eligible for a Special Enrollment period under another plan. Proof of prior Creditable Coverage may be required to enroll in another plan under Special Enrollment or may assist individuals in obtaining an individual insurance policy in the future.

PRE-EXISTING CONDITIONS

There is no Pre-Existing Condition Exclusion.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

Covered Employers are responsible for compliance with the FMLA, and BEST shall support Employers to promote compliance to the extent necessary and feasible by the Plan. Member shall refer to the Employer's FMLA leave policies for specific requirements of the leave and the payment of Member Contributions, if any.

ACTIVE MILITARY DUTY AND MILITARY RESERVISTS & UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1993 and VETERANS BENEFITS IMPROVEMENT ACT

A Member or Dependent going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act and Veterans Benefits Improvement Act under the following terms. This applies only to Members and Dependents who were covered under the Plan immediately before leaving for military service. Members should consult with Employers for specific requirements and payment of Member Contributions, if any. The maximum period of coverage under such an election is the lesser of:

- The 24-month period beginning on the date on which the absence begins; or
- The day after the date on which the individual was required to apply for or return to a position of employment and fails to do so.

An individual who elects to continue coverage under this Plan may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than an active Member's share, if any, for the coverage.

An Employee or Dependent Member returning to work within 90 days from active duty in the armed forces may have coverage reinstated provided such person was covered under the Plan as of the date the individual was called to active duty in the armed forces. The coverage provided shall be the benefits currently provided by the Plan.

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.

INCAPACITATED DEPENDENT CHILD(REN)

Benefits under this Plan for a covered Dependent child may be continued beyond the limiting age of 26 if all the following tests are met:

- the child is incapable of self-sustaining employment because of mental retardation or severe physical handicap and became so incapacitated prior to the date coverage under this Plan would otherwise terminate, and\
- the child is primarily dependent on the Employee Member for support, and
- the Claims Administrator or Employer is furnished proof of the incapacity 31 days prior to the date the child attains age 26 and was covered under this Plan at the time of incapacitation.

However, benefits as to such child may not be continued beyond the earliest of the following occurrences:

- cessation of the incapacity, or
- failure to furnish any required proof of continuing incapacity or to submit to any required examination, or
- termination of coverage as to the child for any reason other than age.

The Claims Administrator or Employer has the right to require proof of the continuation of the incapacity and the right and opportunity to examine the child as often as is reasonably necessary during the continuation of the incapacity. However, an examination will not be required more often than once a year.

WHEN THE PLAN CAN RESCIND MEMBER COVERAGE

A rescission is a cancellation or discontinuation of coverage that has a retroactive effect, e.g., policy void from the date of enrollment, or benefits previously paid that are declared void. Rescission is not a cancellation / discontinuance with a prospective effect, or retroactive cancellation reactive to non-payment of premiums or contributions. The Employer or BEST can rescind coverage for a Member and/or Dependents if the Member and/or Dependent have performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan. An example may include the Employee or Dependent Member made a fraudulent statement, a material misrepresentation, or omitted any material information in any enrollment, claim or other form in order to obtain coverage, services or benefits under the Plan. In the event of a rescission of coverage, BEST shall provide 31 days advance written notice of the rescission. Such rescission of coverage is considered an adverse benefit determination.

EFFECT OF TERMINATION

When coverage terminates, benefits shall not be provided for any Hospital or medical service after termination even though such services are furnished as a result of an Illness or Injury occurring before such termination of coverage unless otherwise provided under this Plan.

CONTINUATION OF MEDICAL COVERAGE

CONTINUATION OF COVERAGE:
In accordance with the Public Health Service Act, under certain circumstances, a Member whose medical coverage under this Plan would otherwise terminate may elect to continue coverage for a specific period of time ("Continuation Coverage").

A Member who is eligible for Continuation Coverage is called a Qualified Beneficiary as defined in the "Definitions" section of this Medical Plan Document. The events making a Member eligible for Continuation Coverage are called Qualifying Events as defined in "Definitions" of this Medical Plan Document. Qualified Beneficiaries are eligible for Continuation Coverage when Qualifying Events occur.

ELIGIBILITY FOR CONTINUATION COVERAGE:
A Qualified Beneficiary may continue coverage under this section for the maximum periods specified below, by making election to do so with the Plan Administrator and submitting the applicable Contribution. Employees should contact their Employers for information about benefits and premium amounts.

MAXIMUM PERIOD(S) OF CONTINUATION COVERAGE:
Unless otherwise required under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") and any other state or federal laws, regulations or rules, the following maximum periods of Continuation Coverage shall apply:

- Eighteen Month Continuation Coverage: A Qualified Beneficiary may elect 18 months of Continuation Coverage if one of the following Qualifying Events occurs to an Employee Member: (1) termination of employment with the Employer (other than by gross misconduct; (2) reduction in hours such that the Employee is no longer an Eligible Employee; or (3) a change in status to a classification not covered by the Plan. Qualified Beneficiaries eligible under this section are entitled to the same coverage made available to Eligible Employees.

- Eleven Month Extension of Continuation Coverage for Disabled Qualified Beneficiaries: If a Qualified Beneficiary is disabled (as determined by the Social Security Administration) at the time a Qualifying Event occurs involving termination of employment or a reduction in hours, or within 60 days after such Qualifying Event, the 18-month continuation period may be extended 11 months, up to a maximum of 29 months for the disabled Qualified Beneficiary and family members who are Qualified Beneficiaries and have also elected Continuation Coverage. A Qualified Beneficiary is responsible for electing the additional 11 months of Continuation Coverage and for notifying the Employer within 60 days of the determination by the Social Security Administration and before the end of the original 18 months of continuation coverage. In addition, the disabled Qualified Beneficiary must notify the Employer within 30 days of the final determination of the Social Security Administration that the disability no longer exists. Qualified Beneficiaries eligible under this section may continue the coverage previously elected.

- Thirty-Six Month Extension of Continuation Coverage for Dependent (spouse/domestic partner/children) Qualified Beneficiaries of a Medicare Eligible Qualified Beneficiary: If an Employee has a Qualifying Event involving termination of employment or a reduction in hours that occurs less than 18 months after the date the Employee became entitled to Medicare benefits, the period of Continuation Coverage for Qualified Beneficiaries who are Dependents will be extended to a maximum of 36 months of Continuation Coverage after the date of the initial Qualifying Event. Qualified Beneficiaries eligible under this section may continue the coverage previously elected at the time of the Qualifying Event, subject to applicable amendments of the Plan.

- Thirty-Six Month Continuation Coverage: A Qualified Beneficiary who is a Dependent may elect up to 36 months of Continuation Coverage from the date any of the following Qualifying Events occurs: death of the Employee, legal separation or divorce from the Employee, or a child ceases to qualify as a Dependent eligible for coverage under this Plan. Qualified Beneficiaries eligible under this section may continue the coverage previously in effect at the time of the Qualifying Event, subject to applicable amendments of the Plan.

- Multiple Qualifying Events: If during the 18 month Continuation Coverage period that occurred due to termination of employment or a reduction in hours the Employee dies, is divorced or separated, becomes eligible for Medicare or if a child ceases to be a Dependent eligible for coverage under the Plan, a Qualified Beneficiary may elect to continue coverage for a maximum of 36 months after the date of the initial Qualifying Event. Qualified Beneficiaries eligible under this section may continue the coverage previously in effect.

CONTINUATION OF COVERAGE NOTICE AND ELECTION PERIOD:

In the case of the following Qualifying Events: death of the Employee Member, termination of employment, reduction in hours resulting in loss of eligibility, a change in status to a classification not covered by the Plan, or the Employee becomes entitled to Medicare benefits, a Qualified Beneficiary will receive notice of his or her right to Continuation Coverage and Contribution rates within 14 days of the Qualifying Event.

In the case of the following Qualifying Events: legal separation, divorce, or if a child no longer qualifies as a Dependent eligible for coverage under the Plan, a Qualified Beneficiary must notify the Plan Administrator within 60 days of the Qualifying Event. If notice is not received within 60 days of the Qualifying Event, the Qualified Beneficiary will not be eligible for Continuation Coverage. Within 14 days of timely receipt of notice of a Qualifying Event, the Employer will provide the Qualified Beneficiaries with notice of his or her right to Continuation Coverage and Contribution rates. Notification to an individual who is a Qualified Beneficiary of the spouse/domestic partner of the Employee Member shall be treated as notification to all other Qualified Beneficiaries residing with such spouse/domestic partner at the time such notification is made.

The Qualified Beneficiary will have 60 days to elect Continuation Coverage, after the later of:

- the date that the Qualified Beneficiary would lose coverage as a result of the Qualifying Event; or
- the date that the Qualified Beneficiary receives notice of his or her rights to Continuation Coverage. Notice will be deemed to have been received three days after the date the notice is sent.

If a Qualified Beneficiary does not elect Continuation Coverage within the 60 day time period described above, the Qualified Beneficiary and his or her Dependents will not have any health coverage under the BEST Health Plan after the date that coverage ends.

COST OF CONTINUATION COVERAGE AND REQUIRED PAYMENTS:

For a Qualified Beneficiary to continue coverage under this Plan, the full cost of coverage must be paid to the Employer each month. The Contribution will be no more than 102% of the applicable Contribution for similarly situated Employee Members and Dependents. If the 18 month Continuation Coverage period is extended because of disability, the Contribution will be 150% for the 11 month period that follows the 18th month of Continuation Coverage. The Plan Administrator will provide Qualified Beneficiaries with notice of the amount of Contribution for the Continuation Coverage that is in effect at the time the individual becomes entitled to it. The cost of Continuation Coverage may be subject to future increases during the period it remains in effect.

The first monthly payment (which will include Contributions for all periods of time since coverage terminated) must be received by the Employer within 45 days of the date the Qualified Beneficiary elects to continue coverage. Each subsequent payment is due by the first day of the month for which coverage is intended, and shall be considered timely if received within 30 days of the date due. No Claims for Covered Expenses will be paid until the Employer receives the contribution payment.

If Contributions are not received within the time period described, coverage will terminate as of the due date of the Contribution. No Claims will be paid until the Plan Administrator receives the Contribution.

For additional information on Continuation Coverage you may contact your Employer, the Plan Administrator or The BEST Health Plan. Employer and Plan contact information is set forth in Appendix A of this Plan.

TERMINATION OF CONTINUATION COVERAGE:

Continuation Coverage as provided under this section will terminate on the earliest of the following dates, as applicable:

- the date the Qualified Beneficiary first becomes covered under any other group health plan as an Employee or Dependent after Continuation Coverage is elected; or
- the last day of the period for which the last payment was made for coverage in a timely manner; or
- the maximum Continuation Coverage period has been exhausted; or
- the date the Qualified Beneficiary first becomes entitled to Medicare benefits after Continuation Coverage is elected; or
- the date the Employer ceases to provide any group health plan to any employee; or
- 30 days after the date that a Qualified Beneficiary ceases to be disabled according to the Social Security Administration after an 11 month disability extension has begun.

BENEFIT PROVISIONS

The Plan does not impose a maximum lifetime benefit on Members of this Plan.

PAYMENT FOR YOUR COVERAGE

Your Employer pays the difference between the full Contribution cost of this Plan and the amount contributed by Members. The Contribution amount paid by Members for this coverage is based on the cost of the Plan for all the Members that it covers with variations that depend on the coverage each Member selects. Periodically, the Employer establishes the specific amount Members must pay and dates on which such amounts must be paid. Coverage for Members may be terminated if the Contributions for the Plan are not current.

Contributions may be paid for the Plan coverage on a pre-tax basis. This means that your contributions are deducted from your income before federal, state, PERA and Medicare taxes are withheld, resulting in a reduced taxable income amount.

Because pre-tax contributions are not subject to PERA contributions, to ensure the highest possible PERA retirement benefit, you may want to pay contributions on an after-tax basis. Employee Members may contact PERA for details.

PRE-AUTHORIZATION

Inpatient Confinement - A Member planning to enter a Participating facility as an inpatient is required to notify the Claims Administrator by telephone of this possibility prior to the proposed confinement. In the case of Urgent or Emergency Care admission, notification by the patient, the patient's family or in the absence of family, the patient's representative is required within 48 hours of admission. All confinements will be reviewed to evaluate the necessity and appropriateness of admission. Further, the Claims Administrator will determine appropriate review intervals with the attending Physician.

Surgeries, Designated Specific Services and/or Procedures – A Participating Provider, on behalf of a Member, or the Member, is required to obtain pre-authorization from the Claims Administrator. In the case of certain non-Urgent or non-Emergency Care planned surgeries, services, treatments, and procedures this should be completed at least two weeks in advance or as soon as scheduling has taken place. In some cases, the Claims Administrator as part of the authorization process may require an independent medical evaluation. Urgent / Emergency services do not require Pre-Authorization; however, the Claims Administrator must be notified within 48 hours after urgent / Emergency services are provided.

(a) Surgery (whether inpatient or outpatient):
All inpatient and outpatient surgeries unless waived by BEST Health Plan because the Member received an expert medical opinion through Apostrophe that recommends Surgery.

(b) Diagnostic Tests:
Magnetic Resonance Imaging (MRI)
Computerized Axial Tomography (CAT Scan)
Positron Emission Tomography (PET Scan)
Single-Photon Emission Computerized Tomography (SPECT Scan)
Testing for Sleep Apnea

(c) Services/Procedures:
Home Health Care visits in excess of ten
Durable Medical Equipment over $500.00
Organ Transplant services
Breast Reconstruction Procedures
Services for Sleep Apnea
Services for Cleft Lip/Cleft Palate

Utilization of Non-participating Providers or Hospitals

TERMS OF COVERED EXPENSES

If a Member has expenses for Covered Expenses from a Participating Provider which are Medically Necessary and within the scope of that provider's license, subject to all the terms, conditions, limitations and exclusions identified in this Medical Plan Document including required co-pays and pre-authorization, the Plan will pay for the following services:

- PHYSICIAN SERVICES
  - Physician consultations, services and supplies provided in the Physician office including diagnostic tests (x-rays, electrocardiograms, and electroencephalograms). Other Covered Expenses include voluntary family planning, the application and removal of casts, splints, surgical dressings, trusses, braces and therapeutic injections.
  - Maternity and obstetrical visits and services for pre and post-partum care during pregnancy, childbirth, induced abortion (when necessary to prevent the death of the mother) or any associated complication.
  - Physician services for manual spinal manipulation and treatments such as diathermy, ultrasound, heat and cold of the spinal skeletal system and/or surrounding tissue to restore proper articulation of joints, alignment of bones or nerve functions subject to the limitations indicated in the Schedule of Benefits.
  - Spinal manipulation services performed in a Physician's office will not be subject to an additional Office Visit Co-pay.
  - Physician services for the treatment of dermatological conditions.
  - Physician services and supplies for the stabilization or initiation of treatment of an Emergency condition.
  - Allergy testing and treatment services.
  - Telemedicine services

- INPATIENT HOSPITALIZATION
  - For Confinement in a Participating Hospital, Covered Expenses will be limited to facility charges up to the semi-private room and board rate and other ancillary charges that are Medically Necessary. The Plan will pay the facility private-room rate if this accommodation is Medically Necessary or if the facility only offers private room accommodations.
  - Hospital services and supplies which include nursing care, meals (including the preparation of special diets), the use of operating room and related facilities including Intensive and Coronary Care Units, x-rays, laboratory and other diagnostic tests, drugs and medications, biologicals, anesthesia and its administration, oxygen, internal prosthetics, special duty nursing, radiation therapy, inhalation therapy, blood and blood plasma products and their administration.
  - Physician services to include surgical services, specialists, surgical assistants and anesthesiologists.
  - Cleft Lip and or Cleft Palate. Hospital and Physician services and supplies and anesthesiology services approved in advance and in writing from the Claims Administrator for the correction of cleft lip or cleft palate which has been diagnosed as either (1) a Congenital Anomaly in a newborn child of a Member, or (2) as necessary to safeguard the health of a Member because of a specific non-dental physiological impairment. Covered Expenses for care and treatment include:
    - Oral and facial surgery, surgical management and follow-up care by plastic surgeons and/or oral surgeons; and
    - Prosthetic treatment such as oburator, speech appliances and feeding appliances; and
    - Necessary orthodontic treatment; and
    - Necessary prosthodontic treatment; and
    - Rehabilitative Speech Therapy; and
    - Otolaryngology treatment; and
    - Audio logical assessments and treatment.
  - Reconstructive Surgery. Following a mastectomy, the surgery and reconstruction of the other breast to produce a symmetrical appearance. Prostheses and any medical and physical complication of all stages of a mastectomy, including lymphedemas are also considered Covered Expenses.
  - Artificial limbs and eyes for the loss of natural limbs or eyes, including surgery, repair and replacement.
  - Cornea transplants including replacement of organ or tissue procedures are covered on the same basis as any other Illness or Injury.
  - Services and supplies for renal conditions and dialysis for End Stage Renal Disease (ESRD)
  - Hospitalization for Mental Illness and Substance Abuse in accordance with the limitations identified in the Schedule of Benefits. One day of Hospital confinement will reduce the number of Partial Days by two days. Two days of Partial Days will reduce the number of days of Hospital Confinement by one day.

HOSPITAL LENGTH OF STAY IN CONNECTION WITH CHILDBIRTH

Statement of Rights under the Newborns' and Mothers' Health Protection Act.

- Under federal law, group health plans and health insurance issuers offering group health coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. This Plan's rules for these stays are set forth below.

- Maternity and obstetrical care include pre and post-partum care during pregnancy, childbirth, induced abortion (when necessary to prevent the death of the mother), and any associated complication thereof. Covered Expenses include Physician services, operations and special procedures such as Cesarean sections, Hospital services such as the use of the delivery room, X-ray and laboratory, injectable substances and anesthesia.

- Hospital Confinements are automatically covered for a minimum of 48 hours for normal labor and delivery or 96 hours for a cesarean delivery without preauthorization. However, the Plan does not prohibit the discharge of the mother or a newborn earlier than 48 or 96 hours, provided the mother and the Physician, nurse midwife or Physician Assistant are in agreement.

ORGAN AND MARROW TRANSPLANT BENEFITS

- *OPTUM Transplant Centers of Excellence ("COE") network*
  - The plan includes a Centers of Excellence transplant benefit and offers transplant benefits to eligible candidates through the Optum Centers of Excellence transplant network.
  - Coverage for transplant services rendered at an Optum Centers of Excellence transplant network facility will be paid at 100% of eligible hospital, professional and organ/marrow charges. Co-payments, deductibles and other member responsibilities still apply.
  - To view the current list of eligible providers, please contact Colorado Choice Health Plans at (719)589-3696 or (800)476-8466 or visit the Optum Transplant Centers of Excellence at www.myoptumhealthcomplexmedical.com/gateway/public/transplants/providers.jsp.

- *Covered Transplants* Include solid organs (heart, lung, liver, pancreas, kidney, multi-visceral/small bowel, or any combination thereof as a multi-organ transplant), bone marrow, stem cell and islet transplants.

- *Emergency Transplant Care at NON-OPTUM Transplant COE Providers*
  - Coverage for unplanned and unscheduled emergency transplantation ("Emergency Transplant") is a benefit included in the plan, to be paid according to the contract terms negotiated by OPTUM Transplant COE and agreed to by Plan, or Plan's agent, and Provider; however, if payment terms cannot be agreed upon within 10 days of the emergency transplant, then the transplant shall be paid at 110% of Medicare allowable and be considered payment in full.
  - The transplanting hospital must provide the following documents to OPTUM Transplant COE, who will then forward them onto the Plan, within 24 hours of the Emergency Transplant:
    1) A letter from the transplanting hospital's Surgical Director detailing the medical conditions leading to the Emergency Transplant
    2) A copy of the United Network For Organ Sharing ("UNOS") Status 1 Listing Request and Status 1A confirmation Notice From UNOS; and,
    3) A detailed contract proposal for the Emergency Transplant.

- *Medical Hardships Proposed Transplant Care: NON-EPO Transplant Exceptions*
  - The Plan may approve non-Transplant COE transplant care for documented Medical Hardship cases, to be paid according to the contract terms negotiated by OPTUM Transplant COE and agreed to by Plan, or Plan's agent, and Provider; however, if payment terms cannot be agreed upon within 10 days of Provider's billing proposal to Plan, then payment shall be paid at 110% of Medicare allowable.
  - Medical Hardship, as used here, could include such instances where the patient may be too medically frail to travel, re-transplantation following a successful transplant by the same transplant team, or a living donor hardship. For consideration, Medical Hardship forms must be submitted to OPTUM Transplant COE within three business days of the plan being contacted for transplant benefits or approval for evaluation. All information will be

forwarded to the plan for consideration. For Medical Hardship transplant benefit consideration, the transplant center must complete must complete and submit the following forms:

1) A letter from the Surgical Director to the plan detailing the medical conditions supporting the Medical Hardship;
2) A completed Medical Hardship Form: *Key Outcome Indicators Worksheet*;
3) A completed Medical Hardship Form: *Transplant Billing Report Table* for the prior three years of transplant billing history; and,
4) A detailed contract proposal for the proposed Medical Hardship transplant.

COVERAGE FOR ORGAN AND/OR TISSUE TRANSPLANTS

- *Pre-Authorization Requirement for Organ Transplant**
  - Covered Expenses incurred in connection with any organ or tissue transplant listed in this provision will be covered subject to referral to and pre-authorization by the Plan Administrator's authorized review specialist. Transplant coverage is offered under this plan through an EPO network of credentialed and volume monitored transplant professionals and facilities. Coverage is also provided for transplant services obtained outside the EPO for Emergency Transplants, and for certain transplant cases involving a Plan approved Medical Hardship condition.
  - As soon as reasonably possible, but in no event more than 10 days after a Member's attending physician has indicated that the Member is a potential candidate for a transplant, the Member or Member's physician should contact the Plan Administrator for referral to the network's medical review specialist for evaluation and pre-authorization. A comprehensive treatment plan must be developed for this plan's medical review, and must include such information as diagnosis, the nature of the transplant, the setting of the procedure, (i.e., name and address of the hospital), any secondary medical complications, a five-year prognosis, two qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment. (One or both confirming second opinions may be waived by the plan's medical review specialist.) Additional attending physician's statements may also be required. A non-network hospital may provide a comprehensive treatment plan independent of the EPO, but this will be subject to a Medical Hardship review and may result in no benefit coverage for the transplant at that center.

All potential transplant cases will be assessed for their appropriateness for Large Case Management.

IMPORTANT NOTE: Failure to pre-authorize a transplant procedure will result in the application of a $5,000 deductible to all Covered Expenses incurred as a result of the transplant. This deductible is in addition to any other plan deductible and co-payment requirements, which would normally be applicable to the transplant procedure.

- *Organ Transplant Network*
  - As a result of the pre-authorization review, the Member will be asked if they wish for assistance gathering information about participating transplant programs. The term "participating transplant program" means "a licensed health care facility and transplant program that has met OPTUM's Transplant COE Quality Assurance Program standards for participation, and been declared a Transplant COE program by OPTUM Transplant COE Quality Assurance Committee. The transplant network's goal is to perform necessary transplants in the most appropriate setting for the procedure using some of the nation's most experienced and qualified transplant teams.

- *Transplant Benefit Period*
  - Covered Expenses will accumulate during a Transplant Benefit Period. The term "Transplant Benefit Period" means the period that begins on the date of the initial evaluation and ends on the date, which is 12 consecutive months following the date of the transplant. (If the transplant is a bone marrow transplant, the date the marrow is reinfused is considered the date of the transplant).

- *Covered Transplant Expenses*
  - The term "Covered Expenses" with respect to transplants includes the reasonable and customary expenses for services and supplies which are covered under this plan (or which are specifically identified as covered only under this provision) and which are medically necessary and appropriate to the transplant, including:
    1) Charges incurred in the evaluation, screening, and candidacy determination process;
    2) Charges incurred for organ transplantation;
    3) Charges for organ procurement, including donor expenses not covered under the donor's plan of benefits.
       a) Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ;
       b) Charges for organ procurement for a living donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow up care;
       c) If the transplant procedure is a hematopoietic stem cell transplant, coverage will be provided for the cost of the acquisition of stem cells. This may be either peripherally or via bone marrow aspiration as clinically indicated, and is applicable to both the patient as the source (autologous) and related or unrelated donor as the source (allogeneic). Coverage will also be provided for search charges to identify an unrelated match, treatment and storage costs of the stem cells, up to the time of reinfusion. (The harvesting of the stem cells need not be performed within the transplant benefit period);
    4) Charges incurred for follow up care, including immuno-suppressant therapy; and
    5) Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual, or in the event that the recipient or the donor is a minor, two other individuals. In addition, all reasonable and necessary lodging and meal expenses incurred during the transplant benefit period will be covered up to a maximum of $10,000 per transplant period.

- *Re-Transplantation*
  - Re-transplantation will be covered up to two re-transplants, for a total of three transplants per person, per lifetime.

- *Donor Expenses*
  - Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this plan or any other benefit plan covering the donor. In addition, medical expense benefits for a donor who is not a participant under this plan are limited to a maximum of $10,000 per transplant benefit period when the transplant services are provided out of network. This does not include the donor's transportation and lodging expenses.

- *Extended Benefits in the Event of Termination*
  - In the event of termination of the plan, or of the recipient's termination of membership in an eligible class, if a transplant treatment program had commenced while coverage was in force and benefits had not been exhausted, then benefits will be paid for Covered Expenses related to the same organ transplant which are incurred during the lesser of: (a) the remainder of that transplant benefit period or (b) on month after termination of the plan or membership, as though coverage had not ended.

SKILLED NURSING FACILITY

The Plan pays up to one-half the average hospital semi-private room and board rate, unless private room accommodations are authorized as Medically Necessary. Member costs are outlined in the Schedule of Benefits.

Medical services, supplies and equipment for the care and treatment of an acute Illness or Injury that would otherwise require confinement in a Hospital.

Some services rendered while confined are subject to separate benefit limitations, restrictions and/or Co-pays (i.e., rehabilitation therapies) that are outlined in the Schedule of Benefits.

HOSPICE CARE

Hospice benefits are paid for services and supplies provided under active management through a Hospice regardless of the location or facility in which the services are furnished if pre-authorized by the Claims Administrator. This includes a Hospice Facility, Skilled Nursing Home, assisted living or in the patient's home.

Continued Pre-Authorization is required once every 31 days to verify that the individual's condition continues to require a Hospice environment.

Eligibility for the Hospice benefit is based upon the certification that the patient is terminally ill and has a life expectancy of 6 months or less.

If the Member remains living beyond 6 months, Hospice benefits may be extended for up to an additional three months with proper authorization.

The eligible services and supplies that may be provided are:

- nursing care;
- home health care;
- medical social services;
- Physician's services;
- counseling therapy;
- medical supplies, biologicals, drugs and rental of Durable Medical Equipment (no deductible charge if provided through the Hospice program);
- initial inpatient care limited to two weeks' duration within the hospital facility and;
- subsequent inpatient care for respite of pain control purposes on an occasional basis for a period of no longer than five consecutive days.

OUTPATIENT SERVICES

- Family planning services and supplies including infertility evaluation, birth control counseling and treatment, insertion of Intrauterine Devices (IUD's), measurement for contraceptive diaphragms and voluntary sterilization.
- Artificial limbs and eyes for the loss of natural limbs or eyes, including surgery, repair and replacement.
- Services and supplies for renal conditions and dialysis for End Stage Renal Disease (ESRD)
- Services and supplies for stabilization or initiation of treatment of an Emergency condition at the emergency department of a Hospital, a Physician's office, After Hours clinic or Urgent care Facility.
- Pre-scheduled Outpatient surgery including Physician surgical services, supplies and other medical care including anesthesia, consultation with and treatment by specialists and services of a Surgical Assistant.
- Pre-authorized diagnostic and therapeutic services including x-ray, radiation therapy and laboratory tests and services and pre admission testing in advance of a Hospital confinement.
- Mammography and prostate screening as defined under the Patient Protection and Affordable Care Act.
- Diabetic counseling, supervised by a Physician, to provide information and assistance with the daily management of diabetic therapy.

HOME HEALTH CARE

Intermittent services of a Home Health Agency and Private Duty Nursing care, by or under the supervision of an R.N. in a Member's
home which otherwise would require confinement.

Covered Expenses may include home diagnostic and therapeutic nursing care, Physician visits, Physical, Speech and/or Occupational Therapy, social service guidance, dietary guidance, home health aid services, medical supplies, laboratory services and the rental of Durable Medical Equipment. Refer to the Schedule of Benefits for limitations on these benefits.

EMERGENCY CARE SERVICES

- Services and supplies of an Emergency Department of a Hospital, After Hours Clinic or Urgent Care facility in the case of an Emergency as defined in Definitions for stabilization or initiation of treatment of an Emergency condition.
    - Services for a **Non-**Emergency condition rendered on an Outpatient basis in an Emergency Department of a Hospital will **NOT** be considered Covered Expenses and the Member will be fully responsible for all expenses.

- Emergency services provided by non-participating facilities or providers are covered subject to the terms, conditions, limitations and exclusions of this Plan.

- Urgent or Emergency care outside of the PPO Service Area.
    - Services for an Urgent or Emergency condition rendered on an outpatient basis outside of the PPO Service area may be considered Covered Expenses.
    - The Member will be responsible for the Urgent Care or Emergency Department charges as identified in the Schedule of Benefits.
    - Non-Urgent or non-Emergency conditions will not be considered Covered Expenses.
- The Claims Administrator must be notified within 48 hours after Urgent/Emergency services are initially provided.

PROFESSIONAL AMBULANCE SERVICE

Professional ambulance service by air or ground to and from the nearest local adequate Hospital, Skilled Nursing Facility or Alternative Facility to treat the Member's Illness or Injury, if necessary. Local air and ground ambulance means that the Member must have been transported to a Hospital, Skilled Nursing Facility or Alternative Facility whose locality encompasses the place where the ambulance transportation of the Member began and which would ordinarily be expected to have the appropriate medical facilities for the treatment of the Illness or Injury involved. For the purpose of determining the nearest adequate Hospital, Skilled Nursing Facility or Alternative Facility the Claims Administrator will consider the following factors:

- The Member's Illness or Injury is such that the use of any other method of transportation is not otherwise indicated; and
- The services necessary to treat such Illness or Injury are not available in the Hospital, Skilled Nursing Facility or Alternative Facility in which the Member is confined; and
- The Hospital, Skilled Nursing Facility or Alternative Facility furnishing the services necessary to treat such Illness or Injury is the nearest one with such facilities. The fact that a more distant Hospital, Skilled Nursing Facility or Alternative Facility is better equipped, quantitatively or qualitatively, in the opinion of the attending Physician, to care for the Member does not warrant a finding that a closer Hospital, Skilled Nursing Facility or Alternative Facility is not the nearest.

OTHER SERVICES

The administration of prescribed blood transfusions, including supplies and equipment used in the administration of blood and blood products and derivatives of such products and derivatives are replaced in accordance with the blood bank's requirements. Coverage provided for the drawing and storing of a Member's blood for use by the Member only for blood units used as replacement therapy while the Member is covered under this Plan.

The purchase or rental of Durable Medical Equipment that includes braces, canes, crutches, oxygen, oxygen equipment and wheel chairs. Durable Medical Equipment will be rented or purchased at the Plan's option and the Plan's payment will be based on the amount equal to the generally accepted cost of the item that provides the necessary level of care at the lowest cost. Rental costs must not be more than the purchase price and will be applied to the purchase price. The Plan will only consider the initial purchase of Durable Medical Equipment unless the equipment has served as long as or beyond the normal expected service period of such equipment. Refer to the Schedule of Benefits for the specific Plan limits and pre-authorization requirement (if applicable) on this benefit. Maintenance fees for purchased (purchased under this Plan) Durable Medical Equipment which is considered life sustaining may be considered as Covered Expenses under the Plan. Pre-authorization is required.

Ostomy Supplies are Covered Expenses to the limits detailed in the Schedule of Benefits.

Casts, splints, trusses, braces and surgical dressings are also considered Covered Expenses when necessary, appropriate and provided by a Physician.

SERVICES RENDERED BY NON-PARTICIPATING PROVIDERS

In the event that health services are provided by or through other than a Participating Provider in the PPO Network, a Member will be permitted benefits for Covered Expenses obtained through non-participating providers at the out of network (non network, non PPO) level of benefits.

Covered Expenses may also be eligible for payment to non-participating providers under Medical Case Management that has been authorized in advance by the Claims Administrator.

In the event of an Emergency or serious Illness or Injury requiring immediate medical attention or in the case of life/limb threatening conditions, the Member is to seek immediate medical assistance. The Claims Administrator must be notified within 48 hours of the event, in order to have the medical treatment and/or hospitalization considered a Covered Expenses and be payable under this Plan.

All such services are subject to the out of network level of benefits including deductible, coinsurance, and co-pays, as well as all terms, conditions, exclusions and limitations of the Plan. Services rendered on an Emergency basis are not covered, if, in the opinion of the Claims Administrator, the situation is later determined not to be an Emergency. This determination will be based on generally accepted medical criteria. It is the Member's responsibility to verify that the required written approval from the Claims Administrator has been granted prior to receiving the services from a non-participating provider.

If the Member is hospitalized as a result of an Emergency, the Claims Administrator may elect to transfer the Member to a Participating Hospital as soon as it is medically appropriate. Emergency services rendered by non-participating providers or in non-participating facilities are not covered if the Member chooses to remain in the non-participating facility after the Claims Administrator has notified the Member of the intent to transfer the Member to a Participating Hospital or Participating facility.

If a Member receives care from a non-participating provider, including hospitalization, without the required pre authorization from the Claims Administrator, or as described in the case of an Emergency, the Member may be responsible for all costs associated with that care.

COVERED EXPENSES

Charges that this Plan will consider for payment must fulfill the following conditions and be listed as "Covered Expenses". The actual benefit payment will be subject to all other provisions of this Medical Plan Document.

CONDITIONS REQUIRED FOR EXPENSE ELIGIBILITY

- The charges or expenses must be for treatment, surgery, services, or supplies rendered by a Participating Provider (except as otherwise expressly permitted in this Plan) and prescribed by a Physician operating within the scope of his or her license.
- The individual claiming to recover for expenses must have been a Member in this Plan at the time the expenses were incurred.
- Only those expenses incurred as a result of a non-occupational Injury or Illness will be considered eligible.
- The confinement, treatment, services, or supplies must be Medically Necessary.
- The expenses incurred will be considered Covered Expenses only up to the contracted scheduled fees and may not be provided by a family member of the Member.

COVERED CHARGE LISTING

Subject to all other Plan provisions, the following will be considered Covered Expenses.

- After Hours/Urgent Care received from participating facilities or other facilities in the case of an Emergency.
- Allergy shots and allergy surveys.
- Anesthesia expenses including the charge for administration.
- Certified Nurse Midwife (C.N.M.) expenses when:
  - Provided in a clinical setting under the supervision of a Physician; and
  - The C.N.M. is an insured under such supervising Physician's policy of professional malpractice insurance coverage.
- Confinement Charges made by a Hospital, Skilled Nursing Facility, Hospice, Alternative Medical Facility, Psychiatric, or Alcoholism/Substance Abuse facility for:
  - Room and board up to the semi-private room rate. If the facility has only private rooms, those charges will be considered semi-private. Also, if the private room is necessary for isolation purposes, those charges will be considered as semi-private charges.
  - All other Medically Necessary services, treatment, or supplies while confined as an inpatient, including intensive and coronary care unit charges.
- Diagnostic expenses for X-ray and laboratory examinations medically required for diagnostic or treatment purposes.
- Elective sterilization expenses.
- Emergency service at the Emergency room or Outpatient department of a Hospital or an Ambulatory Surgical facility.
- Expenses for dental services required due to trauma are specifically limited to the functional restoration of structure other than teeth. Treatment of trauma resulting in fracture of the jaw or laceration of the mouth, tongue, or gums is covered.
- Human Organ Transplant Expenses.
  - Cornea - If the recipient of the transplant is a Member the replacement of the organ and tissue procedures will be considered on the same basis as any other Illness or Injury (subject to the approval of the Claims Administrator.)
  - Special Transplant Benefit – Coverage for specified transplant benefits through the Special Transplant Program, described in "Covered Expenses."
- Infertility testing.
- Initial artificial limb(s) or eye(s) or prosthetic appliances when required because of an Illness or Injury that occurred. Adjustments of covered artificial limbs, eyes, or prosthetic appliances for an illness or injury may be considered as Covered Expenses only when necessary to make the equipment serviceable, so long as it continues to be necessary.
- Medical supplies including oxygen and rental and/or purchase of equipment required for its administration.
- Newborn baby expenses – Covered Expenses for the baby immediately following birth provided the newborn is timely enrolled in the Plan.
- Nursing services described in the Benefit Provisions Section when rendered by a R.N. or a L.P.N. not related to the patient.
- Physician charges for diagnosis, treatment, or Surgery identified in Benefit Provision Section.
- Preadmission testing.
- Professional Ambulance service when Medically Necessary (for Urgent or Emergency Care only) to and from the nearest Hospital where appropriate treatment can be given.

- Psychiatric services for Mental Illness or emotional disorders for which there is a specific diagnosis and course of treatment.
- Radium and radioactive isotopes as deemed Medically Necessary.
- Reconstructive breast surgery. Implantation or removal of breast prosthesis when performed solely and directly as a result of a mastectomy procedure. This shall include all stages of reconstructive surgery performed on a non-diseased breast to establish symmetry with the diseased breast including prostheses and physical complications of all stages of mastectomy, including lymphedema.
- Rehabilitative speech, occupational, physical or respiratory therapy.
- Rental of Durable Medical Equipment required for temporary therapeutic use or in certain instances, the purchase of such equipment if it can clearly be demonstrated that such a purchase cost would be less than the anticipated cost of renting. The Plan will pay for initial purchase only, unless the equipment has served as long as or beyond the normal expected service period of such equipment. Maintenance fees for purchased (purchased under this Plan) Durable Medical Equipment which is considered life sustaining may be considered as Covered Expenses under the Plan. Pre-authorization is required.
- Routine Benefits as required under the Patient Protection and Affordable Care Act.
- Routine immunizations as required under the Patient Protection and Affordable Care Act.
- Routine mammograms as required under the Patient Protection and Affordable Care Act.
- Routine prostate cancer screenings as required under the Patient Protection and Affordable Care Act.
- Second surgical opinions.
- Surgical Assistant charges when acting as part of the surgical team for a Surgery meeting the eligibility requirements set forth in the Medical Plan Document, when it is Medically Necessary for a Surgical Assistant to participate in the surgery. If the Participating Hospital provides the surgical assistance, the expense is included in the Hospital charges.
- Surgical supplies, casts, splints, trusses, braces and crutches.

PPO MEDICAL PLAN EXCLUSIONS

If any service, supply or treatment is not specifically addressed as a Covered Charge or as an Exclusion, it is not to be assumed that such service, supply or treatment is covered under this Plan. Members are strongly encouraged in the absence of a specific coverage or exclusion to contact The BEST Health Plan. In addition to the specific limitations described in the Medical Plan Document, no payment will be made under this Plan for expenses incurred in connection with:

- Any confinement, treatment, supply or service not prescribed by a Physician as defined in this Plan or one that is not Medically Necessary.
- Charges for or in connection with any work related or occupational Illness or Injury covered under any Workers' Compensation law, employer's liability law or similar state, federal or municipal law regardless of whether such amounts are collectible, the individual has filed a claim, or the individual has received an award or settlement pursuant to such law.
- Any charge for any confinement, treatment, supply or service or portion thereof for which the Member is not legally required to pay.
- Any confinement, treatment, supply or service which is paid for or is reimbursable by or through Medicare, Medicaid or any governmental agency or instrumentally except as provided under the Coordination of Benefits Section.
- War or any act of war, declared or undeclared, or participation in insurrection or riot, or in the commission of or attempted commission of an assault or any illegal act.
- Any confinement, treatment, supply or service which is or should have been covered by an automobile insurance policy. When medical payments are available under automobile insurance, this Plan shall pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan shall always be considered the secondary plan with respect to automobile insurance regardless of the Member's election under coverage with the automobile carrier. Exceptions are as provided under Subrogation. See Reimbursement to the Plan section in this document.
- Any confinement, treatment, supply or service if the expenses are covered under a Health Maintenance Organization (HMO) plan or Employee health clinic plan or provided to an individual who is an employee of a mutual benefit association, other than this Plan.
- A drug, device, medical treatment or procedure that is Experimental or Investigative, or does not meet accepted standards of medical practice. A drug, device, medical treatment or procedure is Experimental or Investigative if:
    - the drug, device, medical treatment or procedure is governed by the United States Food and Drug Administration ("FDA") and the FDA has not approved the drug, device, medical treatment or procedure for the particular condition at the time the drug, device, medical treatment or procedure is provided; or
    - 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
    - Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental, study or investigational arm of ongoing phase III clinical trials as defined by the National Institute of Health, National Cancer Institute or the FDA, 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
    - 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 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 treatment facility of the protocol(s) utilized by other facilities studying substantially the same drug, device, medical treatment or procedure; or the written informed consent document used by the treating facility or by other facilities studying substantially the same drug, device, medical treatment or procedure.
- Any routine physical, psychiatric, psychological, premarital, pre-employment or gynecological services, testing, vaccinations, immunizations or treatments not otherwise covered under the Plan and when such services, testing, vaccinations, immunizations or treatments are for the purposes of obtaining, maintaining or otherwise related to employment or insurance, marriage, school admissions, foreign travel, playing sports, or relating to judicial or administrative proceedings or orders, or which are conducted for the purposes of medical research or to obtain or maintain a license of any type.

- Cosmetic procedures, plastic or reconstructive Surgery for developmental malformations or as a result of an earlier cosmetic, plastic or reconstructive Surgery unless the Surgery is necessary:
    - for repair or alleviation of damage resulting from a non-occupational Injury, or
    - in the case of Cleft Lip/Cleft Palate; or
    - as a result of a mastectomy procedure, or
    - because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect.

  Cosmetic procedures include, but are not limited to, pharmaceutical regimes, nutritional procedures or treatments, plastic Surgery including reduction mammoplasty and reconstruction mammoplasty.
- Hearing aids or examinations, cochlear implant devices and implant procedures.
- Services provided for the treatment or removal, in whole or in part, of corns, callosities, hypertrophy or hyperplasia of the skin, or any subcutaneous tissues, or the cutting, trimming or other partial removal of toenail or any other routine foot care; treatment of flat foot conditions and prescribed supportive devices (orthotics) or the treatment of subluxations of the foot. Based upon Medical Necessity, toenail paring for endocrine disorders may be considered a Covered Charge.
- Any dental surgery, treatment or care (including overbite, underbite, maxillary and mandibulary osteotomies and orthognathic conditions whether or not related to temporomandibular joint dysfunction); dental x-rays, supplies or appliances and all associated expenses arising out of such dental surgery, treatment or care including hospitalization. Dental services required due to trauma are limited to functional restoration of structures other than the teeth. Treatment of trauma resulting in fracture of the jaw or laceration of the mouth, tongue or gums is considered a Covered Charge if rendered within ninety (90) days of trauma.
- Any Hospital or facility confinement primarily for the purpose of conducting tests, studies, examinations, evaluations or observations or for convenience, environmental control or custodial purposes.
- Any confinement, treatment, supply, service or pharmaceutical related primarily to obesity or weight control, unless there exists morbid obesity that shall be defined as 100 plus pounds overweight or 100% over recommended target weight, and the existence of co-morbidities. Any such treatment, including gastric bypasses, gastric balloons, stomach stapling, wiring of the jaw, and/or jejunal bypasses, requires written pre-authorization from the Claims Administrator.
- Any personal hygiene, comfort or convenience items obtained or rendered on an Inpatient or Outpatient basis such as air conditioners, telephone, barber or beauty shop services, guest services, humidifiers, physical fitness equipment and similar incidental services or supplies which are not Medically Necessary.
- Charges a Provider may apply for failure to keep a scheduled office or outpatient visit.
- Any testing upon admission by a Hospital that duplicates preadmission testing without clear Medical Necessity.
- A billing for confinement, treatment, supply or service which does not properly identify the charge with the patient or provide sufficient detail for audit purposes.
- Vaccinations, immunization, inoculations or preventive injections except for those provided as Covered Expenses by the Plan for Dependent children under the Patient Protection and Affordable Care Act or those required for treatment of an Injury or exposure to disease or infection such as anti-rabies, tetanus, anti-venom, or immunoglobulin.
- Reversal of sterilization procedures
- Treatment for sexual reassignment (inter-sex surgery, gender dysphoria surgery, etc.) or for the complications thereof unless otherwise determined to be Medically Necessary.
- Induced abortion except that any medical services necessary to prevent the death of either a pregnant woman or her unborn child will be covered under circumstances where every reasonable effort is made to preserve the life of each.
- Home childbirth.
- In Vitro fertilization procedures, embryo transport, artificial insemination and embryonic implantation procedures, Gamete Intra-Fallopian Transfer, surrogate parenting, donor semen, outpatient injectable substances and supplies related to the treatment of infertility. For the purposes of this Plan, treatment of infertility means the use of methods that do not correct the inability to conceive, but create the conditions for the individual to conceive by stimulating the individual's natural reproductive system by implantation. Methods used to correct the inability to conceive are not subject to this limitation.
- Any treatment or service rendered by a person who generally lives in the same house as the Member or who is a member of the immediate family of the Member (Employee, spouse/domestic partner, child, brother, sister or parent of the Employee or spouse/domestic partner).
- Organs or bone marrow from sources other than humans for transplants identified in Covered Expenses.
- Charges for Vocational Rehabilitation, by any name called.

- The amount of any surcharge imposed by a state or federal government, and incurred as a result of the Member's utilization of services in a jurisdiction where such surcharge applies. Such surcharge shall be the responsibility of the

Member; and if paid by the Plan, such surcharge shall represent an overpayment by the Plan of benefits on behalf of the Member, for which the Member shall promptly reimburse the Plan. Future benefits under the Plan to the Member may be used by the Plan to offset any such overpayments for which the Member has failed to reimburse the Plan.

- Charges for which the Member is not obligated to pay, is not billed or would not have been billed except for the fact that the person was covered under this Plan, unless care is rendered in a Veteran's Administration Hospital for a non-service connected disability.
- Charges incurred for Disability claimed while the Member is not under the direct care of a Physician.
- Charges for treatment by a Physician that is not within the scope of the Physician's license.
- Charges for which benefits are not provided under this Plan.
- Charges for non-Emergency services rendered on an outpatient basis in an Emergency Department of a Hospital.
- Charges for services or supplies that are for custodial or domiciliary care and rest cures.
- Charges for mental health services and supplies for conditions not attributable to mental disorders. These include: court ordered behavioral health services and other behavioral or developmental disabilities; counseling for vocational disabilities or learning disabilities; counseling for mental retardation; residential care services; marriage/partner counseling, relationship counseling or counseling for other interpersonal problems; custody evaluations and counseling; personal growth counseling; counseling or therapy for weight reduction; behavioral training; lifestyle or vocational counseling; biofeedback; pain control; hypnosis; counseling for sexual dysfunction, inadequacy, or trans-sexualism, early infant stimulation or psychotherapy credited toward earning a degree or required for educational purposes.
- Charges with travel or transportation except as specifically detailed under Professional Ambulance Service and Special Transplant Program.
- Charges for services otherwise covered under the Plan related to a specific condition or treatment when a Member has terminated the scheduled service or treatment against the advice of the Physician or has left the Hospital, Skilled Nursing Facility or Alternative Facility against medical advice.
- Charges associated with penile implant devices or procedures.
- Charges for foods and nutritional supplements including, but not limited to, home meals, formulas, foods, diets, vitamins and minerals regardless if they are available over-the-counter or require a prescription. The exception is when items are provided during hospitalization and for prenatal vitamins requiring a prescription.
- Charges for services otherwise covered under the Plan, but rendered before the Effective Date of Coverage or after the date the Member's coverage under the Plan ended.
- Charges associated with the treatment of temporomandibular joint syndrome (TMJ).
- Charges that are not necessary to the care or treatment of an Illness or Injury except as otherwise specifically provided in the Plan.
- Charges for services and associated expenses for megavitamin therapy, psychosurgery, radial keratotomy, lasik or any other corneal corrective procedure (other than corneal transplants), nutritional based therapy for Substance Abuse, salabrasion, chemosurgery or other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne, RAST Testing, except when skin testing is medically impossible, acupuncture, services for chelation therapy, treatment for sleep apnea unless Medically Necessary (except treatment for Sudden Infant Death Syndrome), or Chronic Fatigue Syndrome.
- Outpatient nutritional and dietary services in the absence of a physiological condition requiring these services for sustaining life.
- Any charges incurred through Medicare private contracting arrangements.
- Services provided outside the United States except in the case of Urgent or Emergency Care. In the case of Urgent or Emergency Care, expenses for any services administered will not be considered Covered Expenses if the Member traveled to the location where services were rendered for the purpose of obtaining such services.
- Expenses for prayer, religious healing or spiritual healing.
- Prescription drugs, unless administered during an inpatient stay.
- Expenses excluded from reimbursement by the reinsurer.
- The Member is required to pay certain expenses (including Deductibles, Co-pays or required Coinsurance) under the terms of this Plan. The requirement that the Member pay these applicable expenses cannot be waived by a provider under any "fee forgiveness", "not out-of-pocket" or similar arrangement. If a provider waives the required expense, the Member's claim may be denied and the Member will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Member provides satisfactory proof that he or she paid the required expense under the terms of this Plan.

PRESCRIPTION DRUG PLAN

The BEST Health Plan has selected OptumRx as the provider of the Prescription Drug Plan for Members. OptumRx is a nationwide Pharmacy Benefit Manager with state of the art technology to support the supplying of prescription medication needs of Members through numerous convenient methods. Additional wellness tools and resources are also available on the OptumRx website at www.MyOptumRx.com.

When a prescription drug medication is required, discuss the medication with your health care provider to become educated and to discuss optional medications and other therapies and/or treatments that may be appropriate in your specific case. Being an active participant in your health care decisions can enhance your comfort level with the treatment decisions and can ensure that appropriate options have been considered. This is one way for you to contribute to keeping Plan costs as low as possible while still receiving the level of care you need.

PRESCRIPTION DRUG PLAN DEFINITIONS

- Brand Name Drug means a covered prescription proprietary drug that meets all the Federal Food and Drug Administration (FDA) standards.
- Compound Drug is one that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.
- Exclusion means any provision of the Plan whereby coverage of a specific drug, service or supply is entirely eliminated regardless of medical necessity.
- Federal Legend Drug means any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution-Federal Law prohibits dispensing without a prescription."
- Formulary Drug means a Preferred Prescription formulary list of prescription medications, including strength and dosages that the National Pharmaceutical and Therapeutic Committee prefer Physicians to prescribe based on quality and cost effectiveness. This Formulary List is provided in the Welcome Kit sent to each Employee BEST Member and is also available online from www.MyOptumRx.com. OptumRx retains the right to modify this Preferred Prescription formulary from time to time without notice.
- Generic Drug means a covered Prescription Drug that contains the same active ingredients as a higher priced Brand Name Drug with the same use and metabolic disintegration of a Brand Name Drug. The Generic Drug must meet all Federal Food and Drug Administration (FDA) bio-availability standards. All Brand Name Drugs do not have a generic equivalent.
- Innovative Technologically Advanced medication is a list of Brand Name Drugs that are current or new products introduced to the market.
- Non-Formulary Drug is one that is not included on the Preferred Prescription formulary list.
- Non-Federal Legend Drug known as Over-the-Counter medications, means those medications that do not require a written prescription.
- Over-the-Counter Medications, also known as Non-Federal Legend Drugs, means those medications and other products that do not require a written prescription.
- Participating Pharmacy or Participating Retail Pharmacy means a Pharmacy that has contracted with OptumRx to provide prescription drugs to BEST Members.
- Pharmacist means a person who is licensed under the laws of the state or jurisdiction where the services are rendered, and trained to prepare, compound and dispense drugs and medicines, and who acts within the scope of his license.
- Pharmacy or Retail Pharmacy shall mean any area, room, rooms, place of business, department, or portion of any of the foregoing, where prescriptions are filled or where drugs, dangerous drugs, or poisons are compounded, sold, offered, or displayed for sale, dispensed, or distributed to the public. A pharmacy must also meet the following requirements:
    - It must be licensed by the Board of Pharmacy; and
    - It must maintain records in accordance with federal and state regulations; and
    - It must be staffed with a licensed registered Pharmacist.
- Prescribed Drugs (or prescription drugs) are defined as drugs, biological and compounded prescriptions which (1) can be dispensed only pursuant to written prescription given by a Physician, (2) are listed and accepted in the United States Pharmacopoeia, National Formulary, or AMA Drug Evaluations published by the AMA, (3) are prescribed for human consumption, and (4) are required by law to bear the legend: "Caution – Federal law prohibits dispensing without prescription." Prescription Drugs includes Federal Legend drugs and State Restricted Drugs.

HOW THE PLAN WORKS

When a Physician prescribes Medically Necessary prescription drugs that are covered under this Plan, for a covered Illness or Injury, the Plan will pay benefits after the Member pays the copayment described in the Schedule of Benefits.

BEST Members have a number of choices as to how to have the prescription filled; at a Participating Retail Pharmacy, through OptumRx Home Delivery, or through BriovaRx (specialty medications).

At a Participating Retail Pharmacy, take the Prescription Drug Identification Card along with the prescription to be filled. The pharmacist, based on the Plan design and the medication prescribed, will identify the payment required of the BEST Member and this will be paid at that time. The BEST Member may also be required to sign a form in acceptance of the medication.

Medications that are taken on a frequent or ongoing basis can be conveniently ordered through OptumRx Home Delivery. New prescriptions may be set up for Home Delivery by completing and mailing a OptumRx Home Delivery order form (with the new prescription and payment information attached) to OptumRx Home Delivery. Refills can be ordered and refilled via the internet at: www.MyOptumRx.com.

GENERIC SUBSTITUTION

The Plan encourages the use of Generic Drugs and OptumRx Home Delivery in order to control costs. If the prescription is written as Brand and the Physician has not requested that it be dispensed as written (DAW), the pharmacist may automatically substitute a generic equivalent**.** A Physician and/or a BEST Member can request that the prescription not be filled using a generic substitution. In this case, the BEST Member will pay the applicable generic copayment plus the difference in cost for the medication.

PARTICIPATING PHARMACIES

OptumRx has contracted with retail pharmacies across the United States. BEST Members may obtain prescription medications at the described copayment amount by utilizing those specific pharmacies. A complete list of names and addresses can be obtained by accessing this information at: www.MyOptumRxRx.com or by calling OptumRx Member Services toll free at the number indicated on the Prescription Drug Identification Card.

NON-PARTICIPATING PHARMACIES

There should be few circumstances requiring the use of a non-participating retail pharmacy. In this instance, the BEST Member will be responsible for the payment of the full amount of the charge. The BEST Member can complete a Claim Form, attach the invoice and mail it to OptumRx at the address shown on the Claim Form. The BEST Member will be reimbursed the amount that the medication would have cost at a participating pharmacy less the required copayment for the drug.

HOME DELIVERY PROGRAM

OptumRx Home Delivery should be used when there is an ongoing need for medication. By using this service, a BEST Member can obtain prescribed medication required on a non-emergency, extended-use basis. The quantity of a prescribed drug ordered through this program can be up to a 90-day supply.

BEST Members can place orders for new prescriptions with OptumRx Home Delivery by completing and mailing to OptumRx Home Delivery a completed order form (with the new prescription and payment information attached). BEST Members can place refill orders online at: www.MyOptumRx.com. This is a convenient method for ordering required medications when it is convenient for the BEST Member. These medications will be delivered to the BEST Member's home or elsewhere as requested by the BEST Member.

Specific information on these programs is detailed in the brochure provided in the Welcome Kit from OptumRx.

Prescribed medications that are covered by this Plan at participating retail pharmacies are also covered by OptumRx Home Delivery. However, certain medications cannot be supplied by mail easily (for example, controlled substances) and may not be available through this program.

The law requires that pharmacies dispense the exact quantity prescribed by the Physician. If your Physician authorizes the maximum OptumRx Home Delivery order quantity, the prescription must be for the supply detailed in the Schedule of Benefits.

For maintenance prescriptions ordered through OptumRx Home Delivery, ask your Physician to write your prescription for an appropriate days-supply plus 3 refills. For example, for a medication you would take on a daily basis, your Physician should write your prescription for a 90-day supply with three refills. You may not order refills until you have consumed 75% of the dispensed medication, calculated by your Physician's prescribing orders.

When using OptumRx Home Delivery, the prescription is reviewed by a Pharmacist, checked for drug interactions, dispensed, and verified by quality control before it is mailed.

You may also refill a current prescription through the Internet at www.MyOptumRx.com.

There will be times when a prescription is needed immediately. On these occasions, the prescription should be filled at a retail pharmacy. If the medication is needed immediately but will be taken on an ongoing basis, ask the Physician for two prescriptions. The first should be for a 14-day supply that you can have filled at a retail pharmacy; the second prescription should be for a 90 day supply. Send the 90 day prescription with the required copayment and completed order form to OptumRx Home Delivery.

Important Note: Certain controlled substances and several other prescribed medications may be subject to other dispensing limitations and to the professional judgment of the Pharmacist.

Maximum quantities dispensed are limited at a participating retail pharmacy and through OptumRx Home Delivery. If using OptumRx Home Delivery, be sure to inform the Physician that the prescription will need to be written for the maximum day supply allowed, plus the appropriate number of refills if the medication is for maintenance (e.g. high blood pressure). A prescription written for more than the permitted day supply for either the retail or OptumRx Home Delivery will not be filled. The Pharmacy may not combine refills to make up a maximum home delivery days' supply. For example, if a home delivery prescription is written for a 30-day supply with three refills, then only 30-days will be dispensed with each order and the full home delivery copayment will be taken for each dispensing event.

SPECIALTY DRUGS

For BEST Members who need specialty drugs, BEST Members can only access these drugs through Briova Rx. BriovaRx is the specialty pharmaceuticals service for OptumRx. Specialty drugs are only dispensed for a 30 day maximum supply. BEST Members just beginning a regimen with these drugs, or those who are not comfortable with self-administration, are required to access these drugs through BriovaRx but may have them administered during a Physician office visit. For assistance with or questions about specialty drugs, contact BriovaRx at: 855.427.4682.

COVERED EXPENSES

Covered Expenses for prescription drugs, devices, and medicines are charges for any of the following: (Refer to the Schedule of Benefits for any limits on this coverage and maximum day supply for retail, OptumRx Home Delivery and BriovaRx.)

- Non-injectable Prescription (Brand or Generic) Drugs requiring the written prescription of a Physician including birth control (oral, transdermal, intravaginal) and prenatal prescription vitamins.
- Contraceptives, injectable.
- Compound medications of which at least one ingredient is a prescription drug.
- Injectable insulin, including disposable insulin needles/syringes, diabetic supplies, test strips, and glucose monitoring machines.
- Inhaler assisting devices.
- Influenza, Pneumococcal and Zoster vaccines, at a Retail Pharmacy that gives injections.
- Vitamin A derivatives (e.g. Retin-A, Altinac, Avita) all forms, ONLY if Medically Necessary. Coverage is not provided in the instance of cosmetic purposes.
- Non-Insulin Syringes with or without needles (for self-injection of covered medications).
- Emergency Allergic kits.
- Substance Abuse Treatment (e.g. Antabuse).
- Smoking Cessation products, with prescription, as provided under the Patient Protection and Affordable Care Act.
- Glucagon Emergency Kits.
- Drugs that have been approved by the Food and Drug Administration (FDA) for use in treating AIDS (acquired immune deficiency syndrome).
- Migraine medications (injectable form-other forms are covered under Federal Legend Drugs.)
- Specific approved medications for self-injection.

PRESCRIPTION DRUG PLAN EXCLUSIONS

A charge for any of the following prescription drugs, devices, and medicines will not be covered:

- A drug or medicine that can legally be bought without a written prescription (over-the-counter), or a drug or medicine for which there is a non-prescription equivalent available. This does not apply to injectable insulin.
- Therapeutic Devices or Appliances of any type, even though such devices may require a prescription, except where specifically indicated as a Covered Charge. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- A drug or medicine labeled: "Caution - Limited by Federal Law to Investigational Use," or a drug or medicine that has not been approved by the Food and Drug Administration (FDA).
- Experimental or Investigative drugs and medicines, even though a charge is made to the BEST Member or medicines or drugs that are in the Food and Drug Administration Phases I, II or III testing.
- Any charge for the administration of a covered Prescription Drug with the following exception: in some cases, for the use of Specialty Drugs which must be injected, BEST Members may be able to have these administered during an Office Visit with the Physician under the Medical Plan.
- A drug or medicine that is to be taken by the BEST Member, in whole or in part, while confined in a Hospital. This includes being confined in any institution that has a facility for or allows to be operated on its premises, a facility for the dispensing of drugs and medicines on its premises.
- A charge for Prescription Drugs that may be properly received without charge, or for which the provider's charge is less than the required copayment.
- Any drug received for which there is no legal obligation to pay, or charges that would not be made but for the availability of benefits under this Plan.
- Vaccination, immunization, inoculation or preventive injections required for treatment of an injury or exposure to disease or infection (such as anti-rabies, tetanus, anti-venom or immunoglobulin).
- Charges arising out of any employment related injury or illness that would entitle the BEST Member to a benefit under any Workers' Compensation act or similar laws, including those situations whereby the BEST Member lawfully chose not to be covered or waived or failed to assert any rights under a Workers' Compensation law, act, or similar legislation.
- Any charges for any condition, disability or expense resulting from or sustained as a result of war or any act of war, declared or undeclared or voluntary participation in or being engaged in an insurrection, riot, commission of, or attempted commission of, an assault or any illegal act.
- Any prescription refilled in excess of the number of refills specified by the Physician or any refill dispensed after the limitations of the Physician's original order.
- Any prescription dispensed prior to the BEST Member's Effective Date of Coverage or after the termination date of coverage.
- Charges furnished or covered by, or on behalf of, the United States or any state, province, or other political subdivision (or by an Employer pursuant to this Plan) unless there is an unconditional requirement to pay such charges whether or not there is insurance.
- Charges incurred due to an Illness or Injury which results from war, declared or undeclared, any act incident to war, and any Illness or Injury occurring, or arising from, service in the armed or military forces of any country.
- The following specific drugs, or categories of drugs are specifically excluded from coverage under this Plan:
    - All Over the Counter products except with prescription as provided for under the Patient Protection and Affordable Care Act; and
    - Allergy serums; and
    - Anabolic steroids; and
    - Anorexic (weight loss) medications, including amphetamine or non-amphetamine; and
    - Anti-obesity medications or preparations; and
    - Blood or Blood Products; and
    - Charges for the administration or injection of any drug, except as identified above; and
    - Cosmetic medications, preparations or products; and
    - Fertility or Infertility medications or agents; and
    - GlucoWatch Products; and
    - Hair Growth Stimulants and products such as Rogaine and Minoxidil indicated only for cosmetic use; and

- Human Growth Hormones, except with Pre-Authorization in the cases of growth failure and AIDS wasting; and
- Injectable medications other than those specifically covered by the plan; and
- MED Drugs (for male impotency); and
- Mifeprex; and
- Minerals, nutritional supplements, appetite suppressants, dietary supplements and formulas; and
- Naturopathic or holistic substances; and
- Non-Federal Legend Drugs; and
- Non-Systemic contraceptives, devices; and
- Ostomy supplies; and
- Over the counter Contraceptives (foams, condoms); and
- Over the counter Smoking Deterrents (patches, gum), except with prescription as provided for under the Patient Protection and Affordable Care Act; and
- Topical fluoride products, except as provided for under the Patient Protection and Affordable Care Act for children under age six;
- Tretinoin, all dosage forms (e.g., Retin-A), except to treat a non-cosmetic condition; and
- Vitamins, over the counter or with a prescription, except prescription prenatal vitamins, Folic Acid, Iron and Vitamin D as provided for under the Patient Protection and Affordable Care Act.

Important Note: The Plan reserves the right to limit quantities dispensed of Innovative Technologically Advanced medicines and to add medicines to the exclusion list if the U.S. Food and Drug Administration (FDA) has issued a warning or recall, voluntary or otherwise.

OptumRx Pharmacists may choose to decline to fill a prescription based on their best judgment. They are licensed and can choose not to dispense a drug if in their opinion based on their knowledge and expertise the medication may cause harm to the BEST Member in the form of a potential drug interaction, or other situation where the BEST Member's health may be at risk.

COORDINATION OF BENEFITS

Under certain circumstances a Member may be entitled to reimbursement for medical expenses from more than one insurance plan or policy. The provisions of this Section describe the coordination of benefits rules that determine whether this plan will pay as the primary plan or secondary plan when compared to another plan covering the Member. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total Allowable Expense. It is the intent of the Plan to follow the coordination of benefits rules applicable to group health plans and adopted by the Colorado Division of Insurance and this section shall be interpreted in a manner consistent with such rules. In following such guidelines, the Plan is not subject to the oversight or the jurisdiction of the Colorado Division of Insurance.

DEFINITION OF WORDS AND TERMS USED IN THIS SECTION:

- "Allowable Expense" means any necessary, reasonable, usual and customary item of expense at least a portion of which is covered under at least one of the plans covering the individual for whom Claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid. The following are examples of services that are not Allowable Expenses:
  - If a Member is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the patient's stay in a private room is Medically Necessary or one of the plans routinely provides coverage for hospital private rooms, or a private room is not available) is not an Allowable Expense.
  - If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usually and customary fees for a specific benefit is not an Allowable Expense.
  - If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
  - If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements shall be the Allowable Expense for all plans.
  - The amount a benefit is reduced by the primary plan because a Member does not comply with the plan provisions such as preauthorization/pre-certification of admission, and participating provider provisions.
- “Claim” means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:
  - Services (including supplies);
  - Payment for all or a portion of the expenses incurred;
  - A combination of the first two sub-bullets points under Allowable Expense above; or
  - An indemnification.
- "Claim Determination Period" means for any Member that portion of a Calendar Year during which he would be eligible to receive benefits under this Plan.
- “Custodial Parent” means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.
- "Plan" means any policy or plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by:
  - any group, franchise, hospital or medical service, prepayment or other coverage arranged through an employer, trustee, union, employee benefit or other association; or
  - any coverage under governmental programs, and any coverage required or provided by any statute; or
  - any coverage sponsored by, or provided through, a school or other educational institution; or
  - automobile insurance policy; or
  - any coverage under Medicare. For the purposes of this Section, benefits shall be considered payable by Medicare whether or not the Medicare-eligible Member has enrolled in or applied for benefits under Medicare Part A, or has failed to take any other action required by Medicare to qualify for benefits, or would have received benefits payable by Medicare had the Medicare-eligible Member received services in a facility to which Medicare would have paid benefits.
- "Plan" shall be construed separately with respect to each plan, policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such plan, policy, contract or other arrangement which

reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

- "This Plan" means those Sections of this Medical Plan Document/Summary Plan Description, which provide the benefits subject to these provisions.

ORDER OF BENEFIT DETERMINATION RULES

These "Coordination of Benefits Provisions" shall apply in determining a Member's benefits under this Plan for any Claim Determination Period if the sum of:

- the benefits that would be payable under this Plan in the absence of these provisions, and
- the benefits that would be payable under all other plans in the absence of similar Coordination of Benefits provisions would exceed the Allowable Expenses incurred by the Member during any Claim Determination Period.

As to any Claim Determination Period for which these provisions apply, the benefits payable for the Allowable Expenses incurred under this Plan shall be reduced to the extent necessary so that the sum of such reduced benefits and all other benefits payable for such Allowable Expenses under all other plans, except as provided in the next paragraph, shall not exceed 100% of the total of such Allowable Expenses. Benefits payable under another plan include the benefits that would have been payable had the claim been fully made thereunder.

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- The benefits of a plan which does not contain a Coordination of Benefits provision consistent with the Colo. Ins. Reg. 4-6-2 is always primary, except that coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. (Examples of such coverage includes major medical coverage that are superimposed over base plan hospital and surgical benefits and insurance type coverage that are written in connection with a closed panel plan to provide out-of-network benefits.)
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:
    - Non-Dependent or Dependent. The plan that covers the person other than as a dependent, (for example, as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.
    - Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:
        - The primary plan is the plan of the parent whose birthday is earlier in the year if: (a) the parents are married; (b) the parents are not separated (whether or not they have ever been married); or (3) a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.
        - If both parents have the same birthday, the plan that has covered either of the parents longer is primary.
        - If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.
        - If the parents are separated (whether or not they were ever married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and parent's spouse/domestic partner (if any) is :
            I. The plan of the custodial parent;
            II. The plan of the spouse/domestic partner of the custodial parent;
            III. The plan of the noncustodial parent; and then
            IV. The plan of the spouse/domestic partner of the noncustodial parent.

- Active or Inactive Employee. The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retiree and as a dependent of that individual's spouse/domestic partner who is an active worker will be determined under the *Non-Dependent or Dependent* paragraph above.
- Continuation Coverage. A person who has elected Continuation Coverage under this Plan and also has coverage under another plan, the plan covering the person as an employee, member, subscriber, retiree or dependent is primary.
- Longer Length of Coverage. The plan that covered the person as an employee, member, subscriber or retiree longer is primary.
- If the preceding rules do not determine the primary plan, the Allowable Expenses shall be shared equally between the plans meeting the definition of plan under this section. In addition, this Plan will not pay more than it would have paid had it been primary.

When these provisions operate to reduce the total amount of benefits otherwise payable as to an individual covered under this Plan during any Claim Determination Period, each benefit which would be payable in the absence of these provisions shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limits of this Plan.

If both spouses/domestic partners are employed by the Employer and are covered as Employee Members, these provisions will apply in the same manner as if the spouses/domestic partners were covered under two different plans.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION:
For the purpose of determining the applicability of and implementing the terms of these Coordination of Benefits Rules under this Plan or any provision of similar purposes of any other plan, BEST or the Plan Administrator may, without the consent of or notice to any individual, release to or obtain from any insurance company or other organization or individual any information, with respect to any individual, which BEST or the Plan Administrator deems to be necessary for such purposes. Any individual claiming benefits under this Plan shall furnish to BEST or the Plan Administrator such information as may be necessary to implement these provisions.

FACILITY OF PAYMENT:
Whenever payments which should have been made under this Plan in accordance with these provisions have been made under any other plans, BEST shall have the right, in its sole discretion, to pay to any plans making such other payments any amount it shall determine to be warranted in order to satisfy the intent of these Coordination of Benefits provisions and amounts so paid shall be treated as benefits paid under this Plan and, to the extent of such payments, BEST and the Employer shall be fully discharged from liability under this Plan.

RIGHT TO RECOVERY:
Whenever payments for Allowable Expenses have been made by this Plan in a total amount, at any time, in excess of the maximum amount of payment required under these Coordination f Benefits Rules, the Plan shall have the right to recover such excess payments from one or more of the persons it has paid or for whom payment was made, or any other person or organization that may be responsible for the benefits or services provided for the individual.

AUTOMOBILE COVERAGES
Benefits under this Plan will be coordinated with a Member's automobile insurance medical payments coverage, automobile insurance uninsured and underinsured benefits, and automobile insurance personal injury protection coverage. This Plan will be the Secondary Plan when benefits are coordinated with the automobile coverage set forth herein. The Plan reserves the right to require proof that the medical payments coverage, uninsured and underinsured benefits, and personal injury protection coverage have paid all benefits.

REIMBURSEMENT TO THE PLAN (SUBROGATION)

If the Member has received benefit payments from this Plan for an Illness or Injury and if subsequently the Member or representative acting on behalf of the Member, has received an "Other Payment" related to such Illness or Injury, an amount equal to all or part of such Other Payment must be paid by the Member to the Plan as provided in this Section.

PAYMENT CONDITION

- The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of a Member, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Member(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

- Member(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Member(s) agrees the Plan shall have an equitable lien on any funds received by the Member(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Member(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

- In the event a Member(s) settles, recovers, or is reimbursed by any Coverage, the Member(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Member(s). If the Member(s) fails to reimburse the Plan out of any judgment or settlement received, the Member(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

- If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Member(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

SUBROGATION

- As a condition to participating in and receiving benefits under this Plan, the Member(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Member(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

- If a Member(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Member(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

- The Plan may, at its discretion, in its own name or in the name of the Member(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

  If the Member(s) fails to file a claim or pursue damages against:
  - the responsible party, its insurer, or any other source on behalf of that party;
  - any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
  - any policy of insurance from any insurance company or guarantor of a third party;
  - worker's compensation or other liability insurance company; or

- any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;
- the Member(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Member(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Member(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

- The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Member(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Member(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

- No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

- The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Member(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

- These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Member(s).

- This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

EXCESS INSURANCE

- If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

  The Plan's benefits shall be excess to:
  - the responsible party, its insurer, or any other source on behalf of that party;
  - any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
  - any policy of insurance from any insurance company or guarantor of a third party;
  - worker's compensation or other liability insurance company or
  - any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

SEPARATION OF FUNDS

- Benefits paid by the Plan, funds recovered by the Member(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Member(s), such that the death of the Member(s), or filing of bankruptcy by the Member(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH

- In the event that the Member(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

OBLIGATIONS

- It is the Member(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
  - to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
  - to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
  - to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
  - to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
  - to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
  - to not settle or release, without the prior consent of the Plan, any claim to the extent that the Member may have against any responsible party or Coverage.

- If the Member(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Member(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Member(s).

- The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Member(s)' cooperation or adherence to these terms.

OFFSET

- Failure by the Member(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Member(s) may be withheld until the Member(s) satisfies his or her obligation.

MINOR STATUS

- In the event the Member(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

- If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

LANGUAGE INTERPRETATION

- The Plan retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan may amend at any time without notice.

SEVERABILITY

- In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

MEDICARE

The term "Medicare" refers to the program of medical care benefits provided under federal law as Title XVIII of the Social Security Act, the Health Insurance for the Aged Act, July 30, 1965, P.L. 89-97, 42 U.S.C. Section 1395, et seq., as amended from time to time.

Generally anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period. Persons with end stage renal disease ("ESRD") are also entitled to Medicare coverage under certain circumstances.

If the Member, the Spouse/domestic partner or Dependent child becomes covered by Medicare, whether because of ESRD, disability or age, the Member may retain or cancel coverage under this Plan:

- If a Member and/or any Dependents are covered by both this Plan and by Medicare, as long as the Employee Member remains actively at work and the Employer has twenty or more employees, this Plan will continue to provide the same benefits and the Member contributions will remain the same as for all other active members. However, Members actively at work who are age 65 or older are required to enroll in Medicare Part A when first eligible.
- If a Member is disabled but maintains a job-attached status, or a disabled Dependent of a Member with a job-attached status, coverage under this Plan will be paid without regard to coverage under Medicare.
- If the Employee Member is covered by Medicare and cancels coverage under this Plan, coverage for the Spouse/domestic partner and/or Dependents will also terminate, however, they may be entitled to Continuation Coverage as provided under this Plan.
- If any Dependents are covered by Medicare and the Employee Member cancels that Dependent's coverage under this Plan, that Dependent will not be eligible for Continuation Coverage.

The choice of retaining or canceling coverage under this Plan for a Medicare eligible participant is that of a Member who is either actively at work or a job attached Employee. Neither this Plan nor the Employer will provide any consideration, incentive or benefits to encourage a Member to cancel coverage under this Plan.

If a Member is legally determined to be Totally Disabled, as defined by the Medicare program, and therefore entitled to Medicare due to the disability, the Member will no longer be considered to be actively at work. As a result, upon becoming entitled to Medicare due to the disability, Medicare will be Primary and this Plan will be Secondary. Benefits shall be payable under this Plan after Medicare have been paid whether or not such Member is disabled and not in an active employment status and under or over the age of 65 other than as specified for an ESRD beneficiary.

End Stage Renal Disease (ESRD) Medicare Beneficiary. Benefits for Covered Expenses shall be payable under this Plan without regard to a Member's entitlement to Medicare as an ESRD beneficiary, when not more than 30 months has elapsed since the first month the individual is entitled to Medicare, UNLESS, the Member is already entitled to Medicare due to other disability or age and Medicare is already the Primary payer. If this Plan is Primary the 30 months starts the earlier of:

- the month in which Medicare ESRD coverage begins; or
- the first month in which the Member receives a kidney transplant.

Beginning with the 31st month after the start of Medicare coverage, Medicare will be primary and this Plan will pay as secondary.

The Spouse/domestic partner, age 65 or older, of any active Employee Member is given the option to elect as primary this Plan or Medicare. If the affected Spouse/domestic partner elects the benefits of this Plan as primary, the Plan will provide benefits equivalent to the benefits available under this Plan to individuals under age 65. If a Spouse/domestic partner elects Medicare as primary, this Plan will not provide benefits complementary to Medicare. (The Coordination of Benefits provision will not apply.)

For any Member covered under this Plan pursuant to Continuation Coverage who first becomes enrolled in either Part A or Part B of Medicare prior to the date of an election to continue coverage, benefits under this Plan will be payable to the extent that Covered Expenses are not covered by Medicare. The Coordination of Benefits provision will apply. (This paragraph does not apply to Continuation Coverage Members eligible for Medicare because of permanent kidney failure, i.e. End Stage Renal Disease.)

STATEMENT OF BEST MEMBERS' RIGHTS

In addition to other rights enumerated in this Medical Plan Document, and as provided under applicable state and federal laws, as a Member in this Plan, an individual is entitled to certain rights including the right to:

- Examine, without charge, at the Plan Administrator's office all Plan documents, including insurance contracts.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. (The Plan Administrator may make a reasonable charge for the copies).
- Expect proper and equitable treatment from the persons who are responsible for the operation of the Plan.
- Continue health care coverage for yourself and/or your Dependents (if any) if there is a loss of coverage under the Plan as a result of a Qualifying Event as described in this Plan. You and/or your Dependents will be required to pay for such coverage within the required timeframes, if it is elected.
- Receive a Certificate of Creditable Coverage, free of charge, shortly after your coverage under this Plan ends for any reason. If you become entitled to Continuation Coverage, that Certificate will be made available to you on or about the time that your Notice of Election for Continuation Coverage is made available to you; and if you elect Continuation Coverage, again when your Continuation Coverage ends for any reason, and also whenever you request it at any time for up to twenty-four (24) months after your coverage ends.

FILING A CLAIM AND AN APPEAL OF A DENIED MEDICAL CLAIM

Appeals

1. General Procedures

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. You may appeal any *adverse benefit determination* to the *plan administrator*. The *plan administrator* is the sole fiduciary of the *Plan*, and exercises all discretionary authority and control over the administration of the *Plan* and has sole discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*.

The *plan administrator* will conduct a full and fair review of all benefit appeals, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports such individual(s) and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. You will also have the opportunity to submit to the *plan administrator* written comments, documents, records and other information relating to your claim for benefits. The *plan administrator* will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *plan administrator* will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

2. Form and Timing

All requests for a review of a denied ***pre-service claim*** (other than *urgent care claim*) must be in writing and should include a copy of the *adverse benefit determination, if applicable,* and any other pertinent information that you wish the *plan administrator* to review in conjunction with your appeal. Send all information to:

Colorado Choice Health Plans
700 Main Street – Suite 100
Alamosa, CO 81101
(719) 589-3696 Voice
(800) 475-8466 Toll Free Voice

You may appeal an *adverse benefit determination* of an ***urgent care claim*** on an expedited basis, either orally or in writing. You may appeal orally by calling the *Plan Administrator* at (719) 365-5025. All necessary information, including the *plan administrator's* benefit determination on review, will be transmitted between the *Plan Administrator* and you by telephone, facsimile, or other available similarly expeditious method.

All requests for a review of a denied ***post-service claim*** must be in writing and should include a copy of the *adverse benefit determination* and any other pertinent information that you wish the *Plan Administrator* to review in conjunction with your appeal. Send all information to:

Colorado Choice Health Plans
700 Main Street – Suite 100
Alamosa, CO 81101
(719) 589-3696 Voice
(800) 475-8466 Toll Free Voice

You or your authorized representative must file any appeal of an adverse benefit determination within 180 days after receiving notification of the adverse benefit determination.

Requests for appeal which do not comply with the above requirements will not be considered.

Time Period For Deciding Appeals

Appeals will be decided by the plan administrator as follows:

1. Urgent care claims

   Appeals of urgent care claims will be decided by the plan administrator as soon as possible, taking into account the medical emergencies, but not later than 24 hours after the plan administrator receives the appeal. A decision communicated orally will be followed-up in writing.

2. Other pre-service claims

   Appeals of pre-service claims will be decided by the plan administrator within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the plan administrator receives the appeal. The plan administrator's decision will be provided to you in writing.

3. Post-service claims

   Appeals of post-service claims will be decided by the plan administrator within a reasonable period of time, but not later than 30 days after the plan administrator receives the appeal. The plan administrator's decision will be provided to you in writing.

Notification of Appeal Denials

If your appeal is denied, the *plan administrator's* written *notification* will include:

1. the specific reason(s) for the *adverse benefit determination*;
2. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based;
3. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records and other information that are relevant to the claim;
4. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline protocol, or other similar criterion was relied upon in denying the appeal and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
5. if the denied appeal was based on a *medical necessity*, *experimental/investigational* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request; and
6. a statement describing any additional appeal procedures offered by the *Plan* and your right to obtain information about such procedures.

Notification of the decision on an *urgent care claim* may be provided orally, but a follow-up written notification will be provided no later than three days after the oral notice.

Second Level Appeal of Post-Service Claims

If your appeal of a post-service claim is denied, you or your *authorized representative* may request further review by the claim administrator. This request for a second-level appeal must be made, in writing, within 60 calendar days of the date you are notified of the original appeal decision. For post-service claims, this second-level review is mandatory.

The claim administrator will promptly conduct a full and fair review of your appeal, independently from the individual(s) who considered your first level appeal or anyone who reports to such individual(s) and without affording deference to the initial denial. You will again have access to all relevant records and other information and the opportunity to submit written comments and other information, as described in more detail under the section entitled "General Procedures" above.

If the adverse benefit determination was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are experimental / investigational, or not medically necessary or appropriate, the claim administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was consulted neither in connection with the adverse benefit determination nor the initial appeal denial and who is not a subordinate of any such individuals.

Second-level appeals of post-service claims will be decided by the claim administrator within a reasonable period of time, but not later than 30 calendar days after the claim administrator receives the appeal. The claim administrator's decision will be provided to you in writing, and if the decision is a second denial, the notification will include all of the information described in the section entitled "Notification of Appeal Denials" above.

External Review of Claims

If your appeal of a post-service claim is denied, you or your authorized representative may request further review by an independent review organization (IRO). This request for external review must be made, in writing, within four months of the date you are notified of an adverse benefit determination or final adverse benefit determination.

Within 5 business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

1. The claimant is or was covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
2. The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);
3. The claimant has exhausted the plan's internal appeal process;
4. The claimant has provided all the information and forms required to process an external review.

The Plan will notify the claimant within one business day of completion of its preliminary review if:

1. the request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA [3272]);
2. the request is not complete, in which case the notice will describe the information or materials needed to make the request complete, and allow the claimant to perfect the request for external review within the four-month filing period, or within the 48 hour period following receipt of the notification, whichever is later.

NOTE: If the adverse benefit determination or final internal adverse benefit determination relates to a participant's or beneficiary's failure to meet the requirements for eligibility under the terms of the Plan, it is not within the scope of the external review process, and no external review may be taken.

If the request is complete and eligible, the Plan Administrator will assign the request to an IRO. Once that assignment is made, the following procedure will apply:

1. The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the plan.
2. The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.
3. Within five business days after the date of assignment of the IRO, the plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.
4. Upon receipt of any information submitted by the claimant, the assigned IRO must within one business day forward the information to the plan. Upon receipt of any such information, the plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the plan must not delay the external review. The external review terminated as a result of the reconsideration only if the plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the plan.

5. The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim *de novo* and not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
   a. The claimant's medical records;
   b. The attending health care professional's recommendation;
   c. Reports from appropriate health care professionals and other documents submitted by the Plan, claimant, or the claimant's treating provider;
   d. The terms of the claimant's plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
   e. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
   f. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and,
   g. The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available.
6. The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the plan.
7. If the IRO reverses the plan's adverse benefit determination or final adverse benefit determination, the plan must immediately provide the coverage or reimburse the expenses that were the subject of the IRO's reversal.
8. The assigned IRO's decision notice will contain:
   a. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial);
   b. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
   c. The references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
   d. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
   e. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;
   f. A statement that judicial review may be available to the claimant; and
   g. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Expedited External Review of Claims

A claimant may make a request for an expedited external review if either:

1. a claimant receives an adverse benefit determination that involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited appeal; or
2. a claimant receives a final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or

would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or,

3. health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether:

1. The claimant is or was covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
2. The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);
3. The claimant has exhausted the plan's internal appeal process;
4. The claimant has provided all the information and forms required to process an external review.

The Plan will notify the claimant within one business day of completion of its preliminary review if:

1. the request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA [3272]);
2. the request is not complete, in which case the notice will describe the information or materials needed to make the request complete, and allow the claimant to perfect the request for external review within the four-month filing period, or within the 48 hour period following receipt of the notification, whichever is later.

Upon a determination that a request is eligible for external review following the preliminary review, the plan will assign an IRO as set forth above. The plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim *de novo* and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to the claimant and the Plan.

FILING A CLAIM AND AN APPEAL OF A DENIED PRESCRIPTION CLAIM

In the event you receive an adverse benefit determination following a request for coverage of a prescription benefit claims, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been denied, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to:

Colorado Choice Health Plans, 700 Main Street – Suite 100, Alamosa, CO 81101

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to receive, upon request and at no charge, the information used to review your appeal. CLIENT SHOULD INDICATE IF FOREIGN LANGUAGE REQUIREMENT APPLIES THAT PARTICIPANT ALSO HAS RIGHT TO RECEIVE NOTICES IN FOREIGN LANGUAGE AND DESCRIPTION OF OTHER FOREIGN LANGUAGE RIGHTS.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second level appeal, provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been denied the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to:

Colorado Choice Health Plans, 700 Main Street – Suite 100, Alamosa, CO 81101

You have the right to review your file and present evidence and testimony as part of your appeal, and the right to a full and fair impartial review of your claim. A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for an appeal. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to receive, upon request and at no charge, the information used to review your second level appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

You also may have the right to obtain an independent external review. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination. External reviews are not available for decisions relating to eligibility.

In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 24 hours of receipt of the claim. An urgent care claim is any claim for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 24 hours of receipt of the information. If you don't provide the needed information within the 48-hour period, your claim will be deemed denied.

You have the right to request an urgent appeal of an adverse benefit determination (including a deemed denial) if you request coverage of a claim that is urgent. Urgent appeal requests may be oral or written. You or your physician may call **(800) 475-8466** or send a written request to:

Colorado Choice Health Plans, 700 Main Street – Suite 100, Alamosa, CO 81101, Attn: Urgent Appeals

In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have the right to receive, upon request and at no charge, the information used to review your appeal. If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding. You also have the right to obtain an independent external review. In situations where the timeframe for completion of an internal review would seriously jeopardize your life or health or your ability to regain maximum function you could have the right to immediately request an expedited external review, *prior to* exhausting the internal appeal process, provided you simultaneously file your request for an internal appeal of the adverse benefit determination. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination.

For direct claims:

Your plan provides for reimbursement of prescriptions when you pay 100% of the prescription price at the time of purchase. This claim will be processed based on your plan benefit. To request reimbursement you will send your claim to:

OptumRx, P.O. Box 968022, Schaumburg, IL 60196-8022

If your claim is denied, you will receive a written notice within 30 days of receipt of the claim, as long as all needed information was provided with the claim. You will be notified within this 30 day period if additional information is needed to process the claim, and a one-time extension not longer than 15 days may be requested and your claim pended until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, you will be notified of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be deemed denied.

If you are not satisfied with the decision regarding your benefit coverage or your claim is deemed denied, you have the right to appeal this decision in writing within 180 days of receipt of notice of the initial decision. To initiate an appeal for coverage, you or your authorized representative (such as your physician), must provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been reduced or denied, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to:

Colorado Choice Health Plans, 700 Main Street – Suite 100, Alamosa, CO 81101

A decision regarding your appeal will be sent to you within 30 days of receipt of your written request. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provision on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to receive, upon request and at no charge, the information used to review your appeal. CLIENT SHOULD INDICATE IF FOREIGN LANGUAGE REQUIREMENT APPLIES THAT PARTICIPANT ALSO HAS RIGHT TO RECEIVE NOTICES IN FOREIGN LANGUAGE.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of receipt notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second level appeal, provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been reduced or denied, the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes) and any additional information that may be relevant to our appeal. This information should be mailed to:

Colorado Choice Health Plans, 700 Main Street – Suite 100, Alamosa, CO 81101

You have the right to review your file and present evidence and testimony as part of your appeal, and the right to a full and fair impartial review of your claim. A decision regarding your request will be sent to you in writing within 30 days of receipt of your written request for appeal. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to receive, upon request and at no charge, the information used to review your second level appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

You also may have the right to obtain an independent external review. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination. External reviews are not available for decisions relating to eligibility.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT PROVISIONS

COMPLIANCE WITH HIPAA PRIVACY AND SECURITY STANDARDS:
The Plan is subject to the Standards for Privacy of Individually Identifiable Health Information ("Privacy Standards") and the Security Standards for the Protection of Electronic Protected Health Information ("Security Standards"), as set forth in 65 CFR Parts 160 and 164, and as they may be amended (collectively, "the HIPAA Standards"), promulgated under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act ("HIPAA");

In the course of performing administrative functions on behalf of the Plan, the Plan Sponsor may receive from the Plan certain protected health information ("PHI") as defined in the Standards, regarding Plan's Members;

In order for the Plan to disclose PHI, other than enrollment information and summary health information, to the Plan Sponsor, the Plan documents under which the Plan was established and is maintained must include specific provisions and limitations required by the HIPAA Standards. The purpose of this section of the Plan is to comply with the applicable provisions of the HIPAA Standards in order to permit the Plan Sponsor to receive PHI regarding Members.

USES AND DISCLOSURES OF PHI BY THE PLAN AND THE PLAN SPONSOR FOR PLAN ADMINISTRATION:
The Plan and the Plan Sponsor are permitted to use and disclose PHI for the following Plan administration purposes, to the extent they are not inconsistent with the Privacy Standards:

- For general plan administration, including without limitation, policy holder service functions, enrollment and eligibility functions, reporting functions, legal services, auditing functions, compliance functions, financial functions, and any other authorized insurance, administrative or benefit functions that the Plan Sponsor performs on behalf of the Plan, except that plan administration does not include functions performed by the Plan Sponsor in connection with any benefit or benefit plan offered by the Plan Sponsor other than those described in the Plan.

- As required for computer programming, data processing, computer maintenance, consulting or other work done with respect to the computer programs or systems utilized by the Plan or the Plan Sponsor for administration of the Plan.

- At the request of an individual to assist in resolving claims the individual may have with respect to benefits under the Plan.

- As necessary for the processing and payment of claims, claims management, utilization review, collection activities and other payment-related functions.

- As necessary to conduct quality assessment and improvement activities related to services provided to Plan Members, and to review the qualifications and competence of health care providers who provide services to Plan Members.

- As necessary for processing of grievances, Member complaints and appeals of claim decisions.

- To persons or entities which have entered into Business Associate Agreements with the Plan or the Plan Sponsor to assist the Plan or Plan Sponsor in performing plan administration or to perform specific functions under the Privacy Standards.

- For underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits.

- To obtain premium bids for providing health insurance coverage.

- To modify, amend or terminate the Plan.

- To the extent necessary for the Plan to obtain reimbursement under the subrogation provisions of the Plan.

- To the extent necessary to correspond with and obtain reimbursement from group health plans, insurance companies and other organizations or individuals under the coordination of benefits provisions of the Plan.

- As necessary to participate in any legal proceedings or government investigations related to the Plan.

- For any other treatment, payment or health care operations function (as those terms are defined in the HIPAA Standards) related to administration of the Plan.

OTHER PERMITTED USES AND DISCLOSURES OF PHI BY THE PLANS AND THE PLAN SPONSOR:
The Plan and Plan Sponsor may use and disclose PHI for the following purposes, as permitted by the Privacy Standards and other applicable state and federal laws and regulations and the privacy policies of the Plan:

- Judicial and administrative proceedings, in response to lawfully executed process, such as a court order or subpoena.
- For public health and health oversight activities.
- To law enforcement agencies in response to by lawfully executed process or as permitted or required by law.
- To the extent required by law.
- For research purposes.
- To coroners, funeral directors, and organ procurement organizations.
- To avert a serious threat to health or safety, for specialized government or military or national security or intelligence functions.
- As necessary to comply with workers' compensation laws.
- For other purposes described in the Plan's Privacy Notice.

SHARING OF PHI WITH THE PLAN SPONSOR:
As a condition of the Plan Sponsor receiving PHI from the Plan, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required above.
- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan.
- Ensure that any agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor and further agree to implement reasonable and appropriate security measures to protect the PHI.
- Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- Report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures and any breach of security safeguards of which it becomes aware.
- Make PHI available to Plan participants for the purposes of the rights of access and inspection, amendment, and accounting of disclosures and incorporate any amendments to PHI as required by the HIPAA Standards.
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Regulations.
- If feasible, return or destroy all PHI received from the Plan that the Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for 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 infeasible.

- Ensure that adequate separation between the Plan and Plan Sponsor is established and supported by reasonable and appropriate security measures.

- Certify to the Plan, prior to the Plan permitting disclosure of PHI to the Plan Sponsor, that the Plan Documents incorporate the provisions required by the HIPAA Standards.

SEPARATION BETWEEN PLAN AND PLAN SPONSOR:
Employees to be Given Access to PHI. The following employees (or class of employees) of the Plan Sponsor are the only individuals that may access PHI provided by the Plan:

- **Grievance Committee.** Members of the BEST Grievance Committee will have access to PHI to the extent necessary to fulfill the Committee's responsibility to review and determine appeals from denied claims under the Plan.

- **Plan Sponsor's Benefits Employees.** Individuals who perform or supervise the performance of benefits functions for the Plan Sponsor will have access to PHI as necessary to perform plan administration functions described in USES AND DISCLOSURES OF PHI BY THE PLAN AND THE PLAN SPONSOR FOR PLAN ADMINISTRATION. These employees will also have access to PHI as necessary to make any required disclosures described in OTHER PERMITTED USES AND DISCLOSURES OF PHI BY THE PLANS AND THE PLAN SPONSOR. Employees who perform benefit functions include, but are not limited to, all employees of BEST and with respect to individual Employer Plan Sponsors, individuals in the Employer's human resources, payroll and benefits departments and their respective supervisors. In addition, an Employer's superintendent or his designee, may have access to PHI as necessary to supervise and evaluate the employees who perform benefit functions for the Employer. Each Plan Sponsor shall identify and provide to BEST a list of the categories of employees who may have access to PHI pursuant to this section of the Plan.

- **Board Members.** Members of the governing boards of BEST and Employer Members may have access to PHI for purposes of overseeing the administration of the Plan, making decisions related to the benefits offered under the Plan, Plan termination, oversight and evaluation of employees who perform Plan functions, and general oversight of other Plan administration functions performed by the Plan Sponsor.

- **Plan Sponsor's Legal Counsel.** To the extent a Plan Sponsor has an in-house legal counsel, employees who work in the Plan Sponsor's office of legal counsel will have access to PHI to the extent necessary to provide legal advice and representation to the Plan and Plan Sponsor related to the Plan, including without limitation, assist the Plan with regulatory compliance; respond to, defend against, and provide necessary information to outside counsel for responding to and defending against lawsuits by Plan participants against the Plan and/or Plan Sponsor, other lawsuits that require benefits information or PHI, or government investigations related to the Plan; and enforce the subrogation and coordination of benefits provisions in the Plan.

- **Plan Sponsor's Information Services ("IS") Department.** Employees who perform IS functions for the Plan Sponsor will have access to PHI to the extent necessary to provide information technology services related to the Plan, including, but not limited to, desk side support, application support, and server support.

- **Plan Sponsor's Financial Employees.** Employees of the Plan Sponsor who perform financial functions related to the Plan, including, but not limited to, underwriting or actuarial activities, premium evaluation, tax analysis, as applicable, and other financial activities, will have access to PHI to the extent necessary to perform such functions and provide financial and related advice and assistance related to the Plan.

Restriction to Plan Administration Functions. The access to and use of PHI by the employees of the Plan Sponsor designated above will be limited to plan administration functions that the Plan Sponsor performs for the Plan as described above.

Mechanism for Resolving Issues of Noncompliance. If the Plan Administrator or Plan Privacy Officer determines that an employee of the Plan Sponsor designated above has acted in noncompliance with the plan document provisions outlined above, the Plan Administrator or Plan Privacy Officer shall take or seek to have taken appropriate disciplinary or remedial action with respect to that employee, up to and including termination of employment as appropriate. The Plan Administrator or Plan Privacy Officer shall also document the facts of the violation, disciplinary or remedial actions that have been taken, and the steps taken to mitigate the violation and prevent future violations.

MEDICAL PLAN DEFINITIONS

Accident means an unexpected, unforeseen and unintended event that causes bodily harm or damage to the body. It is not work-related.

Active Work means active full-time or qualified part-time performance of all normal duties of the Employee Member's occupation at his regular workplace or other location to which the Employer requires the Employee to travel.

Actively at Work means an Employee Member deemed engaged in Active Work on each working day, on each day of a regular paid vacation, and on each regular non-working day on which he is not disabled, provided he was "Actively at Work" on the last preceding working day.

Alternative Facility means a non-hospital health care facility or adjunct facility designated as such by a Hospital that provides one or more of the following services on an Outpatient basis: (1) pre-scheduled surgical services, (2) Urgent or Emergency services, (3) pre-scheduled rehabilitative, laboratory or diagnostic services.

Ambulance means a specially designed and/or equipped vehicle, helicopter, airplane or boat that is licensed for transferring the sick or injured by the jurisdiction in which it operates. It must have customary patient care, safety and life-saving equipment and must utilize trained personnel.

Amendment means a formal document that changes the provisions of this Medical Plan Document, is duly signed by an authorized person and is communicated to Members.

Anesthesia means either general anesthesia or Monitored Anesthesia Care ("MAC") that produces unconsciousness in varying degrees with muscular relaxation and a reduction or absence of pain or regional or local anesthesia that produces similar effects to a limited region of the body without causing loss of consciousness. A Physician or Certified Registered Nurse Anesthetist (CRNA) administers anesthesia.

Appliance(s) means the general term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic).

Assignment means a decision to make benefits which ordinarily would be payable to such Member payable directly to the provider.

Benefit, Benefit Payment, Plan Benefit means a dollar amount payable as Covered Expenses for a medical or pharmaceutical Claim after calculation of co-pay, and after the determination of the Plan's exclusions, limitations and maximums.

Board of Directors means the Board of Directors of BEST.

Calendar Year means that period of time beginning on the first day of January and ending on the last day of December in the same Calendar Year.

Certificate of Creditable Coverage means the certificate provided to each Member upon request and when coverage under the Plan is terminated and again, if applicable, when coverage is terminated at the end of the Continuation Coverage period or during such period if the Member cancels this coverage. This is provided at no cost and certifies for each Member the type and length of such coverage that applied under this Plan.

Certified (in reference to eligible providers) means that the institution or individual is certified to provide such services by the jurisdiction in which services are delivered.

Certified Nurse Midwife (C.N.M.) means a professional nurse licensed to practice in the jurisdiction where services are rendered, and who is included in an advanced practice registry as a C.N.M. by the appropriate authority of such jurisdiction.

Claims Administrator means the entity designated by BEST to provide claims administration, and required pre-authorizations in connection with the operation of the Plan and such other administrative functions as may be designated to it.

Clean Claim (Claim) means a claim with the required documentation submitted by a Participating Provider to the Claims Administrator on a Uniform Claim Form (Form CMS 1500, UB-04 or Form CMS 1450, or the equivalent, and also electronic claims populated with similar information in HIPAA-compliant format) with all required fields fully completed correctly, consistent with the provisions of the Participating Provider's agreement with BEST.

Coinsurance means the percentage amount for certain Covered Expenses noted in the Schedule of Benefits and payable by the Member.

Common Law Spouse means an adult, at least 18 years of age, with whom the employee cohabitates; and who represent themselves to the community as married to each other; and there is no legal impediment to the marriage.

Congenital Anomaly means a defective development or formation or a part of the body that is determined by the Physician to have been present at the time of birth.

Continuation Coverage means the requirement that certain group health plans of covered employers give employees and certain family members the opportunity to continue their health care coverage at group rates in certain instances where the coverage would otherwise end. Exhaustion of continuation coverage means that an individual's continuation coverage ceases for any reason other than either failure of the individual to pay contributions on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan).

Contracted Scheduled Fees means the amount agreed upon by the Preferred Provider Organization Eligible Providers as payment in full for services.

Contribution means the amount payable by the Employer or the amount payable by the Employer/Employee jointly for participation in the benefits of the Plan.

Coordination of Benefits means a method used to determine how benefits from two or more plans will be coordinated for payment of claimed expenses. See "Coordination of Benefits Provisions" section in this Medical Plan Document.

Co-pay means the specific dollar amount for certain Covered Expenses noted in the Schedule of Benefits and payable by the Member at the time Covered Expenses are rendered. Co- pays do NOT apply toward satisfying the deductible amounts.

Cosmetic Procedure means one performed solely for the improvement of a Member's appearance rather than for the improvement or restoration of a bodily function and which is not Medically Necessary.

Covered Expenses means eligible expenses for benefits that are specifically included under the terms, conditions, limitations and exclusions of the Plan and described in the Schedule of Benefits, subject to the pre-authorization requirements and rendered by Participating Providers.

Creditable Coverage means coverage an individual has under the following as defined by federal law and applicable regulations:

- A group health plan;
- Health insurance coverage (through a group or individual policy);
- Medicare;
- Medicaid;
- A medical care program of the Uniformed Services;
- A medical care program of the Indian Health Services or of a tribal organization;
- A state health benefits risk pool;
- A state Children's Health Insurance Program;
- A health plan offered under the Federal Employee Health benefits Program;
- A public health plan, including any plan established or maintained by a state, the US government, a foreign country or any political subdivision of the same; or
- A health benefit plan under Section 5(e) of the Peace Corps Act.

Creditable Coverage shall not include coverage for liability, disability income, limited scope dental or vision benefits, specified disease, supplemental benefits and other excepted benefits as defined by federal law and applicable regulations. A period of

Creditable Coverage shall not be counted, with respect to enrollment under a group health plan, if there is a 63-day lapse in coverage between the end of the prior coverage and the beginning of the person's enrollment under this Plan.

Custodial Care means care consisting of services and supplies provided to an individual, whether or not he is disabled, in or out of an institution, primarily to assist him in Daily Living Activities, and without regard to the question of by whom recommended or furnished. Board, room and skilled nursing services are not, however, considered custodial care (i) if provided during confinement in an institution for which coverage is available under this Plan, and (ii) if combined with other necessary therapeutic services, under accepted medical standards, which reasonably can be expected to substantially improve the individual's medical condition.

Daily Living Activities means activities performed as part of a person's daily routine such as getting in and out of bed, bathing, dressing, eating, ambulating and taking drugs and medicines that can be self-administered.

Days mean calendar days.

Deductible means the specific dollar amount (noted in the Schedule of Benefits) for certain Covered Expenses that the Member must pay within each Calendar Year. It is payable by the Member at the time Covered Expenses are rendered. The Plan has an individual Deductible amount and a family Deductible amount. The individual Deductible amount must be met by one Member. The remaining family Deductible amount must be met as follows – another family Member must separately meet the individual Deductible amount. Then any combination of the remaining family Members (other than those already referenced) can meet the final individual Deductible amount. Co-pays do NOT apply toward satisfying the Deductible amounts.

Dependent means a person (other than an Eligible Employee) who is eligible to participate in this Plan as defined in the eligibility section of this Medical Plan Document.

Disability See definition of **Total Disability**.

Domestic Partner means an adult, at least eighteen years of age, who is of the same or opposite gender as the employee, with whom the employee has shared an exclusive, committed relationship for at least one year prior to enrollment with the intent for the relationship to last indefinitely, and who is not related to the employee by blood to a degree that would prohibit marriage, and who is not married to another person.

Durable Medical Equipment means equipment which is (1) able to withstand repeated use; (2) is primarily used to serve a medical purpose; (3) is not generally useful to a person in the absence of an Illness or Injury and (4) is certified in writing by the attending Physician as Medically Necessary for the treatment of an Illness or Injury. It does not include equipment that is disposable with the exception of disposable catheter equipment.

E.S.R.D. means End Stage Renal Disease associated with kidney failure.

Effective Date of Coverage means the date the Employer adopts the Plan or the date that coverage under the Plan begins for Members who are properly enrolled in the Plan.

Eligible Employee or Employee Member means a status necessary in order to elect or apply for coverage under the Plan. This is an individual employed by a participating Employer and who meets the eligibility requirements of the Medical Plan Document.

Emergency Medical Condition means:

- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical condition could be reasonably expected to result in
    - Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
    - Serious impairment to bodily functions, or
    - Serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions
    - That there is inadequate time to effect a safe transfer to another hospital before delivery, or
    - That transfer may pose a threat to the health or safety of the woman or the unborn child.

Employee means an individual employed by a Member Employer.

Employer or Member Employer means a Colorado Association of School Boards (CASB) affiliated school district which has been accepted for membership in BEST and which offers the BEST Health Plan(s) to its Eligible Employees and qualified Dependents.

Exclusions means procedures, conditions, Illnesses, Injuries services and expenses incurred for treatment that will not be paid regardless of Medical Necessity. See the Medical Plan Exclusions section in this Medical Plan Document.

Foster Child means a child under the limiting age for whom an Employee Member has assumed a legal obligation. The following conditions must be met to qualify: (1) the child is being raised as the Employee Member's child; (2) the child depends on the Employee Member for primary support; (3) the child lives in the home of the Employee Member and (4) the Employee Member may legally claim the child as a federal income tax deduction.

Full-Time Employment means the employment status defined in the Eligibility Section of this document that determines eligibility to participate in this Plan.

Genetic Information means information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from Genetic Testing or that may be inferred from a person's family medical history.

Genetic Testing means tests that involve the extraction of DNA from a person's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the person's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations.

Home Health Care means services that may only be provided by a qualified Home Health Care Agency that meets fully all of the following requirements:

- it is primarily engaged in and licensed, if required, by the appropriate licensing authority to provide skilled nursing or other therapeutic services; and
- it has policies established by a professional group associated with the agency or organization. The professional group must include at least one physician and at least one R.N. to govern the services provided; and
- it provides for the full-time supervision of such services by a Physician or by an R.N; and
- it maintains a complete medical record on each patient; and
- it has a full-time administrator.

HIPAA means The Health Insurance Portability and Accountability Act of 1996, enacted on August 21, 1996. HIPAA amends the Public Health Service Act (PHS Act), the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code of 1986 (CODE) and includes the Administrative Simplification provisions of HIPAA. References to any section of HIPAA shall include any successor provisions.

Hospice means a health care program that provides coordinated services rendered at home or in an outpatient or institutional setting for individuals suffering from a disease or condition with a terminal prognosis. A Hospice must have at least one Physician and one R.N. and it must maintain standards of the National Hospice Organization (NHO).

Hospital means:

- A facility that is licensed as an acute Hospital; and
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment and care of injured and sick persons as Inpatients at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- It is accredited by The Joint commission (formerly known as JCAHO), or is recognized by the American Hospital Association (AHA) and is Qualified to receive payments under the Medicare program, or if outside the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- Always provides 24 hour nursing services by registered graduate nurses; and
- Is not a place primarily for maintenance or Custodial Care.

For the purposes of the treatment of Mental Illness and/or Substance Abuse, the definition of Hospital is expanded to include:

- 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; and
- A facility operating primarily for the treatment of Substance Abuse if it meets all of the following requirements:
  - it maintains permanent and full-time facilities for bed care and full-time confinement of at least fifteen (15) resident patients; and
  - it has a Physician in attendance and provides 24-hour a day nursing service by R.N.s; and
  - it has a full-time psychiatrist or psychologist on staff; and
  - it is primarily engaged in providing diagnostic and therapeutic services for the treatment of Substance Abuse.

An eligible provider facility must be licensed currently by the jurisdiction in which located, and if located in the United States, accredited by the Joint Commission on Accreditation of Health Care Organizations under the Consolidated Standards Manual for Child, Adolescent and Adult Psychiatric, Alcoholism and Drug Abuse Facilities and Facilities Serving the Mentally Retarded/Developmentally Disabled.

Hospital Confinement means being admitted as a resident or bed patient in a Hospital upon the recommendation of a Physician.

Illness means non-occupational bodily disorder, Illness, Injury, Mental Illness or a Congenital Anomaly of a newborn child, as diagnosed by a Physician, and as compared to the patient's previous condition. Pregnancy or a chemical dependency resulting in Substance Abuse that results in a loss covered by the Plan is also considered an Illness.

Incurred Charge or Expense means the charge for a service or supply and is considered incurred on the date furnished. Charges must also be defined as "Covered" if they are to be considered for payment under this Plan.

Infertility means the inability, without assistance, to biologically produce a child.

Injury means accidental bodily damage not caused by or resulting from the Member's employment.

Inpatient means a registered bed patient using and being charged for room and board at a Hospital or in a Hospital for 24 hours or more.

Intensive Care Unit means a section within a Hospital operated exclusively for critically ill patients that provides special supplies and equipment and constant observation and care by Registered Nurses and other highly trained personnel. Such a unit does not refer to a Hospital facility maintained for the purpose of providing normal postoperative recovery, treatment or service. It can also mean a "Coronary Care Unit ("CCU") or an Acute Care Unit ("ACU").

Laboratory Services mean testing procedures required for the diagnosis or treatment of an Illness or Injury. This includes the analysis of a specimen of tissues or other material that has been removed from the body. X-ray and radiology services include 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 person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A Special Enrollment Date for the person as defined by HIPAA.

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

Licensed (in reference to Participating Providers) means that the institution or individual is licensed to provide such services by the jurisdiction in which services are delivered.

Licensed Practical Nurse (L.P.N.) means a person with specialized nursing training and practical nursing experience who is licensed to perform nursing services where such services are performed.

Limitation means any provision other than an Exclusion of the Plan, which restricts coverage under the Plan regardless of Medical Necessity.

Medicaid means Title XIX (grants to states for Medical Assistance Programs) of the United States Social Security Act as amended.

Medical Case Management means the review of certain claims to ensure quality or medical care and to maximize benefits under the Plan. 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" are determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance will not obligate the Plan to provide the same or similarly alternative benefits for the same or any other Member, nor will it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

Medical Condition means a physical or mental condition, which is not work related, and results from Illness, Injury, Pregnancy or Congenital Anomaly.

Medically Necessary means a medical service or supply which determined by the Claims Administrator:

- Is provided by or under the direction of a Physician or other duly licensed health care practitioner who is authorized to provide or prescribe it; and
- Is determined by the Claims Administrator to be necessary in terms of generally accepted medical standards in the community in which it is provided; and
- Is approved by the FDA, if applicable; and
- meets all of the following requirements:
    - is consistent with the symptoms or diagnosis and treatment of the Illness or Injury; and
    - is not provided solely for the convenience of the patient, Physician, Hospital, health care practitioner or health care facility; and
    - is an "Appropriate" service or supply given the patient's circumstances and condition; and
    - is a "Cost-Efficient" supply or level of service that can be safely provided to the patient; and
    - is safe and effective for the Illness or Injury for which it is used.
- A medical service or supply will be considered to be "Appropriate" if:
    - It is a diagnostic procedure that is called for by the health status of the patient, and is:
    - as likely to result in information that could affect the course of treatment as; and
    - no more likely to produce a negative outcome than any alternative service or supply, both with respect to the Illness or Injury involved and the patient's overall health condition.
- care or treatment that is:
    - as likely to produce a significant positive outcome as; and
    - no more likely to produce a negative outcome than any alternative service or supply, both with respect to the Illness or Injury involved and the patient's overall condition.
- A medical service or supply will be considered to be "Cost Efficient" if it is no more costly than any alternative "Appropriate" service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.
- The fact that a Physician may provide, order, recommend or approve of a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical coverage provided by the Plan.
- A hospitalization or confinement will not be considered to be Medically Necessary if the Member's Illness or Injury could safely and Appropriately be diagnosed or treated while not confined.
- A medical service or supply that can safely and appropriately be furnished in a Physician's office or other less costly facility will not be considered to be Medically Necessary if it is furnished in a more costly Hospital or Alternative Facility.
- The non-availability of a bed in another Alternative Facility, or the non-availability of a Physician to provide medical services will not result in the determination that continued confinement in a Hospital or other Alternative Facility is Medically Necessary.
- A medical service or supply will not be considered to be Medically Necessary if it does not require the technical skills of a Physician or if it is furnished mainly for the personal comfort or convenience of the Member, the Member's family, any person who cares for the Member or any Physician, Hospital or Alternative Facility.

Medical Therapies

- Therapies must be prescribed by a Physician and performed by a qualified therapist, defined as follows:
    - Occupational Therapist - an individual who is a graduate of an occupational therapy program approved by a nationally recognized accrediting body or who currently holds certification by the American Occupational Therapy Association, Inc., who meets any current legal requirements of licensure, certification or registration in the jurisdiction in which he or she practices, and who is currently competent in the field.

- Physical Therapist - an individual who is a graduate of a physical therapy program approved by a nationally recognized accrediting body, who meets any current legal requirements of licensure, certification or registration in the jurisdiction in which he or she practices, and who is currently competent in the field.
- Respiratory Therapist - an individual who has successfully completed all education, experience and examination requirements and is registered by the National Board for Respiratory Care who meets any current legal requirements of licensure, certification or registration in the jurisdiction in which he or she practices, and who is currently competent in the field.
- Speech Therapist - an individual who has a Certificate of Clinical Competence from the American Speech-Language-Hearing Association who meets any current legal requirements of licensure, certification or registration in the jurisdiction in which he or she practices, and who is currently competent in the field.

Medicare means the Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Member means an Eligible Employee or Employee BEST Member or Dependent who is eligible to participate in this Plan as defined in the eligibility section of this Medical Plan Document

Mental Illness means a psychiatric, psychological or emotional disorder for which there is a specific diagnosis and a well-defined course of treatment. It is also classified as a Mental Illness in the current edition of International Classification of Diseases (ICD) manual published by the Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause, and among other things, autism, depression, schizophrenia and Substance Abuse.

Nurse means one who delivers nursing services in the appropriate medical context and refers either to a Registered Nurse (R.N.), Certified Registered Nurse Anesthetist (C.R.N.A.), Certified Nurse Midwife (C.N.M.), Nurse Practitioner (N.P.), or a Licensed Practical Nurse (L.P.N.) who is licensed in the jurisdiction where nursing services are rendered. Such person shall not be compensated for special nursing services under this Plan if such nurse ordinarily resides in the Member's home or is an employer of the Member's family.

Office Visit means a direct personal contact between a Physician, a Physician's Assistant or Advanced Practice Nurse and a Member in the office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association and with documentation that meets the requirement of such CPT coding. It does not mean a telephone discussion with a Physician nor a visit or interviews in which the Physician does not see the patient for treatment.

Open Enrollment means the annual period, determined by the Employer, when Eligible Employees and Members can enroll, change or decline coverage under the Plan.

Out Of Pocket maximum means the annual amount a Member must pay before the Plan will pay Covered Expenses at 100%. All deductibles, copays and coinsurance are included in the Out of Pocket maximum.

Outpatient means one who is receiving medical care at an approved hospital, clinic or other treatment facility without requiring confinement or involving a charge for room and board.

Partial Hospitalization means in Hospital treatment for Mental Illness or Substance Abuse limited to at least three hours but not more than twelve hours in any twenty-four hour period. It is a program specifically designed for the diagnosis or active treatment where there is a reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse.

Participating Provider means a Physician, Hospital, Skilled Nursing Facility or other provider of medical services that has entered into an agreement to provide medical services to Members under a PPO Plan offered by the Employer.

Partner in a Civil Union means an adult, regardless of the gender of either party, at least 18 years of age who is not a partner in another civil union; who is not married to another person; who is not under guardianship, unless the partner under guardianship has the written consent of his or her guardian; and neither partner is a relative of the other whether the relationship is by the half or the whole blood.

P.E.R.A. means the entity known as the Public Employees' Retirement Association.

Physician:

- **Medical Services**
  "Physician", in the context of a provider of medical services, means a medical doctor or surgeon (M.D.), a podiatrist (D.P.M.) a chiropractor (D.C.), or an osteopath (D.O.) who is licensed by the jurisdiction in which he practices.
- **Surgical and Anesthesia Services**
  "Physician", in the context of a provider of surgical services, means a medical doctor or surgeon (M.D.), a podiatrist (D.P.M.), an osteopath (D.O.), or a dentist (D.D.S) or dental surgeon or oral surgeon (D.M.D) who is licensed by the jurisdiction in which he practices.
- **Psychiatrist or Psychological Services**
  "Physician", in the context of providing psychiatric or psychological services, means a psychiatrist (M.D.), or a psychologist (Ph.D., Ed.D. or Psy.D.) licensed by the jurisdiction in which he practices. A Participating Provider for such services may include a comprehensive health care service corporation, a Hospital, or if within the State of Colorado a community mental health center or other mental health clinic approved by the Colorado Department of Institutions to furnish mental health services and which is a Participating Provider. Such services shall be considered as Covered Expenses provided by a Participating Provider only if provided by a therapist working under the direct supervision of a "Physician" as defined in this subsection and if such Physician either saw the patient and had a written summary of consultations or a personal consultation with the therapist at least once every ninety days during the course of treatment.
- **Diagnostic X-ray or Laboratory Service**
  "Physician", in the context of prescribing diagnostic X-ray or laboratory services, means a medical doctor (M.D.), a podiatrist (D.P.M.), an osteopath (D.O.), a chiropractor (D.C.), or a dentist (D.D.S) or dental or oral surgeon (D.M.D.), who is licensed by the jurisdiction in which he practices.

Pharmaceutical Services

- "Physician", in the context of pharmaceuticals, means a medical doctor or surgeon (M.D.), an osteopath (D.O.), or a dentist (D.D.S.) or dental or oral surgeon (D.M.D.) who is licensed by the jurisdiction in which he practices. The dispenser of pharmaceuticals may be either a prescribing Physician or a registered pharmacist licensed by the jurisdiction in which he practices.

Physician Assistant means a person legally licensed as a Physician Assistant and authorized under the supervision of a Physician, to examine patients and establish medical diagnoses; order, perform, interpret laboratory, radiograph and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; and refer to and consult with the supervising Physician; and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered.

Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of an unmarried child by a person with whom the child has been placed in anticipation of such adoption.

Plan means the Medical Plan that is offered by the Employer and which provides medical coverage as described in this Medical Plan Document.

Plan Administrator means BEST, which may contract with a qualified Claims Administrator and may delegate certain functions to such Claims Administrator or other entity to perform.

Plan Privacy Contact means an individual employed by a Member Employer to perform functions for the Plan Privacy Officer as delegated by the Plan.

Plan Privacy Officer means the person designated by the Plan to serve as the Privacy Officer for the Plan under the HIPAA Privacy Standards referred to in HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT PROVISIONS.

Plan Year means the twelve consecutive month period beginning on July 1st and ending on June 30th.

Pre-admission Testing (PAT) means certain services such as X-rays and laboratory tests done on an outpatient basis prior to a scheduled Hospital admission or an outpatient surgical procedure.

Pre-Authorization means the requirement that prior authorization from the Claims Administrator must be established for planned inpatient confinements (other than in connection with childbirth for the mother or newborn if the length of stay is 48 hours or less following a normal vaginal delivery, or 96 hours or less following a cesarean section), inpatient and outpatient surgeries, utilization of non-network providers in non-emergency situations and certain designated services/procedures. For Emergency admissions and procedures, authorization must be obtained within 48 hours after the admission to a hospital or other treatment facility. **Failure to receive authorization may result in an additional charge of $250.00 and may also result in denial of benefits.**

Pregnancy means the physical state which results in childbirth, abortion or miscarriage and any medical complications arising out of or resulting from such state.

Preferred Provider means a Physician, Hospital, or other service provider that belongs to a Preferred Provider Organization Network through which Plan benefits are offered. These providers have entered into an agreement to provide services to Members within a Preferred Provider Organization at specific contracted scheduled fees.

Preferred Provider Organization (PPO) means a network or panel of licensed Physicians and/or a group of participating health care institutions that have contracted to supply services or supplies for the Plan.

Preventive / Routine Services means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Member's health and well-being, screen for possible detection of unrevealed illness or injury, improve the Member's health, or extend the Member's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Member is being screened. Preventive/Routine Services does not include benefits specifically excluded by this Plan, or treatment after diagnosis of an Illness or Injury.

Qualified Beneficiary as defined under the Public Health Service Act 42 U.S.C. Section 300bb-8 generally means an individual who, on the day before a Qualifying Event occurs as defined in this section, is covered by the Plan as an Employee Member or an Employee Member's Dependent.

(a) A newborn child, adopted child of a Qualified Beneficiary or a child placed for adoption with a Qualified Beneficiary who was not a Member will be entitled to the same Continuation Coverage period available to the Qualified Beneficiary, however, such child shall not become a Qualified Beneficiary.
(b) A newborn child adopted or child placed for adoption with a Qualified Beneficiary who was a Member shall become a Qualified Beneficiary in his/her own right and shall be entitled to benefits as a Qualified Beneficiary.
(c) A person who becomes the spouse/domestic partner of a Qualified Beneficiary (regardless of whether the Qualified Beneficiary is the Employee Member) after a Qualifying Event is not a Qualified Beneficiary.
(d) An Employee Member or a Dependent Member, who does not elect Continuation Coverage in connection with a Qualifying Event ceases to be a Qualified Beneficiary at the end of the election period.
(e) An individual who elects Continuation Coverage ceases to be a Qualified Beneficiary once the Plan's obligation to provide Continuation Coverage has ended.

Qualified Medical Child Support Order (QMCSO) means a valid court order requiring an individual to provide health care coverage for a Dependent child as described in the Eligibility section of this Medical Plan Document.

Qualifying Event means any of the following:
(a) Termination of coverage due to the death of an Employee Member; or
(b) Termination of coverage due to the voluntary or involuntary termination of employment (other than by reason of gross misconduct or violation of law) or reduction in hours of an Employee Member; or
(c) Termination of coverage due to an Employee Member's change in status, to a classification not covered by the Plan; or
(d) The divorce or legal separation of an Employee Member from his/her spouse/domestic partner; or
(e) Termination of coverage due to an Employee Member becoming entitled to either Part A or Part B of Medicare coverage; or
(f) Termination of coverage due to an Employee BEST member becoming newly qualified for Medicaid; or
(g) A Dependent child becoming newly qualified for Children's Health Insurance Program (CHIP) or Children's Medicaid; or

(h) A Dependent child ceasing to be a Dependent child as defined in the Eligibility section of this Medical Plan document.

Registered Nurse (R.N.) means a professional person with 2 to 5 years of specialized training beyond high school in an approved school of nursing who has passed a written examination administered by a licensing authority and is licensed to perform nursing services by the jurisdiction where such services are performed.

Retired Employee or Retiree means an individual who meets the eligibility requirements of the Employer and P.E.R.A.

Room and Board means room, meals and routine nursing services provided by a Hospital, Skilled Nursing Facility or Hospice. Unless otherwise indicated, this is based on the prevailing semi-private room in which at least two patient beds are available per room.

Routine means for the purpose of routinely examining the patient and when no diagnosis exists. **Limitations as per the Patient Protection and Affordable Care Act.** If a diagnosis is indicated, all charges related to the diagnosis will be considered as any other illness.

Schedule of Benefits means a summary of the Plan's benefit provisions. Its primary function is to serve as a convenient list of the major benefit parameters, but it is not a complete or comprehensive statement of the benefit provisions. In the event of a conflict between the Schedule of Benefits and the terms of the Plan, the terms of the Plan shall govern.

Significant Break In Coverage means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

Skilled Nursing Facility means an institution or a distinct part of an institution, operating under a transfer agreement with one or more Hospitals. An eligible provider facility must be primarily engaged in providing inpatient skilled nursing care and related services for patients who require medical or nursing care. Such a facility must be supervised by a Physician, maintain clinical records on all patients, provide 24 hour nursing services with R.N.s responsible for patient care, provide appropriate methods and procedures for dispensing and administering drugs and biologicals, have a utilization review plan, and be duly licensed by the appropriate authorities in the jurisdiction where located, if applicable.

Specific Procedure Review means the Plan's requirement for pre-authorization from the Claims Administrator prior to receiving certain services, therapies, treatments or procedures even when ordered or recommended for a Member by a Participating Provider.

Spinal Manipulation means treatment by means of skeletal adjustments, manipulations or other treatment in connection with the detection and correction by manual or mechanical means of a structural imbalance or subluxation in the 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.

Spouse means an opposite-gender individual to whom the employee is legally married.

Substance Abuse means regular and excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs resulting in the need for treatment. It does not include dependence on tobacco and ordinary caffeine-containing drinks.

Surgery means the medical treatment of an Illness or Injury by manual and instrumental operation(s). When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Claims Administrator will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purposes of determining Plan benefits.

Surgical Assistant means a certified Physician's Assistant, a licensed Registered Nurse or other duly qualified surgical assistant or technician who acts in the stead of an assistant surgeon as part of the surgical team.

Temporomandibular Joint (TMJ) Disorders means conditions of structures lining the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability means in the case of an Employee Member, the inability to perform any and every duty of his or her occupation, or of a similar occupation for which the person is reasonably capable due to education and training as a result of a Non-Occupational Illness or Injury. Total Disability is determined by the Employer.

Totally Disabled Dependent means the inability of the person to perform the normal activities of a person of like age, sex and who is in good health. For the purposes of Continuation Coverage, wherever the terms "totally disabled", "disabled", or "disability" are used, they will mean a disabling condition that results in Social Security Administration Disability Award. This will also apply to a Dependent child, over the limiting age defined in the Eligibility Section, who may remain covered under this Plan due to a disability.

Transplant means the transplant of organs from human to human, including bone marrow, stem cell and cord blood transplants. Transplants include only those transplants that (a) are approved for Medicare coverage on the date the Transplant is performed; and (b) are not otherwise excluded by this Plan.

Trustee means a person or group to whom the responsibility and authority to manage and administer has been given.

Urgent or Emergency Care means the sudden and unexpected onset of a medical condition for which the Member requires immediate medical or surgical attention. While a Member is inside the service area they must go to a participating provider/facility (unless access of services from a Participating Provider/facility would cause sufficient delay that may result in death, serious disability or significant jeopardy to the Member's then current emergent condition.) Some examples of medical emergencies are heart attacks, strokes, poisoning, loss of consciousness or respiration, broken bones/fractures, eye injuries and convulsions. However, the Plan may determine that other similar acute conditions are medical emergencies.

Well Baby Care and Well Child Care means medical treatment and services or supplies rendered to a healthy child or newborn solely for the purpose of routine and preventive health maintenance, and not for the treatment of an Illness or Injury. This may also include appropriate childhood immunizations.

Wellness Care means medical treatment, services, supplies and diagnostic testing for the purposes of routine and preventive health maintenance, and not for the treatment of an Illness or Injury.

[TO NEXT PAGE]

APPENDIX A

PLAN AND AFFILIATE CONTACT INFORMATION

CLAIMS ADMINISTRATOR

To Mail Information:
Colorado Choice Health Plans
Network Claims Administration
700 Main Street, Suite 100
Alamosa, CO 81101

Physical Location:
700 Main Street, Suite 100
Alamosa, CO 81101
Local Telephone Number (719) 589-3696
Outside Alamosa (800) 475-8466

OPTUM Rx
Member Services Number (800) 880-1188

BEST HEALTH PLAN
2253 South Oneida Street
Denver, CO 80224
Local Telephone Number (303) 302-2716

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APPROVED AND ACCEPTED

IN WITNESS WHEREOF, this document is executed at:

Denver, Colorado on July 1, 2017

By: Signature on file
Ken DeLay
CEO, BOARDS OF EDUCATION SELF-FUNDED TRUST

ON BEHALF OF:

BEST HEALTH PLAN

Witness By: Signature on file
Edwin S. Pittaway, Jr.

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