

**SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT**

**FOR THE**

**SAN LUIS VALLEY COMBINED EDUCATORS**

**EMPLOYEE MEDICAL PLAN**

**GROUP NO. 2508**

**PLAN DE BENEFICIOS DE EMPLEADOS  
DE SAN LUIS VALLEY COMBINED EDUCATORS**

Este folleto contiene un resumen en ingles de su plan de derechos y beneficios cubiertos por el plan. Si usted tiene dificultad para entender cualquier parte de este folleto, contacte Irma Santiesteban-Tapia en InterCare.

The Employee Medical Plan as described in this booklet is provided through a combination of insured and self-funded benefits. The final interpretation of any specific provision herein, regardless of whether it is paid out of the self-funded or insured portion, is governed by the terms of a master Plan Document.

This booklet describes the Employee Medical Plan in an easily understood manner as in effect on June 1, 1994, and as revised and restated June 1, 2001. It does not, however, create or confer any rights, as it merely summarizes some of the essential provisions of the Plan and may not describe your particular circumstances. A complete copy of the Plan is available by contacting your District's Benefit Administrator.

The Plan is intended to be consistent with any contracts for policies of insurance under which the contributions are made, and with any contracts for medical review services. To the extent the terms of the Plan are inconsistent with such contracts, the terms of such contracts shall prevail.

The Plan will not be deemed to constitute a contract of employment or give any participant 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 participant.

The Plan is administered by:

InterCare Health Plans  
P.O. Box 3559  
Englewood, Colorado 80155-3559  
(303) 770-5710 or (800) 426-7453

This revised booklet describes the Plan of Benefits in effect as June 1, 2001.

## **FOREWORD**

This booklet summarizes the health care benefits available to the participating members of the Plan.

### **HOW YOU CAN DO YOUR PART**

The benefits described in this booklet have been designed to pay a large part of the customary charges for a broad range of necessary services, treatments, and supplies, and will give you substantial protection against the cost of serious illness and injuries.

Like any good tool, the Plan must be used properly to be effective. For the Plan to work successfully, it is important that the claims submitted by you and other participants be kept reasonable because the cost of the Plan is governed by the claims submitted.

When arranging hospital, medical, and related services, discuss the charges that are to be made with your doctor, the hospital, and others who are to furnish treatment. Generally, your doctor or hospital will be pleased to discuss the charges with you. In fact, most medical societies encourage patients to talk over charges with their doctor in advance.

Satisfy yourself that the charges will not be more than you would pay if you had no coverage, nor more than is generally charged in your area for similar services. If you are in doubt as to the level of the charge, consult InterCare Health Plans Inc., the Claims Administrator. Remember: The amount of any charges that are in excess of reasonable and customary charges are excluded under the Plan. Also, if you make sure that only necessary services are ordered and you utilize the services of a network provider, you will be doing your part to keep the Plan available for everyone, and, at the same time, you will hold your own out-of-pocket expenses to a minimum.

If you have any questions about Group #2508, please contact:

InterCare Health Plans  
(303) 770-5710  
**(800) 426-7453**

Hours:	Monday - Thursday	7:00 a.m. - Midnight
(MST)	Friday	7:00 a.m. - 5:00 p.m.
	Sunday	5:00 p.m. - Midnight

The employer has initiated the Plan to provide benefits for its employees and their eligible dependents, and it shall be maintained for this exclusive purpose.

The employer intends the Plan to be continuous, but since future conditions affecting your employer cannot be anticipated or foreseen, the employer reserves the right to amend, modify or terminate the Plan at any time, which may result in the termination or modification of the coverage. Expenses incurred prior to the Plan's termination will be paid as provided under the terms of the Plan prior to its termination.

The employer desires to provide a health care benefit plan that financially protects employees and dependents from significant health care expenses and assures quality care. While part of increasing health care costs result from new technology and important medical advances, another significant cause is the way health care services are used.

**Employee benefits are affected by certain limitations and conditions which require the employee to be a wise consumer of health services and to use only those services he or she needs.**

Some studies indicate that a high percentage of the cost for health care services may be unnecessary. For example, hospital stays can be longer than necessary. Some hospitalizations may be entirely avoidable, such as when surgery could be performed at an outpatient facility with equal quality and safety.

Alternative care at home, other alternative methods of treatment, or medical care not otherwise covered under the Plan may be suggested to patients for which additional inpatient care is medically necessary. This allows the patient to be discharged from the hospital sooner than would otherwise be possible providing a saving to the employee and the Plan while maintaining quality care equal to a hospital confinement.

**The Plan requires pre-certification prior to receiving certain types of services. For details refer to the Pre-Certification Requirement section of this booklet. Failure to use this feature will result in a reduction of benefits.**

### **SPECIAL ENROLLMENT PERIOD**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to inform you of your rights to Special Enrollment under this Plan when you or your eligible dependents **decline coverage** during the enrollment period.

If you are **declining enrollment** for yourself or your dependents (including your spouse) because of another group health plan or other group health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within thirty (30) days after your alternative group health coverage ends. In order to qualify for the special enrollment period if you decline enrollment because of alternative group health coverage, your District's Benefit Administrator must receive a **written statement** from you at the time of the enrollment period stating that other group coverage was the reason for declining enrollment.

In addition, if you have a **new** dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents, provided that you request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption.

Individuals who enroll under these special enrollment conditions are not considered late entrants.

If you have any questions, please discuss this with your District's Benefit Administrator at the time of your enrollment.

### **CREDIT FOR PRIOR COVERAGE TOWARD THE PRE-EXISTING CONDITION EXCLUSIONARY PERIOD**

The purpose of this notice is to inform you of the following:

This Plan includes a pre-existing condition exclusion period of twelve (12) months for both timely and late entrants. Generally, you are not eligible to receive benefits under this Plan for your pre-existing condition during this period. However, if you have been covered under another health plan within sixty-three (63) days of the date of enrollment into this Plan, the pre-existing condition exclusion period may be reduced by your prior coverage.

A pre-existing condition must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the enrollment date. The enrollment date is defined as the first date the person becomes covered under the Plan or, if earlier, the first day of any waiting period for such enrollment.

The pre-existing condition exclusion does not apply to:

1. Genetic information in the absence of a diagnosis of the condition related to the genetic information.
2. Pregnancy.
3. A newborn child or newly adopted child under age eighteen (18) if the child is covered within thirty (30) days of the date of birth, adoption, or placement for adoption (or who has creditable coverage from birth, adoption, or placement for adoption without a significant break in coverage).
4. Conditions first discovered during the waiting period.
5. Prescriptions purchased using the Prescription Drug Card Program.

The pre-existing condition exclusion period will not exceed twelve (12) months for both timely and late entrants, after the enrollment. A pre-existing condition must be reduced by the period of creditable coverage the individual has under any previous plan as of the enrollment date. The enrollment date is defined as the first date the person becomes covered under the Plan or, if earlier, the first day of any waiting period for such enrollment. "Late entrant" means an employee or dependent who does not enroll during the initial period in which he or she is eligible to enroll, or during a special enrollment period when there is a change in family status or loss of group health coverage under another plan.

1. The pre-existing condition exclusion period for a timely entrant starts on the date you were hired.
2. The pre-existing condition exclusionary period runs concurrently with the waiting period that you need to satisfy before you become effective under the Plan and before any benefits are payable under this Plan.

In order to make a determination of whether you are eligible for credit for your prior coverage, you must submit a Certificate of Prior Health Coverage or any other evidence of prior coverage. If you were covered under more than one (1) plan, you need to provide documentation of coverage from each health plan. Please submit this information to your District's Benefit Administrator immediately upon receipt from your prior employer. You may request a certificate, free of charge, for you or your dependent(s) before losing coverage or within two (2) years of losing coverage. Please let us know if you need our assistance in obtaining this information from your prior employer or carrier.

If it is determined that you and/or your eligible dependents:

1. will receive only a partial credit for the prior coverage towards satisfying the pre-existing condition exclusion period; or
2. will have to satisfy the entire pre-existing condition exclusion period;

based on the information on your prior certificate of health coverage, InterCare Health Plans will inform you of this determination. If you wish to appeal this decision or provide additional evidence of creditable coverage, you may contact the eligibility department at InterCare.

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## **INTRODUCTION**

WHEREAS, the participating school districts of San Luis Valley Combined Educators, hereinafter referred to as the "employer," hereby establish the benefits, rights and privileges which shall pertain to participating employees or Public Health Services Act participants, hereinafter referred to as "participants," and the eligible dependents of such participants, as herein defined, and which benefits are provided through a fund established by the employer and hereinafter referred to as the "Plan."

### **PURPOSE**

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

### **EFFECTIVE DATE**

The effective date of the Plan is June 1, 1994, and as revised effective June 1, 1997, and June 1, 1998, and as restated June 1, 2001.

### **NAMED FIDUCIARY AND PLAN ADMINISTRATOR AND PROCEDURE FOR ALLOCATION OF RESPONSIBILITY**

The Named Fiduciary and Plan Administrator is San Luis Valley Combined Educators Board of Directors, who shall have the authority to control and manage the operation and administration of the Plan in accordance with the Intergovernmental Agreement adopted by the participating district school boards. San Luis Valley Combined Educators Board of Directors may delegate responsibilities for the operation and administration of the Plan. San Luis Valley Combined Educators Board of Directors shall have the authority to amend the Plan, to determine its policies, to appoint and remove other supervisors, fix their compensation (if any), and exercise general administrative authority over them. San Luis Valley Combined Educators Board of Directors has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder.

### **BASIS ON WHICH PAYMENTS ARE TO BE MADE FROM THE PLAN**

The amount of contributions to the Plan are to be made on the following basis:

The employer shall, from time to time, evaluate the costs of the Plan and determine the amount to be contributed by the employer and the amount to be contributed (if any) by each covered participant or Public Health Services Act continuation of coverage participant.

Participation in this Plan is entirely voluntary. The employer reserves the right to modify the amount of any employee contributions. If the fund resulting from employee

contributions is insufficient to pay benefits provided by this Plan, the employer will make the necessary contribution to enable benefits to be paid.

Any employee contributions to this Plan will be initially applied to insurance premiums and then to administrative fees. Any employee contributions in excess of funds needed for premiums and fees will be used to pay claims.

### **FUNDING POLICY**

Notwithstanding any other provision of the Plan, the employer's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph entitled "Basis On Which Payments Are To Be Made From the Plan." Payment of said claims in accordance with these procedures shall discharge completely the employer's obligation with respect to such payments.

In the event that the employer terminates the Plan, then as of the effective date of termination, the employer (and covered employee and dependent participants and Public Health Services Act continuation of coverage participants) shall have no further obligation to make additional contributions to the Plan. In addition, coverage for allowable claims filed after such Plan termination date shall be limited to those remaining assets of the fund (if any) not required to pay claims filed before the effective Plan termination date. If the fund's assets are not sufficient to fund the benefits otherwise payable under this Plan, then such benefits shall not be payable under this Plan and San Luis Valley Combined Educators Board of Directors, or Trustee shall not be liable for such benefits.

### **PLAN INFORMATION**

The following information together with the information contained in this document form the Summary Plan Description/Plan Document.

1. Name of the Plan:

San Luis Valley Combined Educators Employee Medical Plan

2. Name and address of employer whose employees are covered by the Plan:

San Luis Valley Combined Educators  
c/o Gallagher Byerly, Inc.  
7600 E. Orchard Road, Suite 250-S  
Greenwood Village, CO 80111  
Phone: (303) 220-7575

3. Source of contributions to the Plan:

San Luis Valley Combined Educators participating school districts and its employees contribute to the cost of the Plan.

4. Date of the end of the Plan Year:

Plan years end on each May 31. Financial records of the Plan are kept on a Plan Year basis.

5. Plan Administrator:

San Luis Valley Combined Educators Board of Directors  
c/o Gallagher Byerly, Inc.  
7600 E. Orchard Road, Suite 250-S  
Greenwood Village, CO 80111  
Phone: (303) 220-7575

6. Agent for service of legal process:

San Luis Valley Combined Educators Board of Directors has authority to control and manage the operation and administration of the Plan and is the agent for service of legal process.

7. Type of Administration of the Plan:

The partially self-funded Plan is administered directly by the San Luis Valley Combined Educators Board of Directors. San Luis Valley Combined Educators Board of Directors has appointed a Third Party Administrator (TPA) to handle the day-to-day operation of the Plan. The TPA does not serve as an insurer, but just as a claims (processor) administrator (refer to #9).

The TPA processes the claims, then requests and receives funds from the San Luis Valley Combined Educators Board of Directors to pay the claims, and makes payment on the claims to hospitals and other providers. Remember that the Plan Administrator (San Luis Valley Combined Educators Board of Directors) is ultimately responsible for providing Plan benefits, and not the reinsurance carrier, from whom San Luis Valley Combined Educators Board of Directors has purchased coverage for catastrophic claims.

8. Eligibility:

Employees and dependents of the San Luis Valley Combined Educators participating school districts may participate in the Plan based on eligibility requirements set forth herein.

9. Claims Administrator:

InterCare Health Plans  
5500 Greenwood Plaza Blvd., Suite 100  
Englewood, CO 80111

Mailing Address:  
P.O. Box 3559  
Englewood, CO 80155-3559

Telephone: (303) 770-5710  
(800) 426-7453

10. Federal ID #: 84-6011793
11. Plan Number: 501 (This is not the group number.)
12. Plan Termination:

The right is reserved for the employer to terminate, suspend, withdraw, amend or modify the program in whole or in part at any time.

### **PROTECTION AGAINST CREDITORS**

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the employer shall find that such an attempt has been made with respect to any payment due or to become due to any covered participant, the employer in its sole discretion may terminate the interest of such covered participant or former covered participant in such payment. The employer shall apply the amount of such payment to or for the benefit of such covered participant or former covered participant, his or her spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative of a dependent of such covered participant or former covered participant, as the employer may determine. Any such application shall be a complete discharge of all liability with respect to such benefit payment.

The employer is not responsible for any portion of a claim submitted by or on behalf of a covered person or a covered dependent:

1. which is disallowed by the Plan;
2. which is not provided as a benefit under the Plan;
3. which is either not paid or delayed in payment because of financial inability of the employer to make the payment; or
4. for any unpaid claims arising or incurred after the employer, or participant, terminated participation in the Plan.

## **PLAN AMENDMENTS**

This document contains all the terms of the Plan and may be amended from time to time by the employer. Any changes so made shall be binding on each covered participant or Public Health Services Act participant and on any other covered persons referred to in this Plan Document. The terms of this Plan supersede the terms of all previous plans adopted by the employer.

## **PLAN AMENDMENT/MODIFICATION/TERMINATION**

The employer intends to provide benefits under the Plan indefinitely. However, the employer may without prior notice:

1. Change the contributions you must make under the Plan; or
2. Amend or terminate the Plan. In order to do this, the participating school districts of the San Luis Valley Combined Educators Health Plan have adopted the Intergovernmental Agreement which establishes the initial Plan amendment and termination procedures by means of a board resolution. This board resolution must:
  - a. be passed by the San Luis Valley Combined Educators Board of Directors; and
  - b. adhere to the provisions adopted under the Intergovernmental Agreement.

If the Plan is amended or terminated, this will not affect the payment of any claims for expenses incurred prior to the time the change is made.

## **TERMINATION OF PLAN**

The employer intends that the Plan remain in effect for an indefinite period. However, the employer reserves the right at any time to terminate the Plan by a written instrument to that effect. All previous contributions by the employer shall continue to be used for the purpose of paying benefits under the provisions of this Plan with respect to claims arising before such termination, or shall be used for the purpose of providing similar health benefits to covered participants, until all contributions are exhausted.

## **TERMINATION OF PARTICIPATION BY A MEMBER DISTRICT**

In the event a participating School District should for any reason cease to participate in the Plan, payment of claims will stop as of the date of withdrawal from the Plan. All claims incurred prior to the withdrawal date but not yet processed by the withdrawal date will become the responsibility of the School District and will not be paid under the terms of this Plan in accordance with the provisions in the Intergovernmental Agreement.

## **PLAN IS NOT A CONTRACT OF EMPLOYMENT**

This Summary Plan Description constitutes the entire Plan. The Plan will not be deemed to constitute a contract of employment or give any participant 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 participant.

**CONSISTENCY WITH POLICIES OF INSURANCE AND CONTRACTS FOR MEDICAL REVIEW SERVICES**

The Plan is intended to be consistent with any contracts for policies of insurance under which the employer makes contributions, and with any contracts for medical review services. To the extent the terms of this Plan are inconsistent with such contracts, the terms of such contracts shall prevail.

**INSPECTION OF PLAN DOCUMENT**

The employer, upon request, will make the Plan Document available for inspection by any covered person at a reasonably accessible place.

**RIGHTS TO RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY (WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA))**

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires that you be informed of your rights to surgery and prostheses following a covered mastectomy.

The Plan will pay charges incurred for an employee or dependent who is receiving benefits in connection with a mastectomy and then elects breast reconstruction in connection with the mastectomy. Coverage will include (a) reconstruction of the breast on which the mastectomy has been performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (c) prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and patient's attending physician and will be subject to the same deductibles, coinsurance and/or co-payments otherwise applicable under the Plan.

## **ELIGIBILITY**

### **EMPLOYEES ELIGIBLE FOR COVERAGE**

Employees eligible for coverage under the Plan are as follows:

1. Full-time, non-teaching employees who are working or scheduled to work an average of twenty (20) hours per week.
2. Full-time teachers or school employees who are working or scheduled to work twenty (20) or more hours per week for nine (9) months a year.
3. Employees retiring on or before September 30, 2000 who are age fifty (50) years or older and with twenty (20) years or more of service with a participating school district and who are covered under the plan on September 30, 2000. Coverage will terminate on the date the retired employee reaches age sixty-five (65), is eligible for Medicare or becomes covered under another group health plan.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

### **EMPLOYEE'S EFFECTIVE DATE OF COVERAGE**

The employee will be covered under the Plan provided he/she meets eligibility and waiting period requirements as listed, and provided any required contributions are made.

Employees will be eligible on the first working day of the month coinciding with or following the date of hire.

When an employee has satisfied the above requirements, such employee must complete and submit an enrollment card and any additional forms required by the employer within thirty (30) days of satisfying the above requirements.

If an employee fails to enroll within thirty (30) days of the initial date of eligibility, such employee will be unable to apply for coverage until he/she becomes eligible under the special enrollment periods provision or until the next open enrollment period.

### **DEPENDENTS ELIGIBLE FOR COVERAGE**

Dependents eligible for coverage under the Plan are as follows:

1. The employee's lawful wife or husband, unless legally separated, or a spouse by a common-law marriage agreement. A domestic partner is not recognized by the Plan.
2. A child from birth to the end of the month in which the child reaches age nineteen (19), or to the end of the month in which the child reaches age twenty-five (25) if attending

an accredited high school, college, university or vocational school on a full-time basis, or on an approved church mission, provided:

- a. they are not married; and
  - b. they are primarily dependent upon the employee for support and maintenance; and
  - c. they are not covered, as an employee, by another employer group health plan.
3. Semester breaks do not jeopardize a child's full-time status. However, if a child is not attending as a full-time student during the semester following the break, that child will no longer be considered a dependent under the Plan. Coverage will terminate as of the first day of the semester following the break.
4. A previously ineligible dependent child who becomes an attending full-time student at a recognized educational institution at a later date may be enrolled under the Plan as a new dependent within thirty (30) days of the date the semester begins for which the dependent is attending. Proof of attendance as a full-time student from the registrar of the educational institution must be provided to the employer within the thirty (30) day period for coverage to become effective on the first day of the month in which classes start.

If the employee fails to enroll the dependent within thirty (30) days of the initial eligibility, and later wants to add the dependent, the employee will be unable to apply for dependent coverage until he/she becomes eligible under the special enrollment periods provision or until the next open enrollment period.

5. An unmarried dependent grandchild, residing with the employee and for whom the employee is financially responsible and claims an income tax deduction and satisfies the requirements in number 2 above.
6. The term "child" as used herein shall mean an employee's natural child, stepchild, foster child, legally adopted child, or a child placed under the legal guardianship of the employee or the covered spouse of the employee who resides in the employee's home in a parent-child relationship, or a child for whom the employee or covered spouse of the employee claims an income tax deduction, or a child for whose medical care an employee or the covered spouse of the employee is legally responsible through a divorce decree or other court order. In each case, the child must satisfy the requirements in number 2 above.

Coverage for adopted children under the age of eighteen (18) who are enrolled within thirty (30) days of placement begins on the date of placement for the purpose of adoption and is continued unless the placement is disrupted prior to legal adoption of the child. If the employee fails to enroll the child within thirty (30) days of the initial eligibility and later wants to add the adopted child or child placed for adoption, the employee will be unable to apply for coverage until he/she becomes eligible under the special enrollment periods provision or until the next open enrollment period.

Any child covered by a Qualified Medical Child Support Order (QMCSO) is required to be covered under the Plan as of the date of the QMCSO or coinciding with the effective date of coverage, whichever is later. If the covered person does not carry dependent coverage, the Plan will enroll the child(ren) named in the QMCSO, and the covered person must pay any required contribution for family coverage. If the coverage is for a stepchild and the parent named in the QMCSO is covered under the stepparent's health plan, the Plan must enroll that stepchild. All Plan provisions for late entrants will apply.

7. A dependent child's coverage may be extended beyond age nineteen (19), if the child is:
  - a. incapable of self-sustaining employment by reason of mental retardation or physical disability; and
  - b. primarily dependent upon the employee for support and maintenance; and
  - c. not covered, as an employee, by another employer group health plan.

A letter of certification from the parents of the child and the attending physician is required stating that the condition began before or during the year in which the child reached the attained age and shows proof of incapacity and dependency. Such proof must be submitted within thirty (30) days of the dependent's attainment of age nineteen (19), or within thirty (30) days of age twenty-five (25) in case of a full-time student. During the two (2) years after the child reaches the attaining age, the Plan may ask for regular proof of the child's continued disability. A physician's examination may be required as part of the proof. After the two (2) year period, the Plan cannot ask for proof more than once a year. The Plan may require that a physician examine the child before granting a continuation of the dependent's coverage. The Plan chooses the doctor and pays the fees for all required examinations.

This provision stops on the earliest of the following dates:

- a. The date the child is no longer disabled according to the Plan.
- b. The date the Plan is not furnished with proof of the child's disability when requested.

Those situations specifically **excluded** from the definition of a dependent are:

1. A spouse who is legally separated or divorced from the employee. Such spouse must have met all requirements of a valid separation or divorce contract in the state granting such separation or divorce.
2. If both husband and wife are eligible as employees, only one (1) may carry dependent coverage.
3. Any person covered under the Plan may be covered as an employee or as a dependent, not both at the same time.

4. Dependents whose permanent residence is not in the United States are not eligible for coverage.
5. A domestic partner is not recognized by the Plan.

**Note:** The Plan may require proof (such as a copy of the employee's income tax form, court order, legal adoption or legal guardianship papers) that the spouse or child qualifies as a dependent under the employee's coverage.

### **DEPENDENT'S EFFECTIVE DATE OF COVERAGE**

Dependent coverage will not take effect unless the employee's coverage is in effect.

Eligible dependents become covered under the Plan as follows, provided any required contributions are made:

1. If the dependent is eligible as a dependent on the employee's effective date, such dependent becomes eligible under the Plan on the date the employee's coverage commences.
2. If the dependent becomes an eligible dependent after the employee's effective date, such dependent becomes eligible for coverage as specified in the special enrollment periods provision or the next open enrollment period.
3. If coverage is due to a Qualified Medical Child Support Order (QMCSO), coverage will become effective on the date of the QMCSO or coinciding with the effective date of coverage, whichever is later.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

When a dependent has met one (1) of the eligibility requirements above, the employee must complete and submit an enrollment card and any additional forms required by the employer. If the employee notifies his/her employer and completes such forms within thirty (30) days of the initial date of the dependent's eligibility, such dependent will become covered as indicated above. If the employee fails to enroll the dependent within thirty (30) days of the initial eligibility, and later wants to add the dependent, the employee will be unable to apply for dependent coverage until he/she becomes eligible under the special enrollment periods provision or until the next open enrollment period.

The following rules apply for coverage of newborn children from the moment of birth:

1. A newborn child will be covered automatically from the date of birth, provided the employee completes and submits all necessary forms adding the newborn child, changing to family coverage (if necessary) within the first thirty (30) days of the child's date of birth and agreeing to pay the required contribution (if any) for family coverage.

2. If the mother of the newborn child is a dependent child of the employee, the employee must complete all necessary forms to add the newborn child to the existing coverage within the first thirty (30) days of the child's birth and agree to pay the required contribution (if any). In this case, all the requirements in #5 on page 8 must be met.

If the employee fails to enroll such newborn within thirty (30) days of the date of birth, the newborn will be considered a late entrant unless he/she becomes eligible under the special enrollment periods provision.

**Note:** The coverage established for the newborn child is identical to that of the employee. All services provided after the newborn's birth are subject to the terms of the Plan, including the application of deductible and coinsurance. Newborn "well-baby" care is to be considered as part of the mother's expenses, subject to the mother's deductible and out-of-pocket maximum until the baby's initial discharge from the hospital provided the mother is covered for maternity benefits. If the mother is not covered under the Plan, benefits for the newborn's "well-baby" care will be subject to the newborn's own deductible and out-of-pocket maximum.

### **CHANGE IN STATUS**

**It is the covered employee's responsibility to advise the employer in writing of any change in dependent status including marriage, divorce, legal separation, the addition of newborns or adopted children and any desire to change beneficiaries.**

If a person covered under the Plan changes status from employee to dependent or dependent to employee, and the person is covered continuously under the Plan before, during and after the change in status, credit will be applied to all Plan provisions including deductibles and all amounts applied to maximums.

If you and your spouse are both covered under the Plan as employees, having both elected single coverage, either you or your spouse may change to family coverage within thirty (30) days if:

1. you are adding a newborn, adopted child, or child placed for adoption; or
2. you or your spouse terminates employment or ceases to be in a class of employees eligible for coverage with the employer.

If you or your spouse are covered under the Plan and the employee who is covering the dependent children terminates coverage, dependent coverage may be transferred to the other covered employee as long as coverage has been continuous.

### **SPECIAL ENROLLMENT PERIODS (CHANGE IN EMPLOYEE STATUS)**

If an eligible employee or dependent declined coverage under the Plan at the time of initial eligibility (and stated in writing at the time that coverage was declined because of alternative group health coverage); or there is an employee status change as defined below, the

employee may make a written request to change coverage. Such request must be made within thirty (30) days of the employee status change, and such addition or change will take effect on the later of:

1. loss of eligibility under another group health plan or through a health insurance issuer offering group health insurance coverage, no later than the first working day of the month beginning after the Plan receives the completed request for enrollment; or
2. for a marriage, no later than the first day of the first calendar month beginning after the date the Plan receives the completed request for enrollment; or
3. for a birth, the date of birth; or
4. for an adoption or placement for adoption, the date of the adoption or placement.

If written request is not made within thirty (30) days of the event, the employee must wait until the next open enrollment period.

The special enrollment rights may apply with respect to an employee, a dependent of an employee, or both.

The term "special enrollment periods (change in employee status)" means only the following:

1. A loss of eligibility of an employee and/or affected dependents under another group health plan or through a health insurance issuer offering group health insurance coverage due to:
  - a. legal separation,
  - b. divorce,
  - c. death,
  - d. termination of employment,
  - e. reduction in work hours,
  - f. employer contributions for the coverage were terminated, or
  - g. Public Health Services Act continuation coverage under the other plan has been exhausted.

An individual does not have to elect Public Health Services Act continuation coverage or exercise similar continuation rights in order to preserve the right to special enrollment. However, an individual **does not** have a special enrollment right if the individual loses the other coverage as a result of the individual's failure to pay premiums/contributions or for termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan).

2. A change in family status due to:
  - a. marriage,
  - b. birth of a child, or
  - c. adoption or placement for adoption of a child.

The special enrollment rules allow an eligible employee to enroll when he or she marries or has a **new** child (as a result of marriage, birth, adoption, or placement for adoption). A spouse of a participant can be enrolled separately at the time of marriage or when a child is born, adopted, or placed for adoption. The spouse can be enrolled together with the employee when they marry or when a child is born, adopted, or placed for adoption. A child who becomes a dependent of a participant as a result of marriage, birth, adoption, or placement for adoption can be enrolled when the child becomes a dependent. Similarly, a child who becomes a dependent of an eligible employee as a result of marriage, birth, adoption, or placement for adoption can be enrolled if the employee enrolls at the same time. Individuals who enroll under these special enrollment conditions are not considered late entrants.

If application is not made within the thirty (30) day period, the late entrant provision will apply. A "late entrant" means an employee or dependent who does not enroll during the initial period in which he or she is eligible to enroll, or during a special enrollment period when there is a change in family status or loss of group health coverage under another plan.

### **DELETING A DEPENDENT**

To remove a dependent from the employee's coverage, the employee must complete a change form. The employer must receive this form within thirty (30) days after the effective date of change. If the employee fails to timely remove an ineligible dependent, the employer reserves the right to recoup any benefit payments made on behalf of such dependent back to the date such dependent should have been deleted.

### **WAIVER OF PARTICIPATION**

Waiver of participation means an employee's failure to enroll himself/herself and his/her eligible dependent(s) within thirty (30) days of initial eligibility under the Plan. This waiver will also include coverage under the Plan which was canceled by the employee while the person remained eligible.

Waiver of participation means that future coverage under the Plan is subject to the Plan's special enrollment periods provision or enrollment as a late entrant. A "late entrant" means an employee or dependent who does not enroll during the initial period in which he/she is eligible to enroll, or during a special enrollment period when there is a change in family status or loss of group health coverage under another plan.

## **RESCISSION OF COVERAGE DUE TO MISREPRESENTATION**

The employer has the right to rescind any coverage of the employee and/or his/her dependents for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan. The employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The employer reserves the right to collect additional monies if claims are paid in excess of the employee's and/or dependent's paid contributions.

## **EMPLOYEE TERMINATION OF COVERAGE**

(See Continuation of Coverage - Public Health Services Act)

The coverage of any employee will automatically terminate at midnight on the earliest date indicated below:

1. On the last day of the month in which employment ends.
2. On the last day of the month in which an employee ceases to be in a class of employees eligible for coverage.
3. On the date the required contribution for coverage is not made, unless due to a clerical error whereby past contributions may be paid to bring coverage current.
4. On the last day of the month in which coverage is discontinued with respect to the class of employees to which such employee belongs.
5. On the date the Plan is terminated with respect to all employees, or on the date a benefit provided under the Plan is terminated.
6. On the last day of the month in which the employee retires.
7. On the date the employee becomes an active full-time member of the armed forces of any country, or government service which involves employment outside the United States.
8. On the date of the employee's death.
9. On the last day of the month in which the employee elects to terminate coverage.
10. On the date the eligible retired employee reaches age sixty-five (65); is eligible for Medicare; or the date the eligible retired employee is covered under another group health plan including but not limited to P.E.R.A.

## **DEPENDENT TERMINATION OF COVERAGE**

(See Continuation of Coverage - Public Health Services Act)

Dependents' coverage will automatically cease at midnight on the earliest date indicated below:

1. On the date the employee's coverage terminates.
2. On the last day of the month in which the employee ceases to be in a class eligible for dependent coverage.
3. On the date the required contribution for dependent coverage is not made, unless due to a clerical error whereby past contributions may be paid to bring coverage current.
4. On the date the Plan is terminated with respect to all dependents or on the date a dependent benefit provided under the Plan is terminated.
5. On the last day of the month in which such dependent ceases to be a dependent of the employee as defined herein.
6. On the date the dependent becomes an active full-time member of the armed forces of any country, or government service which involves employment outside the United States.
7. On the last day of the month of the employee's death.
8. On the last day of the month in which the employee elects to terminate the dependent's coverage.
9. On the date the dependent becomes effective as an employee under the Plan.
10. On the date the dependent spouse of an eligible retired employee reaches age sixty-five (65); is eligible for Medicare; or the date the dependent and spouse of an eligible retiree is covered under another group health plan including but not limited to P.E.R.A.

## **LEAVE OF ABSENCE**

Coverage for employees and dependent(s) under this Plan may continue for a period of up to ninety (90) days when an employee is on an approved leave of absence from the employer, provided that the employee pays any contribution toward the cost of coverage as normally required when not on a leave of absence. The leave of absence may be extended up to an additional nine (9) months, to be determined on an individual basis by San Luis Valley Combined Educators Board of Directors. At the end of the leave of absence, in order to continue coverage, the employee must either return to full-time service or elect Public Health Services Act continuation of coverage. **If the leave is an approved Family and Medical Leave or an Active Military Duty Leave, the following will apply:**

### **Family and Medical Leave Act (FMLA)**

If a covered employee ceases work due to an employer approved Family Medical Leave of Absence in accordance with the requirements of Public Law 103-3 (or in accordance with any state or local law which provides a more generous medical or family leave and required continuation of coverage during leave), coverage will be continued under the same terms and conditions which would have been provided had the covered employee continued work, provided the employee continues to pay any required contributions. Contributions will remain at the same employer/employee percentage level as on the date immediately prior to the leave (unless contributions change for other employees in the same classifications).

If the covered employee does not return to work after the approved family medical leave or if the covered employee has given the employer notice of intent not to return to service during the leave, coverage may be continued under the Continuation of Coverage (Public Health Services Act) provision of the Plan provided coverage has not lapsed, effective with the date notification is given to the employer and provided the covered employee elects to continue under the Public Health Services Act provision. The covered employee will be totally responsible for the contributions during the Public Health Services Act continuation if elected. Coverage continued during a family or medical leave will not be counted toward the maximum Public Health Services Act continuation period.

Coverage will be reinstated (for those employees and their dependents who were covered at the point contributions ceased) on the date the employee returns to work without re-satisfying any waiting period. Pre-existing condition limitations will apply only to the extent it may have applied on the date coverage terminated provided the employee makes any necessary contribution and enrolls for coverage within thirty (30) days of the return to work.

For additional details regarding this section, refer to your employer's latest policy announcement on leaves of absence.

It is the intent of the Plan to comply with all existing Family and Medical Leave Act regulations. If for some reason the information presented in the Plan differs from actual FMLA regulations, the Plan reserves the right to administer the FMLA in accordance with such actual regulations.

### **Active Military Duty and Military Reservists**

Employees or covered dependents who are called to active military duty will no longer be considered eligible for benefits under the Plan, but may elect Public Health Services Act continuation of coverage.

Employees and/or their eligible dependents returning from active duty in the armed forces may have coverage reinstated under the Plan provided:

1. such person was covered under the Plan as of the day that he or she was called to active duty in the armed forces; and
2. in the event of an employee, becomes reemployed with his/her employer within ninety (90) days of his/her being discharged from active duty, or within one (1) year if such employee was hospitalized or recovering from an illness or injury on the date of his/her discharge; or
3. such employee would have a) remained in the service of his/her employer and, b) under normal circumstances, would have satisfied the eligibility requirements under the Plan, provided such employee makes application for employee and/or dependent coverage within thirty (30) days following his/her date of rehire.

In the case of a dependent returning from active service, application for reinstatement of coverage must be made within thirty (30) days of discharge or within one (1) year if such person was hospitalized or recovering from an illness or injury on their date of discharge, provided such dependent continues to meet the qualifications of an eligible dependent.

The coverage provided will be the benefits currently provided by the Plan. If he/she returns within the same calendar year, credit will be given for eligible charges accumulated toward the satisfaction of provisions such as the out-of-pocket and deductible provisions or calendar year maximums when determining benefits available for the remainder of the calendar year.

It is the intent of the Plan to comply with all existing regulations of The Uniformed Services Employment and Reemployment Rights Act (U.S.E.R.R.A.) of 1993. If for some reason the information presented in the Plan differs from the actual regulations of the U.S.E.R.R.A., the Plan reserves the right to administer the U.S.E.R.R.A. in accordance with such actual regulations.

### **TRANSFER BETWEEN SCHOOL DISTRICTS**

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

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

## **LAYOFF**

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

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

## **EXTENSION OF MEDICAL BENEFITS (Disability)**

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

## **ELIGIBILITY DATE FOR REINSTATED EMPLOYEES**

An employee whose coverage terminates due to termination of employment and who resumes employment with the employer must meet the same eligibility and waiting period requirements as that of a new hire, with the waiting period starting on the date of rehire.

## **REINSTATEMENT OF COVERAGE**

If the employee or his or her covered dependents qualify and elect Public Health Services Act continuation and subsequently again become eligible for coverage under the Plan during the designated Public Health Services Act continuation period (with no break in coverage), the employee and his or her covered dependent(s) are not required to re-qualify as a new Plan participant. All Plan provisions will continue as though there were no lapse of coverage status.

## **LATE ENTRANT PROVISION - OPEN ENROLLMENT PERIOD**

During the annual open enrollment period, the employees may elect coverage for themselves or other family members not currently on the Plan during the months of August and September for an effective date the following October 1 (the election period).

An employee not covered under the Plan or a covered employee wishing to add a family member not currently covered under the Plan, may do so during this open enrollment election period. All Plan provisions, including those which apply to a late entrant, will apply.

Late entrant means an employee or dependent who does not enroll during the initial period in which he or she is eligible to enroll or during a special enrollment period when there is a change in family status or loss of group health coverage under another plan.

## **PARTICIPATION OF A NEW DISTRICT - WHEN COVERAGE BEGINS**

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

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

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

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

## **TERMINATION OF PARTICIPATION BY A MEMBER DISTRICT**

In the event a participating School District should for any reason cease to participate in the Plan, payment of claims will stop as of the date of withdrawal from the Plan. All claims incurred prior to the withdrawal date but not yet processed by the withdrawal date will become the responsibility of the School District and will not be paid under the terms of this Plan in accordance with the provisions in the Intergovernmental Agreement.

## PRE-CERTIFICATION REQUIREMENT

You are required to call InterCare Health Plans to obtain pre-certification at least ten (10) days **before** the following:

1. All inpatient hospitalizations.
2. Inpatient hospitalizations for maternity that exceed forty-eight (48) hours for a normal delivery or ninety-six (96) hours for a Cesarean delivery (c-section). It is highly recommended you notify InterCare within two (2) or three (3) days of a diagnosed pregnancy. This will allow InterCare to coordinate your treatment program throughout the entire pregnancy. Refer to page 47 for information regarding the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) (first paragraph under the Maternity heading).
3. Home health care.

Emergency hospital admissions or emergency inpatient surgery must be phoned in within forty-eight (48) hours of confinement, or the next business day if a weekend or holiday.

Pre-certification must be obtained for newborn infants if hospitalization is required beyond the mother's discharge date.

InterCare will review the proposed hospitalization or proposed surgery and may recommend that a second surgical opinion be obtained at the Plan's expense, or that the procedure be performed in an outpatient setting.

If, following confinement to the hospital, there is a medical reason for a change in the pre-certified length of stay, **the attending physician must contact InterCare before the approved length of stay expires.** If there is no medical reason for the additional length of hospital stay, no benefit is allowed even on a reduced basis.

**IMPORTANT:** Failure to obtain pre-certification does not disqualify your claim; however, it will result in a \$250 penalty deductible per occurrence. Any additional share of expenses which becomes the covered person's responsibility for failure to comply with these requirements will not be considered eligible medical expenses and thus will not apply to any deductible, coinsurance or out-of-pocket maximums of the Plan.

You are free to take the advice of any physician. However, it is highly recommended that you contact InterCare for a surgical review when your physician recommends an elective surgical procedure. **If the review does not support the need for surgery**, the Plan will provide a second and, if necessary, a third medical opinion. It is not necessary that either opinion be confirming. Elective, non-emergency surgery is surgery that can be postponed or avoided without undue risk to the patient. Obtaining an additional opinion may offer you assurance that the proposed surgery is indeed necessary or provide you with suggested alternative methods of treatments.

### **OBTAINING PRE-CERTIFICATION**

When you or the physician's office call in, some detailed questions concerning the services to be performed will be asked. The phone number of the caller will be taken so that after the certifications are completed, a pre-certification number can be given by return phone call. Phone in certifications are completed within twenty-four (24) hours in most circumstances. Written verification to the employee will follow.

#### **For Pre-Certification, Eligibility and/or Benefits Call:**

InterCare Health Plans  
(303) 770-5710  
(800) 426-7453

**Obtaining a pre-certification number means the proposed treatment is appropriate for the condition, but it does not guarantee you are eligible for benefits or that the services are an eligible medical expense under the Plan. Coverage is contingent upon eligibility and all Plan provisions at the time the service is rendered and must be verified by InterCare.**

If requirements under the Plan for pre-certification or referral should differ from the guidelines and procedures set forth under the utilization review contract, as may be amended from time to time, it is the intent of the Plan that the provisions of the Plan's most current utilization review contract shall prevail.

### **CENTERS OF EXCELLENCE PROGRAM**

Please note that as part of the Employee Medical Plan, employees have access to a Centers of Excellence program. This is a voluntary program which allows the employee to use one of several facilities throughout the country that offer the highest quality care at a discounted rate for major procedures such as transplants, heart surgery, etc. In order to receive in-network benefits for transplant expenses, care must be received from "Centers of Excellence." For more information, contact the pre-certification department at InterCare.

## **CASE MANAGEMENT AND ALTERNATE TREATMENT PROVISION**

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

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

**SCHEDULE OF MEDICAL BENEFITS**

Benefits will be payable during a calendar year as shown below, and will vary depending upon whether or not needed care is received from a hospital, physician or other provider who has contracted with the Network.

The Network is a group of health care providers who give quality care and accept discounted fees, making it possible to reduce the cost of medical care for you and your family.

You are not required to arrange your treatment through a primary care physician. You may arrange your care with a primary care physician or specialist of your choice.

If you use a provider within the Network, your benefits will be paid at a higher percentage than if you select a health care provider out of the network (Non-Network). These benefit levels are shown below and on the following pages.

The Network: Sloans Lake Managed Care

**MEDICAL LIFETIME MAXIMUM**, per Individual:  
(includes all other medical maximums) \$1,000,000

The term "lifetime maximum" means the total amount of benefits which may be payable while an eligible person is covered under the Plan. It will not be interpreted to mean the lifetime of the covered person.

**DEDUCTIBLE**, per Calendar Year (combined Network and Non-Network):  
(subject to all covered expenses unless specifically indicated otherwise)

	<b><u>Network Providers</u></b>	<b><u>Non-Network Providers</u></b>
Per Individual	\$ 350	\$ 500
Per Family	\$1,050	\$1,500

The Non-Network hospital per confinement deductible does not apply to the calendar year deductible.

**Carryover Deductible**: Covered expenses incurred in the last three (3) months of a calendar year and used toward the individual's deductible of that year may be used to satisfy the individual's deductible for the next calendar year. Any carryover deductible will be used on satisfying the out-of-pocket limits.

**Maximum Family Deductible:** The Plan will consider each person's deductible to be satisfied for a calendar year once you and your dependent(s) incur covered expenses for a calendar year which satisfy part, or all, of each person's separate deductible; and together equal the maximum family deductible.

The term "deductible" means a specified dollar amount of covered expenses which must be incurred during a calendar year or as specified before any other covered expenses can be considered for payment according to the applicable benefit percentage.

**COPAY:**

The term "copay" means a specific dollar amount required per visit or purchase payable by the covered person at the time of service. The copay does not serve to satisfy the deductible or out-of-pocket maximums. In those instances where a copay applies, the amount is indicated.

**COINSURANCE**, per Calendar Year:

(subject to all covered expenses unless specifically indicated otherwise)

Per Individual: Eligible charges will be paid at 80% for Network services and 60% for Non-Network services until the out-of-pocket maximum is satisfied; then 100% of eligible charges for the remainder of the calendar year or to the maximums of the Plan, whichever occurs first.

The term "coinsurance" means the amount payable by the Plan for a covered expense. The covered person is required to pay the amount not paid by the Plan.

**OUT-OF-POCKET MAXIMUM** per Calendar Year, **including** calendar year deductible:  
(combined Network and Non-Network)

	<b><u>Network Providers</u></b>	<b><u>Non-Network Providers</u></b>
Per Individual	\$1,850	\$ 6,500
Per Family	\$4,050	\$13,500

The following expenses will not be considered towards the out-of-pocket limits, nor will they be paid at 100% once the out-of-pocket limits have been reached:

1. Network provider copays, including prescription drug copays.
2. Penalty for failure to obtain pre-certification as required.
3. Expenses for inpatient, partial, or outpatient treatment of mental health disorders or chemical dependency.

4. Non-covered expenses.
5. Non-Network hospital per confinement deductible.

The term "out-of-pocket maximum" means the total amount in deductibles and any coinsurance amounts a covered person must pay during a calendar year. All eligible accumulated deductibles and coinsurance amounts payable by the covered person are combined to satisfy the respective out-of-pocket maximums under all levels of benefits.

**Covered charges are subject to usual, customary, and reasonable expenses. Take special note of the Pre-Certification Requirement, General Plan Exclusions and Limitations, and Pre-Existing Condition Exclusion.**

	<b><u>Network Providers</u></b>	<b><u>Non-Network Providers</u></b>
<b><u>Accident Benefit</u></b>		
Per Injury	No ded/100%	No ded/100%
Maximum paid per injury	\$100 *	\$100 *
* Expenses exceeding the \$100 benefit are payable the same as any other condition subject to copay, deductible and coinsurance provisions.		
<b><u>Ambulance</u></b>		
Ground or Air Transport	Ded/80%	Ded/60%
<b><u>Ambulatory Surgical Facility</u></b>		
All Covered Expenses	Ded/80%	Ded/60%
<b><u>Chemotherapy</u></b>		
In Physician's Office	Ded/80%	Ded/60%
Inpatient Facility	Ded/80%	Ded/60%
Outpatient Facility	Ded/80%	Ded/60%
Freestanding Facility	Ded/80%	Ded/60%

	<b><u>Network Providers</u></b>	<b><u>Non-Network Providers</u></b>
<b><u>Chiropractic Care</u></b>		
Office Visits and all eligible charges incurred during visit including interpretation fees	Ded/50%	Ded/50%
Maximum paid per calendar year	\$ 500	\$ 500
Maximum paid per lifetime	\$2,500	\$2,500
<b><u>Diagnostic X-Ray and Lab Expenses</u></b>		
In Physician's Office	Ded/80%	Ded/60%
Inpatient Facility	Ded/80%	Ded/60%
Outpatient Facility	Ded/80%	Ded/60%
Freestanding Facility	Ded/80%	Ded/60%
<b><u>Durable Medical Equipment</u></b>		
Per Item	Ded/80%	Ded/60%
<b><u>Home Health Care</u></b>		
Per Visit	Ded/80%	Ded/80%
Maximum per calendar year	100 Visits	100 Visits
<b><u>Hospice Expenses</u></b>		
Inpatient Hospice Care	Ded/80%	Ded/80%
Home Hospice Care	Ded/80%	Ded/80%
Maximum Hospice Care	26 Weeks	26 Weeks
<b><u>Hospital Expenses</u></b>		
Inpatient Facilities	Ded/80%	\$250 Non-Network * Hospital deductible, then Ded/60%
Outpatient Facilities	Ded/80%	Ded/60%
Emergency Room Facilities	Ded/80%	Ded/60%

\* The Non-Network hospital per confinement deductible applies to elective admissions and does not apply to newborns before initial discharge from the hospital. It does not apply toward any other deductible or to the out-of-pocket maximums under the Plan.

	<b><u>Network Providers</u></b>	<b><u>Non-Network Providers</u></b>
<b><u>Marital Counseling Benefit</u></b>		
All Covered Expenses	Ded/50%	Ded/50%
Maximum paid per lifetime	\$1,500	\$1,500
<b><u>Maternity Expenses</u></b> (employee or covered dependent)		
Inpatient Hospital Expenses	Ded/80%	\$250 Non-Network * Hospital deductible, then Ded/60%
Inpatient Physician Expenses	Ded/80%	Ded/60%
24-Hour Hospital or Birthing Center Facility Expenses (mother and baby)	Ded/80%	Ded/60%

\* The Non-Network hospital per confinement deductible applies to elective admissions and does not apply to newborns before initial discharge from the hospital. It does not apply toward any other deductible or to the out-of-pocket maximums under the Plan.

**Mental Health Disorders and Chemical Dependency**

**Mental Health Disorders**

<u>Inpatient</u> Hospital Treatment	Ded/50%	\$250 Non-Network * Hospital deductible, then Ded/50%
Maximum days per calendar year	45 days inpatient or 90 days partial hospitalization	45 days inpatient or 90 days partial hospitalization

\* The Non-Network hospital per confinement deductible applies to elective admissions and does not apply to newborns before initial discharge from the hospital. It does not apply toward any other deductible or to the out-of-pocket maximums under the Plan.

<u>Outpatient</u> Treatment	Ded/50%	Ded/50%
Maximum paid per calendar year	45 visits	45 visits

	<b><u>Network Providers</u></b>	<b><u>Non-Network Providers</u></b>
<b>Chemical Dependency</b>		
<u>Inpatient</u> Hospital Treatment	Ded/50%	\$250 Non-Network * Hospital deductible, then Ded/50%
Maximum days per calendar year	45 days inpatient or 90 days partial hospitalization	45 days inpatient or 90 days partial hospitalization

\* The Non-Network hospital per confinement deductible applies to elective admissions and does not apply to newborns before initial discharge from the hospital. It does not apply toward any other deductible or to the out-of-pocket maximums under the Plan.

<u>Outpatient</u> Treatment	Ded/50%	Ded/50%
Maximum paid per calendar year	\$2,000	\$2,000

Chemical Dependency inpatient, partial, and outpatient treatment combined:

Lifetime Maximum	\$25,000 per person	\$25,000 per person
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**Newborn Well-Baby Nursery Expenses**  
(included in the mother's expenses)

Inpatient Hospital Expenses	No Ded/80%	No Ded/60%
Inpatient Physician Expenses	No Ded/80%	No Ded/60%

**Pain Clinics, Facilities, Centers**  
(for chronic pain)

Inpatient/Outpatient	As any other illness	As any other illness
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**Physical/Occupational/Speech Therapy**

Per Visit	Ded/80%	Ded/60%
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	<b><u>Network Providers</u></b>	<b><u>Non-Network Providers</u></b>
<b><u>Physician Expenses</u></b>		
Inpatient Hospital Visits	Ded/80%	Ded/60%
Outpatient Hospital Visits	Ded/80%	Ded/60%
Emergency Room Visits	Ded/80%	Ded/60%
Office Visits and all eligible charges incurred during visit including interpretation fees	Ded/80%	Ded/60%
Injections without office visit	Ded/80%	Ded/60%
Allergy Expenses per Visit:		
Office Visit	Ded/80%	Ded/60%
Allergy Testing and Treatment	Ded/80%	Ded/60%
Allergy Injections	Ded/80%	Ded/60%

**Pre-Admission Testing**

All Covered Expenses	Ded/80%	Ded/60%
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**Private-Duty Nursing Care (Inpatient or Outpatient)**

Per Visit	Ded/80%	Ded/60%
Maximum paid per calendar year	\$2,000	\$2,000
Maximum paid per lifetime	\$5,000	\$5,000

**Routine (Wellness) Benefit**

Routine checkups, including mammograms, pap smears, prostate exams, routine diagnostic x-ray and lab tests, well-baby care, immunizations, vaccinations, and preventive shots performed and billed by the examining physician's office at the time of visit:

Per Visit	Ded/80%	Ded/60%
Maximum paid per calendar year	\$200	\$200

**Second Surgical Opinions \***

All Covered Expenses	No ded/100%	No ded/100%
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\* A third surgical opinion will be paid if requested by InterCare Health Plans.

	<b><u>Network Providers</u></b>	<b><u>Non-Network Providers</u></b>
<b><u>Skilled Nursing Care Facility Benefit</u></b>		
All Covered Expenses	Ded/80%	Ded/60%
Maximum per calendar year	60 Days	60 Days

**Sleep Apnea**

All Covered Expenses	Ded/50%	Ded/50%
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**Surgery Expenses**

Inpatient	Ded/80%	Ded/60%
Outpatient	Ded/80%	Ded/60%
Emergency Room	Ded/80%	Ded/60%
In Physician's Office	Ded/80%	Ded/60%

**Transplants**

In order to receive in-network benefits for transplant expenses, care must be received from "Centers of Excellence." Please refer to the Pre-Certification Requirement section of the Plan.

All Covered Expenses	As any other illness	As any other illness
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**Urgent Care Facilities**

(not emergency room of hospital)

Emergency or Illness Care	Ded/80%	Ded/60%
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**All Other Eligible  
Services and Supplies**

Ded/80%	Ded/60%
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The term "as any other illness" means covered expenses will be paid based on the type of service rendered.

All stated deductibles, out-of-pocket maximum amounts, and Plan maximums are common to both Network and Non-Network covered expenses and may be satisfied by a combination of such expenses.

## PRESCRIPTION DRUG BENEFITS

	<u>RxPlus Pharmacies</u>	<u>All Other Pharmacies</u>
<b>Retail</b>		
Generic drugs	15% Copay/100% 34-day supply or 100 units	Ded/60% 34-day supply or 100 units
Brand drugs	30% Copay/100% 34-day supply or 100 units	Ded/60% 34-day supply or 100 units
<b>Mail Order</b>		
Generic drugs	15% Copay/100% 90-day supply	N/A
Brand drugs	30% Copay/100% 90-day supply	N/A

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### RESIDING IN THE PREFERRED PROVIDER AREA

If a covered person has attempted to utilize a Network provider for the treatment of an illness or injury that is of an immediate life threatening nature, which develops suddenly or unexpectedly, demanding immediate treatment, and the Network provider was unable to provide the necessary covered medical services, the Plan will pay the Non-Network providers services at the Network benefit levels. A statement from the Network provider may be required to verify that it was beyond the control of the covered person.

Expenses incurred for Non-Network provider services while outside the Network service area will be paid at the Non-Network level of benefits, unless the expenses are incurred for "Life-Threatening Emergency Situations" as defined below.

The Plan will pay Non-Network provider services ordered by a Network provider at the Network provider level of benefits. This includes Non-Network hospital admissions as long as equal services and treatment facilities were **not available from a Network hospital**. The employee will not be penalized when the use of a Non-Network provider is beyond his/her control.

However, expenses will be paid at the Non-Network level of benefits for elective Non-Network hospital admissions that are based upon admitting physician or plan participant preference or due to the fact that the physician does not have admitting privileges at a Network hospital, whether or not that admitting physician was a Network provider.

A statement from the Network provider may be required to verify that it was beyond the control of the covered person. Any charges associated with obtaining these statements (documentation) are the responsibility of the covered person and are not reimbursable under the Plan.

**Immediate Life-Threatening Emergency Situations:** Care received for acute illness or injury at a Non-Network hospital or emergency facility will be paid at the Network benefit level **provided** the acute illness or injury is one that is of an immediate life- or limb-threatening nature, develops suddenly and unexpectedly, demands immediate treatment, **and** you are unable to access a Network hospital or emergency facility. If the illness or injury does not meet these requirements, benefits will be paid at the Non-Network level. If flight-for-life air ambulance is required in the state of Colorado, all expenses incurred in connection with the flight and subsequent hospitalization expenses will be paid as Network benefits.

#### **Availability of Network Provider Services**

Expenses for Non-Network provider services will be paid at the PPO level of benefits **if**:

1. a covered person has contacted the Network in an attempt to utilize a Network provider; and
2. the covered person is advised that the Network does not contract with any providers in the given specialty.

## COVERED MEDICAL EXPENSES

Covered medical expenses shall include, subject to the "General Plan Exclusions and Limitations," only usual, reasonable and customary charges for services and supplies which are incurred by a covered person and are:

1. Administered or ordered by a physician.
2. Medically necessary for the diagnosis and treatment of an illness or injury unless otherwise specifically included as a covered expense.
3. Not excluded under any provision or section of the Plan.

An expense is incurred on the date of treatment, service or purchase. Covered expenses are limited to:

1. **Acupuncture** performed by a physician or licensed acupuncturist when medically necessary to treat a covered illness or injury.
2. **Allergy testing, treatment, and injections.** RAST (radioallergosorbent test) allergy testing will be allowed only when medically necessary as the only alternative to traditional allergy testing.
3. Professional **ambulance** service when the covered person cannot be safely transported by any other means to the nearest facility where emergency care or treatment is rendered or when medically necessary, from one facility to another for care; or for professional ambulance from the facility to the patient's home when medically necessary. Air ambulance is covered only when terrain, distance or condition warrants. Ambulance charges for convenience are not covered.

If the medical consultants decide that ground ambulance services could have been used, then payment will be limited to ground ambulance benefits.

4. Expenses made by an **ambulatory surgical center, urgent care facility, or minor emergency medical clinic** when treatment has been rendered.
5. Expenses for **amniocentesis testing and/or genetic counseling**, when recommended by a physician for a covered person who is thirty-five (35) years of age or older at the time of delivery, or for a documented high-risk pregnancy, or family history of genetic disorder. Any procedure intended solely for sex determination is not covered.
6. The cost and administration of an **anesthetic** by a physician or by a nurse anesthetist (CRNA) if necessary for a covered surgery. Benefit allowances are based on the complexity of the surgical procedure, the amount of time needed to administer the anesthetic, and the patient's physical condition at the time the service is provided.

Standby anesthesia is a benefit when anesthesia services may potentially be required. These benefits depend upon the procedure and the circumstances of the case.

7. **Assistant surgeon's** fee when the procedure requires an assistant surgeon due to medical necessity.
8. **Birth centers.**
9. **Blood transfusions**, blood processing costs, blood transport charges, blood handling charges, administration charges, the cost of blood, plasma and blood derivatives, and autologous storage of blood. Any credit allowable for replacement of blood plasma by donor or blood insurance will be deducted from the total of eligible covered expenses.
10. Medical care and treatment of **chemical dependency** furnished on an inpatient or outpatient basis by a hospital, treatment facility, physician, or licensed **therapist for psychotherapy** under direct supervision of an M.D., D.O., Ph.D., Ed.D., or Psy.D., and as described later in this section of the Plan. When direct supervision is not required by the state, that licensed therapist will be a recognized provider.
11. **Chiropractic services** will only be covered for the detection and correction by manual or mechanical means of a structural imbalance, distortion or subluxation in the human body or for the removal of nerve interference, where such interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column. Maximum payable per calendar year is \$500, and the maximum payable per lifetime is \$2,500.

Charges for any devices or supplies made, ordered, supplied or prescribed by a chiropractor for any reason, including purchase from any commercial facility will not be covered.

12. Accredited facilities, clinics, or centers involved in the testing and treatment of **chronic pain** for a covered illness or injury.
13. **Cleft palate and cleft lip** expenses as described later in this section of the Plan.
14. **Dental treatment** as described later in this section of the Plan.
15. Electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established **diagnostic tests** generally approved by physicians throughout the United States.
16. The rental or purchase (whichever is less) of **durable medical equipment**. When purchase of durable medical equipment is covered, repair, maintenance, replacement and adjustments will also be covered. Items such as air conditioners, purifiers, vibrating chairs, whirlpools, saunas and dehumidifiers are not covered items.

17. Prescription **eyeglasses, frames or contact lenses** will be covered when their function is to replace the human lens absent at birth or lost through intraocular surgery or ocular injury or when caused by a medically ascertainable problem. Limitation will be to one (1) pair of prescription eyeglasses or contact lenses, unless due to a change in prescription as a result of the surgery, injury, or medically ascertainable problem.

The Plan will also cover eyeglasses or contact lenses when prescribed by the covered person's physician as the only method of treatment available for the treatment of aphakia or keratoconus.

18. **Fetal surgery** will be considered as part of the mother's care.
19. **Head halter or other traction apparatus.**
20. Expenses for treatment of kidney disorder by **hemodialysis or peritoneal dialysis** as an inpatient in a hospital, or other facility, or for expenses in an outpatient facility or in your home, including the training of one (1) attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces inpatient or outpatient dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in your home.
21. **Home health care** benefits as described later in this section of the Plan.
22. **Hospice** benefits as described later in this section of the Plan.
23. When hospitalized in a licensed **hospital**, reimbursement will be provided for care by a hospital for semiprivate room and board, intensive care, coronary care unit, or private room rate when documented in writing from the physician as medically necessary for treatment of the condition, and for all other medically necessary services and supplies. Expenses for a private room will also be paid at the private room rate when the hospital only has private rooms.

Benefits are also payable for outpatient hospital services and charges made by the hospital for outpatient surgery, emergency room treatment and other outpatient medical care.

24. Expenses incurred for the initial diagnosis and initial testing to determine **infertility and impotency**, whether a medical problem exists or not is covered; expenses incurred in connection with the treatment of infertility, impotency or promotion of conception are not covered, including drug therapy.
25. **Insulin**, related supplies, syringes.
26. **Laboratory and pathology services, and x-ray and radiology services.**

27. **Medical supplies**, including, but not limited to: dressings, sutures, casts, splints, trusses, crutches, colostomy bags, catheters, syringes and needles for administering covered drugs, medicines or insulin, special bras or harnesses required as a result of a mastectomy, limited to a maximum of three (3) per calendar year. Items that would not serve a useful medical purpose, or which are used for comfort, convenience, or personal hygiene, are not included.
28. Medical care and treatment of **mental illness or nervous disorder** furnished on an inpatient or outpatient basis by a hospital, psychiatric hospital, mental health facility, physician, nurse practitioner or licensed **therapist for psychotherapy** under direct supervision of an M.D., D.O., Ph.D., Ed.D., or Psy.D., and as described later in this section of the Plan. When direct supervision is not required by the state, that licensed therapist will be a recognized provider.
29. Licensed or registered **midwife**.
30. Any expenses for care or treatment provided by the United States government for **non-service connected disabilities** will be reimbursed to the Veterans Administration to the extent that the services are otherwise covered under the Plan.
31. **Occupational therapy** performed by a licensed therapist when medically necessary to treat a covered illness or injury. Occupational therapy must be rendered when the covered person is confined as an inpatient or as part of a home health care program and must be done to restore a physical function.
32. **Oxygen** and other gases, and equipment necessary for its administration.
33. **Physical therapy** performed by a physician or licensed physical therapist.
34. The services of a legally qualified **physician** for medical care and/or surgical treatments including but not limited to office visits, home visits, hospital inpatient care, consulting physician services, hospital outpatient visits/exams, clinic care, and second opinion consultations.
35. **Physician's assistant** fee when the procedure requires a physician's assistant due to medical necessity, in lieu of the service of an assistant surgeon.
36. Expenses for **pre-admission testing**, as described later in this section of the Plan.
37. **Prescription drugs** requiring the written prescription of a physician. Growth hormone therapy must be previously authorized with a letter from the physician documenting the need for such therapy in advance of dates of service.

Prescription drugs or injections dispensed or filled in a physician's office, or by a hospital, ambulatory, emergency, or urgent care facility are also covered.

38. Expenses incurred for **private-duty nursing** services by a practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.) for:
- a. inpatient care only if the hospital does not have such intensive care facilities or can not provide the level of care necessary; or
  - b. outpatient care in the covered person's home or other outpatient location.

The private nurse cannot be employed by the hospital and cannot reside in the same household with the covered person nor be related by blood, marriage or legal adoption to the employee or employee's spouse.

**Maximum Payment Limit:** Private duty nursing benefits are limited to a maximum combined inpatient and outpatient payment of \$2,000 each calendar year, up to a maximum lifetime benefit of \$5,000 per person.

All claims for private duty nursing services must include a physician's certification that such services are medically necessary and indicate the nurse's degree and license number.

39. **Prostheses and orthopedic appliances** including, but not limited to:

- a. artificial arms, legs, larynx or eyes;
- b. leg braces, including attached shoes;
- c. arm and back braces;
- d. maxillofacial prostheses;
- e. cervical collars; and
- f. non-cosmetic surgical implants.
- g. prosthetic bras following a partial or radical mastectomy.

Benefits include charges for the fitting, adjusting, repair or maintenance of such prosthetic or orthopedic appliances, and charges for the replacement of prosthetic or orthopedic appliances when determined by the attending physician to be medically necessary because of a change in the patient's condition or wear of an appliance.

Orthopedic shoes are covered when ordered by a physician, limited to two (2) pair per calendar year. Orthotics and arch supports are not covered, regardless of the relief they may provide for a medical condition.

40. **Radiation therapy, chemotherapy, radium, and radioactive isotope therapy.**
41. **Rehabilitation expenses** as described later in this section of the Plan.
42. **Respiratory therapy** ordered by a physician and performed by a registered respiratory therapist or qualified medical personnel.

43. Expenses for **restoration or reconstructive surgery** and related expenses are covered when such surgery is required as a result of a congenital anomaly, accidental injury, disease process or its treatment. Reconstructive surgery due to a mastectomy will include the symmetrical reconstruction of the remaining breast.
44. Expenses for **routine medical checkups**, including pap smears, mammograms, prostate examinations and other routine diagnostic x-ray and lab tests, well-baby care including vaccinations, inoculations and preventive shots performed and billed by the examining physician to a maximum paid of \$200 per person, per calendar year.
45. Expenses for **second or third surgical opinion** as described later in this section of the Plan.
46. **Skilled nursing care facility** benefits as described later in this section of the Plan.
47. Expenses in connection with treatment or testing of **sleep apnea**. Expenses incurred for all other conditions of **sleep disorders** are not covered.
48. **Speech therapy**, also called speech pathology, and audio diagnostic testing services for diagnosis and treatment of speech and language disorders. The Plan will provide benefits for speech therapy when all of the following criteria are met:
  - a. There is a documented condition or delay that can be expected to improve with therapy in a reasonable time.
  - b. Improvement would **not** normally be expected to occur without intervention.
  - c. Treatment is **not** rendered for **stuttering, lisping, tongue thrust or dyslexia**.
  - d. Treatment is **not** rendered for a **developmental or communication delay, changing an accent, or hearing loss which cannot be medically documented**.
  - e. Treatment is rendered for a condition that is the direct result of a diagnosed congenital defect (provided corrective surgery has been performed), neurological, muscular, or structural abnormality affecting the organs of speech.
  - f. Therapy has been prescribed by the speech language pathologist or physician and includes a written treatment plan with estimated length of time for therapy, along with a statement certifying all above conditions are met.

Speech therapy services must be performed by a therapist with a Clinical Competence Certification or Equivalency Statement from either the American Speech and Hearing Association or the Peer Review Board of the State Speech and Hearing Association.

49. Services for voluntary **sterilization**; tubal ligations or vasectomies for employees and dependent spouses. Reversals are not covered.
50. A **surgical procedure** performed by a physician, nurse practitioner, or licensed or registered midwife. There will be a reduction for secondary surgeries/procedures performed in the same operative session.

51. **Transplant and replacement procedures**, including but not limited to the following, are covered as any other illness:

- a. artery or vein transplants;
- b. bone marrow transplants, including a bone marrow transplant for breast cancer;
- c. cornea transplants;
- d. heart valve replacements;
- e. implantable prosthetic lenses in connection with cataracts;
- f. joint replacements;
- g. kidney transplants;
- h. prosthetic bypass or replacement vessels;
- i. human heart transplants (mechanical, artificial or other than human heart transplants are not covered);
- j. heart and lung transplants;
- k. lung transplants;
- l. liver transplants;
- m. pancreas transplants; and

any human organ transplant not considered to be experimental or investigational in nature under standards set by the Health Care Financing Administration (HCFA) and/or the National Institute of Health (NIH). Procedures that are considered experimental or investigational in nature under HCFA or NIH guidelines are subject to medical review for determination of coverage.

In addition, the following limitations apply and are included in the lifetime maximum:

- a. Donor and Search and Procurement Expenses: If a covered person receives a transplant, the donor's expenses and the search and procurement expenses will be considered to be the covered person's even if the donor is covered under the same family plan as the covered person. Benefits will be paid for the donor's covered charges to the extent an actual charge is made that is not paid or payable by any other plan covering the donor. The maximum benefit that will be paid is limited to \$30,000 per covered procedure. The maximum amount may be increased to cover expenses over \$30,000, subject to medical review for determination of coverage.
- b. Charges for Transportation, Lodging and Meals: Maximum paid is \$10,000 per covered procedure. If the recipient is a minor, this will include both parents, otherwise just the recipient and one (1) other adult.
- c. Mandatory Second Surgical Opinion Requirement. This must certify that the patient has no alternative procedure, service, or course of treatment that would be effective in the treatment of the patient's condition.

**In order to receive in-network benefits for transplant expenses, care must be received from "Centers of Excellence." Please refer to the Pre-Certification Requirement section of the Plan.**

52. Expenses incurred while **traveling outside the United States** on business or pleasure. Expenses incurred outside the United States, if the covered person traveled to such a location for the primary purpose of obtaining medical services, drugs, or supplies, are not covered.

### **ACCIDENT BENEFIT**

Expenses for an accidental bodily injury will be paid at 100% for the first \$100 of covered services. Thereafter, the deductible and coinsurance provisions apply. These expenses when paid at 100% do not count toward the deductible nor do they count toward the out-of-pocket maximum.

### **CHILDBIRTH CENTERS**

Charges made by a childbirth center are covered for services and supplies furnished for:

1. prenatal care; and
2. delivery of child(ren).

A birthing center is a licensed facility which:

1. provides: a) prenatal care; b) delivery and immediate postpartum care; and c) care of a child born at the birthing center; and
2. is directed by a physician specializing in obstetrics and gynecology; and
3. has a physician or licensed or registered midwife present at all births and during the immediate postpartum period; and
4. extends staff privileges to physicians who practice obstetrics and gynecology in the area; and
5. has at least two (2) beds or birthing rooms for use by patients during labor and delivery; and
6. provides full-time skilled nursing services (directed by an R.N. or licensed or registered midwife) in the delivery and recovery rooms; and
7. provides diagnostic x-ray and lab services for the mother and newborn; and
8. has the capacity to administer a local anesthetic and perform minor surgery (including episiotomy and repair of perineal tear); and
9. is equipped and staffed to handle medical emergencies and provide immediate life support measures; and

10. accepts only patients with low risk pregnancies if a stand-alone facility, not part of a hospital; and
11. has a written agreement with an area hospital for emergency transfer of patients and ensures its staff is aware of such procedures; and
12. provides an on-going quality assurance program; and
13. keeps a medical record on each patient.

### **CLEFT PALATE AND CLEFT LIP**

The Plan will provide benefits for cleft palate and cleft lip. Cleft palate is defined as a birth deformity in which the palate (the roof of the mouth) fails to close, and cleft lip is defined as a birth deformity in which the lip fails to close.

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

1. Oral and facial surgery, surgical management and follow-up care by plastic surgeons and oral surgeons.
2. Habilitative speech therapy.
3. Otolaryngology treatment.
4. Audiological assessments and treatment.
5. Orthodontic treatment.
6. Prosthodontic treatment.
7. Prosthetic treatment such as obturators, speech appliances, and feeding appliances.

### **DENTAL BENEFITS (Under the Medical Plan)**

The Plan will provide benefits for expenses incurred for the following dental services only.

1. Excision of exostosis of the jaw (removal of bony growth).
2. Surgical correction of accidental injuries of the jaws, cheeks, lips, tongue, floor of the mouth, and soft palate (provided the procedure is not done in preparation for dentures or dental prosthesis).
3. Treatment of fracture of facial bones.

4. Incision and drainage of cellulitis (inflammation of soft tissue).
5. Incision of accessory sinuses, salivary glands or ducts.
6. Excision of impacted teeth, bony and soft tissue.
7. Excision of tumors or cysts from the mouth.

The Plan will pay for the charges of a semiprivate room and covered hospital ancillary services in a hospital if a covered person has a hazardous medical condition (such as heart disease), which requires that an otherwise non-covered dental procedure be performed in the hospital. However, the Plan will not pay for the services of the physician, dentist, oral surgeon or any other provider in relation to that non-covered dental procedure even if the hospital charges are paid.

The Plan will also allow benefits for accident-related dental expenses when all of the following criteria has been met.

1. The injury occurred on or after the covered person's effective date of coverage.
2. Treatment must be for injuries to **sound natural teeth**.
3. Treatment must be necessary to restore the teeth to the condition they were in immediately before the accident.
4. Related services must be performed within one (1) year after the accident, unless it can be shown that it was not medically possible to provide treatment within this period of time.
5. All services must be performed while the covered person's coverage is in effect.

The Plan will **not** pay for restoring the mouth, teeth, or jaws because of injuries from biting or chewing.

### **Limitations and Exclusions**

1. **Restorations** - Benefits for restorations are limited to those services, supplies, and appliances determined to be appropriate in restoring the mouth, teeth, or jaws to the condition they were in immediately before the accident.

No benefits will be paid for duplicate, or spare dental appliances, personalized restorations, cosmetic replacement of serviceable restorations, and materials (such as precious metals) that are more expensive than necessary to restore damaged teeth.

2. **Surgical Preparations for Dentures** - Artificial implanted devices and bone grafts for denture wear are not covered.

### 3. **Temporomandibular Joint Surgery or Therapy.**

#### **HOME HEALTH CARE**

Home health care benefits will include covered charges which meet all of the following requirements:

1. They are medically necessary for the care of a covered individual who is totally disabled and who would otherwise have been confined as a bed patient in a hospital or skilled nursing facility, provided:
  - a. the covered person is under the direct care of a doctor; and
  - b. the plan of treatment for the home health care agency is established in writing by the attending doctor prior to the start of such treatment; and

Periodic assessment visits by either a physician or a licensed nurse will be required to determine the patient's condition, progress, and level of care needs. After the period of time specified on the prescribed treatment plan, continuation of care depends on a reevaluation of the patient's status.

2. They are for services provided by a home health agency. A "home health agency" means an agency which meets the following requirements:
  - a. its primary services are those listed in 4. below; and
  - b. it is federally certified as a home health agency; and
  - c. it is licensed, if licensing is required.
3. Home health care benefits will include charges by a home health care agency to a maximum of one hundred (100) visits per calendar year. A visit by a representative of a home health care provider, other than an aide, will be one (1) home health care visit. A visit by a home health care aide will be counted as one (1) visit for any four (4) hours or portion thereof.
4. Home health care benefits will be allowed for the following services:
  - a. Professional nursing services performed by a registered nurse (R.N.), or under the supervision of an R.N.
  - b. Physical therapy performed by a registered physical therapist.
  - c. Occupational therapy performed by a properly accredited registered occupational therapist (OTR) or a certified occupational therapy assistant (COTA).
  - d. Respiratory and inhalation therapy performed by a therapist trained or licensed to provide these services.
  - e. Speech therapy and audiology given for speech disorders caused by a primary or secondary muscular or structural abnormality. Services must be provided by a properly accredited speech therapist who has received a Clinical Competence Certification or Equivalency Statement from either the American Speech and

Hearing Association or the Peer Review Board of the State Speech and Hearing Association.

- f. Medical social services ordered by the attending physician and provided by a qualified medical or psychiatric social worker to assist you or your family in dealing with a specific medical condition. The individual providing such services must possess a degree in social work, psychology or counseling, or the documented equivalent in a combination of education, training and experience.
- g. Home health aide services required and supervised by a registered nurse or a physical, speech or occupational therapist.
- h. Medical supplies furnished to the covered person by the home health agency during visits for services.
- i. Nutrition counseling by a nutritionist or dietitian.
- j. The following additional items and services are eligible expenses under a home health care program. However, some of these expenses may also be covered under benefits otherwise provided by the Plan:
  - 1) Prostheses and orthopedic appliances.
  - 2) Rental or purchase of durable medical equipment.
  - 3) Expenses for prescription drugs, medicines, or insulin.

### **Limitations and Exclusions**

No home health care benefits will be paid for:

1. **Custodial Care.** The Plan will pay for one-time training for a family member, household resident, or non-professional person employed by the patient or family. This training covers the services necessary for the custodial or maintenance levels of care.
2. **Non-Covered Services.** The following list of services are not home health care benefits. However, some of these expenses may be covered under benefits otherwise provided by the Plan:
  - a. Blood, blood plasma, or blood derivatives.
  - b. Services provided by a hospital.
  - c. Services provided by a physician.
  - d. Services related to non-covered conditions and surgeries, as excluded in the Plan.
  - e. Services or supplies for personal comfort or convenience, including homemaker services.
  - f. Services related to well-baby care.
  - g. Food or meal services other than dietary counseling.
  - h. Transportation expenses.
3. **Psychiatric Social Worker Services.** The services of a psychiatric social worker which are not related to a home health program prescribed by a physician may be covered and paid as **Outpatient** benefits as described in **Mental Health Disorders and Chemical Dependency**.

4. **Review of Treatment.** The Plan reserves the right to review treatment plans at periodic intervals.

## **HOSPICE CARE**

### **Definition**

An alternative way of caring for terminally ill individuals which stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the patient. Hospice care addresses physical, social, psychological, and spiritual needs of the patient.

### **All Hospice Benefits**

Benefits are allowed for hospice care provided under active physician and nursing management through a licensed hospice agency which is responsible for coordinating all hospice care services, regardless of the location or facility in which such services are furnished. Hospice care is provided in the covered person's home or on an inpatient basis in a licensed health care facility.

Benefits are allowed only for a terminally ill covered person with a life expectancy of six (6) months or less, who, alone or in conjunction with a family member or members, has voluntarily requested admission and been accepted into a hospice program.

All claims must include a physician's certification of the covered person's illness, including a prognosis for life expectancy and a statement that hospice care is medically necessary and a copy of the hospice agency's treatment plan.

**Benefit Period.** The benefit period for hospice care is limited to twenty-six (26) weeks from the date the terminally ill person entered hospice care or until death if the covered person continues to live beyond the prognosis for life expectancy.

The following services are covered:

1. Inpatient hospice care or hospice day care services provided on a regularly scheduled basis in a day care facility governed by the hospice board of directors to ensure the overall continuum of patient care.
2. Hospice home care services provided in the covered person's home to meet the covered person's physical requirements and/or to accommodate a covered person's maintenance or supportive needs. This benefit is payable for any combination of the following:
  - a. Professional nursing services provided by or under the supervision of a registered nurse (R.N.).
  - b. Home health aide services under the supervision of a registered nurse or specialized rehabilitative therapist.

- c. Physical therapy performed by a registered physical therapist.
- d. Occupational therapy performed by a properly accredited registered occupational therapist (OTR) or a certified occupational therapy assistant (COTA).
- e. Speech therapy and audiology provided by a properly accredited speech therapist who has received a Clinical Competence Certification or Equivalency Statement from either the American Speech and Hearing Association or the Peer Review Board of the State Speech and Hearing Association.
- f. Respiratory and inhalation therapy performed by a therapist trained or licensed to provide these services.
- g. Nutrition counseling by a nutritionist or dietitian.
- h. Medical social services provided by a qualified individual who possesses a degree in social work, psychology, or counseling or the documented equivalent in a combination of education, training, and experience. Such services must be provided at the recommendation of a physician for the purpose of assisting the covered person or immediate family in dealing with a specified medical condition.
- i. Family counseling related to the covered person's terminal condition.
- j. Respite care which provides temporary relief for the covered person's family or other caregiver for unforeseen emergencies and from the daily demands of care for the patient.
- k. Short-term inpatient care or continuous home care which may be required during a period of crisis, for pain control or for acute intervention alternatives and chronic symptom management. Benefits are limited to a separate thirty (30) day period for such care, require prior certification of the interdisciplinary team and, except for emergencies, require prior benefit certification. Please refer to the heading **Pre-Certification** for details.
- l. Medical supplies, including prescription drugs and biological.
- m. Prostheses and orthopedic appliances.
- n. Rental or purchase of durable medical equipment.
- o. Bereavement support services for the immediate family during the three (3) month period following the death of the covered person.

Counseling services received in connection with a terminal illness as described above will not be considered to have been received due to a mental or nervous disorder.

Patient's immediate family means only the patient's spouse and any children or parents and siblings who are covered under the Plan.

### **Limitations and Exclusions**

1. **Non-Covered Services.** The following items and services are not covered expenses under this hospice care program. However, some of these expenses may be covered under benefits otherwise provided by the Plan:
  - a. Blood, blood plasma, or blood derivatives.
  - b. Services provided by a hospital.
  - c. Services related to non-covered conditions and surgeries, as excluded in the Plan.
  - d. Services related to well-baby care.

- e. Food services or meals other than dietary counseling.
  - f. Services or supplies for personal comfort or convenience, including homemaker services, except in crisis periods or in association with respite care.
  - g. Estate planning, drafting of wills, or other legal services.
  - h. Funeral arrangements or services.
2. **Review of Treatment.** The Plan reserves the right to review treatment plans at periodic intervals.
  3. Any covered charge paid under hospice benefits will not be considered a covered charge under any other benefit in the Plan.

### **MATERNITY**

This Plan complies with the requirements of the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) of 1996. This Plan may not, under federal law, restrict benefits for any length of hospital stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. The Plan may not penalize individuals nor provide incentives for earlier discharge, although the Plan may allow earlier discharge if the mother and physician agree.

Maternity expenses are covered as any other medical illness, including expenses for the diagnosis and care of a pregnancy and for the delivery services. Benefits are limited to covered employees and covered dependents as follows:

1. Maternity benefits will be subject to all Plan provisions.
2. Delivery must occur while the individual is a covered person under the Plan in order for delivery expenses to be a covered expense.
3. Fetal surgery will be considered as part of the mother's care.
4. Expenses incurred as a result of elective induced abortions are not covered, except if carrying the fetus to full term would seriously endanger the life of the mother, or the pregnancy is the result of incest or rape. In the event complications arise after performance of an abortion, any eligible expenses incurred to treat those complications will be considered; however, the initial costs relating to this abortion will not be covered.

### **MENTAL HEALTH DISORDERS AND CHEMICAL DEPENDENCY**

Outpatient Treatment: Eligible charges including prescription medications are covered and payable per the Schedule of Medical Benefits.

Inpatient Treatment: Eligible charges are covered and payable per the Schedule of Medical Benefits. Each two (2) days of partial hospitalization will count as one (1) day inpatient care. "Partial Hospitalization" means continuous treatment at a hospital or treatment facility for at least three (3) hours but not more than twelve (12) hours in any twenty-four (24) hour period.

Expenses for inpatient, partial, or outpatient treatment do not apply toward medical out-of-pocket maximums.

### **Special Limitations For Chemical Dependency Treatment**

1. When the purpose of admission is for convalescent or custodial care, no benefits are available. In those instances where the type of care rendered during a continuous period of confinement develops into convalescent or custodial care, that portion of the stay beginning on the day of such development is excluded from benefit.
2. If a covered person shall remain in a hospital or treatment center after being advised by appropriate authority at said hospital or center that further inpatient care is unnecessary, benefits under this section will not be furnished for the remainder of that inpatient admission.
3. Benefits for inpatient or outpatient care for alcoholism, drug and/or substance abuse are available only when the covered person completes the full continuum of care including detoxification and rehabilitation and the facility or physician discharging the covered person so certifies.

Admissions solely for detoxification, which do not include rehabilitation, are limited to one (1) per person, per lifetime and to the removal of the toxic substance or substances from the system, including diagnosis, evaluation and care of emergency or acute medical conditions. Nutrition-based therapy for alcoholism or other chemical dependency is not covered.

### **NEWBORN CARE**

**Hospital Confined** - Surgical and birthing centers, hospital and doctor's charges for a newborn, "well-baby" including circumcision, shall be considered a covered expense from birth until initial discharge from the hospital. Newborn "well-baby" care is to be considered as part of the mother's expenses, subject to the mother's deductible and out-of-pocket maximum until the baby's initial discharge from the hospital provided the mother is covered for maternity benefits. If the mother is not covered under the Plan, benefits for the newborn's "well-baby" care will be subject to the newborn's own deductible and out-of-pocket maximum.

**Non-Hospital Confined** - Routine examination and checkup charges, including immunizations, are covered expenses and payable according to the Schedule of Medical Benefits. Doctor visits for treatment of sickness or injury shall be treated as an illness, subject to his/her own deductible and out-of-pocket maximum.

**In order for newborn care to be covered the employee must follow the enrollment requirements. Please refer to pages 10 through 11.** Failure to properly enroll the newborn child will result in a denial of benefits.

### **PRE-ADMISSION TESTING**

The Plan will pay for covered expenses for pre-admission testing incurred within seven (7) days on an outpatient basis prior to a hospitalization for surgery. The charges must be related to the illness or injury that ultimately causes confinement. Pre-admission testing that is repeated in the hospital will not be paid unless medically necessary.

### **REHABILITATION CENTER BENEFIT**

The Plan will pay for covered expenses the employee or his/her eligible dependent incur for a sickness or injury that results in the need for rehabilitation services as provided or offered in a rehabilitation hospital or center. The employee or his/her eligible dependent must be under the care of a physician for any benefits to be payable.

"Rehabilitation services" means a formal program of treatment that:

1. is provided to those individuals who have severe disabling impairments of recent onset or recent progression or persons who have not had prior exposure to these services and who require an identifiable intensity of services; and
2. is performed in a rehabilitation hospital or center either as an inpatient or an outpatient; and
3. is prescribed by a physician as medically necessary and is periodically reviewed; and
4. is prescribed in place of a stay in the acute setting of a hospital or is an extension of a hospital stay; and
5. is provided in a hospital or facility that is licensed and qualified to render rehabilitation services.

The primary emphasis of the program is providing, in a coordinated manner, those comprehensive services deemed appropriate to the needs of a person with a disability, in a program designed to achieve objectives of improved health, welfare and the realization of one's maximum physical, social, psychological and vocational potential for useful and productive activity.

Services must be of such a level of complexity or the condition of the patient must be such that services can be safely performed only by the qualified therapist or pathologist.

The Plan will not pay benefits for any alcohol and drug rehabilitation expenses under this provision.

### **SECOND SURGICAL OPINIONS**

The Plan will pay for exams, x-rays and lab work for second surgical opinions incurred on an outpatient basis by a qualified physician in the approved specialty, to substantiate medical necessity of the procedure to be performed. A third opinion will be paid for in case of a conflict between the first two (2) opinions if requested by InterCare Health Plans.

### **SKILLED NURSING CARE FACILITY BENEFIT**

Expenses incurred for daily room and board and general nursing services for each day of confinement in a skilled nursing care facility are payable for no more than sixty (60) days per calendar year. The daily rate allowed cannot exceed the lesser of the facility's regular daily semiprivate rate or 50% of the most common charge for semiprivate room charges made by the hospital in which the covered person was confined before transfer to the facility.

Skilled nursing care facility confinement means confinement in a skilled nursing care facility which:

1. begins while covered under this benefit; and
2. begins within seven (7) days after discharge from:
  - a. a hospital confinement of at least three (3) consecutive days; or
  - b. a prior covered skilled nursing care facility confinement; and
3. is necessary for care or treatment of the same bodily injury or sickness which caused the prior confinement; and
4. occurs while the covered person is under the regular care of a physician who certified the required confinement.

### **SURGICAL BENEFITS**

Surgical benefits are provided for surgeries resulting from illness or accidental bodily injury. The maximum amount of payment for a particular surgery is based upon the usual, customary, and reasonable surgical charge.

More than one (1) surgery performed by one (1) or more physicians during the course of only one (1) operative period is called a "multiple surgery." Because allowances for surgery include benefits for pre- and post-surgical care, total benefits for multiple surgeries are

reduced so that pre- and post-surgery allowances of the major surgery are not duplicated. The reduced benefits vary, depending upon the circumstances of the multiple surgery. Variables include the number of incisions required, the location of the incision and the complexity of each surgical procedure.

Multiple surgery benefits for procedures performed on the same day, under the same anesthesia, will be allowed as follows:

1. For surgeries performed through the same incision, the Plan will allow 100% of the usual, customary and reasonable allowance for the procedure with the greatest value, plus 50% of the usual, customary and reasonable allowance for each additional procedure.
2. For surgeries performed through different incisions, the Plan will allow 100% of the usual, customary and reasonable allowance for the procedure with the greatest value, plus 80% of the usual, reasonable and customary allowance for the other procedure(s).
3. For similar procedures performed on the same day on opposite sides of the body, the Plan will allow 100% of the usual, customary and reasonable allowance for the first procedure plus 80% of the usual, reasonable allowance for the other procedure(s).
4. Multiple surgery performed on the same foot: The Plan will allow 100% of the usual, customary and reasonable allowance for the procedure of greatest value. For the procedure of the second greatest value, the Plan will allow 50% of the usual, customary and reasonable allowance, and for all other surgeries the Plan will allow 25% of the usual, customary and reasonable allowance.
5. For similar surgical procedures performed on both feet on the same day, the Plan will allow 100% of the usual, reasonable and customary allowance for the procedure with the greatest value plus 80% of the usual, customary and reasonable allowance for the procedure of the second greatest value and 50% of the usual, customary and reasonable allowance for the procedure with the third greatest value. For each additional surgery, the Plan will allow 25% of the usual, customary and reasonable allowance.

Surgical benefits are payable whether the operation is performed in the hospital or in the doctor's office. The physician's assistant expenses will be calculated at 15% and the assistant surgeon's expense will be calculated at 20% of the covered surgeon's fees.

## **PRESCRIPTION DRUG PROGRAM**

### **HOW THE PROGRAM WORKS**

Under this program, when you have a prescription filled at a participating pharmacy, benefits for prescription drugs are payable as described below.

1. When your doctor prescribes medically necessary prescription drugs for a covered illness or injury, the Plan will pay benefits after you pay the copay as shown on the Schedule of Medical Benefits for a generic or brand name drug prescription order.
2. You must show your card to the participating pharmacy, and sign any required form at the pharmacy in order for benefits to be paid under the program.

### **Mail Order Drug Benefit Option (How to Use the Mail Order Program)**

The mail order drug benefit option is available for purchase of consistently prescribed maintenance long-term medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer covered persons significant savings on their prescriptions.

You must obtain an order/enrollment form from your benefit office and complete the form; mail this form along with the physician's original prescription and payment to the mail order pharmacy.

### **COVERED EXPENSES**

This benefit applies only when a covered person incurs charges for a covered prescription drug as follows:

1. Non-injectable prescription legend (brand or generic) drugs requiring the written prescription of a physician including prenatal vitamins, oral contraceptives and attention deficit disorder drugs.
2. Compound medications of which at least one (1) ingredient is a prescription legend drug.
3. Injectable insulin, including disposable insulin needles/syringes.
4. Immunosuppressants.
5. Drugs that have been approved by the Food and Drug Administration (FDA) for use in treating AIDS (acquired immune deficiency syndrome).

Maximum quantities dispensed are limited to a thirty-four (34) day supply or one hundred (100) units, whichever is greater when purchased at a pharmacy or a ninety (90) day supply through the mail order program.

### **EXPENSES NOT COVERED**

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

1. A charge excluded under General Plan Exclusions and Limitations.
2. A drug or medicine that can legally be bought without a written prescription (non-legend), or drug or medicine for which there is a non-prescription equivalent available. This does not apply to injectable insulin and needles and syringes.
3. Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
4. Immunization agents or biological sera.
5. A drug or medicine labeled: "Caution - Limited by Federal Law to Investigational Use."
6. Experimental drugs and medicines, even though a charge is made to the covered person.
7. Any charge for the administration of a covered prescription drug.
8. Any drug or medicine that is consumed or administered at the place where it is dispensed.
9. A drug or medicine that is to be taken by the covered person, in whole or in part, while hospital confined. This includes being confined in any institution that has a facility for or allows to be operated on its premises, a facility for the dispensing of drugs and medicines on its premises.
10. A charge for prescription drugs which may be properly received without charge under local, state or federal programs, or covered under workers' compensation or similar law.
11. Injectable prescription drugs, other than injectable insulin.
12. A charge for prescription drugs for smoking cessation (i.e., nicotine gum).
13. A charge for smoking deterrent patches.

14. A charge for infertility or impotency medication.
15. A charge for contraceptive devices.
16. A charge for drugs prescribed for the treatment of chemical dependency.
17. Any drug received without charges unless there is a requirement to pay whether or not there is insurance.
18. Expense related to accidental injury or sickness arising out of occupation or employment.
19. Expenses related to participating in a riot or committing an illegal act. Participating in a riot means you are taking an active part in common with three (3) or more others by using or threatening to use force or violence without authority of law.
20. Expense related to intentional self-inflicted injury.
21. Anorexic medications.
22. Anabolic steroids.
23. Rogaine.
24. Tretinoin, all dosage forms (e.g., Retin-A), except to treat a non-cosmetic condition for dependents to age nineteen (19) years.
25. Cosmetic medications.
26. Vitamins, except prescription prenatal vitamins to treat a covered pregnancy.
27. Minerals, nutritional supplements, appetite suppressants, dietary supplements and formulas.
28. Any prescription refilled in excess of the number specified by the physician or any refill dispensed after one (1) year from the physician's original order.
29. Medicines or drugs which are in the Food and Drug Administration Phases I, II or III testing.

## GENERAL PLAN EXCLUSIONS AND LIMITATIONS

No benefits will be payable under any part of the Plan with respect to the following, unless specifically indicated otherwise:

1. **Ambulance** expense for convenience is not covered. Any expense for commercial transport, private aviation, or air taxi services are not covered regardless of the circumstances or their Federal Aviation Authority Certification. Any expenses for transportation by private automobile, commercial, or public transportation are not covered. The Plan will not pay for any of these services even if other means of transportation were not available.
2. Any expenses for **artificial insemination**, including but not limited to, in vitro fertilization, GIFT procedure, surrogate parents, or expenses related to other direct attempts to induce pregnancy including drug therapy.
3. Services and treatment, including drugs related to **behavioral disorders**, communication delays, conduct problems, learning disabilities, and developmental delays, attention deficit disorders, special education, counseling, therapy, or training. Expenses incurred for initial diagnostic testing to determine the diagnosis will be covered. Expenses for the medication and medical management of the medication for attention deficit disorders will be covered.
4. **Biochemical analysis of hair.**
5. **Biofeedback, biofeedback equipment** and related services or supplies.
6. Expenses for **birth control injections, implants, devices**, or other contraceptive methods, including insertion and removal of devices or implants.
7. Expenses for **birthing classes.**
8. Expenses for **breast pumps** and **infant formula.**
9. Any expenses which are reimbursed or which are indemnified through any **charitable or governmental public program.**
10. Care or treatment for injury resulting from the voluntary taking of or while under the influence of any **controlled substance**, drug, hallucinogen or narcotic not administered on the advice of a physician.
11. Expenses required only for the **convenience of** the covered person or the covered person's physician.

12. Expenses for trimming, removal of **corns, calluses, or trimming of toenails**, except when necessary in the treatment of a metabolic or peripheral vascular disease. **Orthotics and arch supports** are not covered regardless of the relief they may provide for a medical condition.
13. Any expenses for **cosmetic surgery**, or the revision of a previous procedure performed for cosmetic purposes, including, but not limited to, breast augmentation unless due to symmetrical reconstruction as provided under the reconstructive surgery benefit.

Benefits for cosmetic surgery and related expenses are allowed only when such surgery is required as the result of a congenital anomaly or an accidental injury.

14. Any expenses incurred as a result of a **court order**, unless the expenses would be covered expenses under the Plan in the absence of a court order.
15. Any expenses related to **custodial care**, sanitarium care, or rest care.
16. Expenses for **deluxe or luxury items**: examples are motorized equipment when manually operated equipment can be used, wheelchair sidecars.

Air conditioners, purifiers, humidifiers, corrective shoes, heating pads, hot water bottles, exercise equipment, whirlpools, waterbeds or other floatation mattresses, self-help devices, and other clothing and equipment which is not medical in nature are not covered, regardless of the relief they provide for a medical condition.

The Plan will cover deluxe equipment **only** when additional features are required for effective medical treatment, or to allow the covered person to operate the equipment without assistance.

17. Any expenses for **dental services or dental supplies**, except where specifically indicated as a covered expense.
18. Expenses incurred for **diagnostic admissions**. If the covered person is admitted as an inpatient to a hospital for diagnostic procedures, and could have received these services as an outpatient without endangering his/her health then the Plan will not pay for hospital room and board charges or other charges that would not have been incurred if the covered person had received the services as an outpatient.
19. Expenses incurred for **domiciliary care**. Care provided in a residential institution, treatment center, half-way house, or school because a covered person's own home arrangements are not appropriate, and consisting chiefly of room and board, is not covered, even if therapy is included.

20. Expenses for examinations for **employment, licensing, insurance, adoption, or premarital** purposes.
21. Services or supplies received from a dental or medical department maintained by, or on behalf of, an **employer, a mutual benefit association, labor union, trustees**, or similar person or group.
22. Expenses which are deemed **experimental or investigational** or are considered an unproven health practice as determined by a medical review organization, The Health Care Financing Administration (HCFA) and/or the consensus of the medical industry or community.
23. Expenses for routine **eye examinations**, routine refractive examinations, eyeglasses, contact lenses, or prescriptions for such services and supplies except where specifically indicated as a covered medical expense. The Plan will not pay for any surgical, medical or hospital services and/or supplies rendered in connection with radial keratotomy or any procedure designed to correct farsightedness, nearsightedness or astigmatism.
24. Expenses for **health club membership**.
25. **Hearing aids and supplies, hearing examinations**, evaluation for hearing aids, and hearing therapy.  
  
A cochlear implantation (a device implanted in the ear to facilitate communication for the profoundly hearing impaired) will be a covered expense. Pre-certification for the surgery must be done in advance of the date of services.
26. Expenses related to **hypnosis** whether for medical or anesthesia purposes.
27. Expenses incurred in connection with an injury which occurred as a result of a covered person's **illegal use of alcohol**.
28. Any expenses for testing or treatment of an **illness or injury** which is **not recommended by** or for which a covered person is **not under the regular care of, a physician**.
29. Expenses incurred in connection with the treatment of **infertility, impotency**, or promotion of conception, including drug therapy.
30. **Inpatient admissions** before coverage becomes effective. When inpatient services begin before coverage under the Plan becomes effective, the entire hospital or facility stay will not be covered.
31. Any expenses for **late claims filing**. Expenses submitted for coverage more than fifteen (15) months after the date of service.

32. Services or supplies for which there is no **legal obligation** to pay, or charges which would not be made but for the availability of benefits under the Plan.
33. Expenses for **lifestyle and personal growth counseling**.
34. Expenses incurred for replacement of **lost, stolen, or broken eyeglass lenses, frames, or contacts**.
35. Expenses for **mailing or sales tax**.
36. Any expenses incurred by a **masseur**, physical culturist, or physical education instructor are not covered.
37. Any expenses for preparing **medical reports, including preparation and presentation, or itemized bills**, unless requested by InterCare.
38. Expenses for examinations and treatment conducted for the purpose of **medical research**.
39. Any expenses not **medically necessary** for diagnosis or treatment, except as specifically indicated as a covered medical expense.
40. Expenses for **missed appointments** in a provider's office and/or charges incurred when **scheduled services are canceled** by the covered person.
41. Any services, supplies or drugs related to **non-covered services or complications** arising from such non-covered services are not a benefit (such as non-covered artificial conception, cosmetic surgery, sex change operations, and experimental/ investigational procedures).
42. **Non-medical expenses** such as training, education instructions, educational materials, or studies, modifications to home, vehicle, or workplace to accommodate medical conditions, even if they are performed or prescribed by a physician.
43. Expenses for services or supplies **not included as a covered expense under the Plan**, even though provided, ordered or referred by a recognized provider of the Plan.
44. The Plan will not pay for **occupational, physical, or speech therapy** services to maintain function at a level to which it has been restored, or when no further significant practical improvement can be expected.
45. **Orthognathic (Jaw) Surgery**. The only circumstance under which benefits will be allowed for upper or lower jaw augmentation or reduction procedures is when restoration is required as the result of an accidental injury which occurred after the covered person's effective date.

46. Any expenses for professional services performed by a **person who ordinarily resides** in the covered person's household or who is **related to the covered person**, such as a spouse, parent, child, brother or sister, whether such relationship is by blood or exists in law.
47. Services or supplies used primarily for **personal comfort or convenience** that are not related to the treatment of the covered person's condition. Examples: guest trays, beauty and barber shop services, gift shop purchase, telephone, television, admission kits and personal laundry services.
48. The Plan does not make available to a covered person or dependent, to the extent of the minimum coverage required by the **personal injury protection (PIP)** or no-fault law, coverage for injuries suffered while operating or riding in a motor vehicle owned by the covered person or dependent if said vehicle is in operation on the public highways and such vehicle is not covered by personal injury protection (PIP) or no-fault automobile insurance as required by law.

The Plan will pay benefits related to a covered person injured in any motor vehicle accident if the injured covered person is a non-owner operator or a passenger or a pedestrian even though the vehicle(s) involved are not covered by personal injury protection (PIP) or no-fault automobile insurance.

49. Services related to **post-mortem testing**.
50. Expenses that are subject to the **pre-existing condition restrictions provision**, except as specifically provided.
51. Expenses for **prescription drugs or substances** not approved for general use by the Food and Drug Administration (FDA) and drugs which have been labeled "Caution, Limited by Federal Law for Experimental Use."
52. Benefits for **prescription drugs and medicines** will not be provided when a written prescription is not required in order to purchase a certain drug or medicine, even though a prescription number has been assigned.
53. Expenses incurred **prior to** the covered person's effective date of coverage and expenses after the date the covered person **ceases to be** covered under the Plan.
54. Care in any **private institution, or any institution owned or operated by the federal, state, or local government**, which would be provided to the covered person without charge were it not for the fact that benefits were available to such covered person under the Plan. This exclusion will not apply if the claim is made by the Veterans Administration under Title 38 of the U.S. Code for treatment of a veteran not having a service connected disability.

55. **Psychoanalysis or psychotherapy** that can be credited towards earning a degree or furtherance of the education or training of a covered person regardless of diagnosis or symptoms that may be present.
56. Any treatment or service furnished by a physician or other health care provider who is a **resident or intern of a general hospital** or who is reimbursed for his or her services by a general hospital or who is a resident of a covered person's household or member of the immediate family.
57. Benefits for **restoration or reconstructive surgery** and related expenses are allowed only when such surgery is required as a result of a congenital anomaly, accidental injury, disease process or its treatment.
58. Any expenses for **rhinoplasty, blepharoplasty or brow lift** except expenses for rhinoplasties and blepharoplasties to correct a functional condition, or expenses for rhinoplasty to correct a condition as a result of an accidental injury.
59. Expenses for **smoking cessation programs**, treatment of nicotine habit or addiction.
60. The Plan will not pay for **speech therapy** or diagnostic testing related to the following conditions:
  - a. Learning disorders which accompany mental retardation.
  - b. Stuttering, at any age.
61. Expenses incurred due to injury or sickness caused or contributed to by attempted **suicide** or **intentionally self-inflicted** injury, while sane or insane. Psychiatric care for treatment of this condition will be a covered expense to the maximums stated for mental health disorders and chemical dependency.
62. Medical or surgical services related to **temporomandibular joint treatment (TMJ)** or surgery, regardless of the reason(s) such services are necessary.
63. Expenses incurred for treatment, testing, procedures, devices, drugs, **therapy and training and self-help programs** include but are not limited to:
  - a. Recreational, sex addiction, primal scream, and Z therapies.
  - b. Self-help, stress management, and smoking cessation.
  - c. Transactional analysis, encounter groups, and transcendental meditation (TM).
  - d. Sensitivity or assertiveness training.
  - e. Religious counseling.
  - f. Holistic medicine, environmental medicine, and naturopathic medicine.
  - g. Megavitamin therapy.
  - h. Myotherapy or massage therapy.
  - i. Rolfing.

- j. Any type of goal-oriented or behavior modification therapy.
  - k. Educational programs such as diabetic instruction, cardiac class or arthritis class.
64. Any services, care or treatment for **transsexualism, gender dysphoria, sexual reassignment or change or sexual dysfunction or inadequacy** procedures, including drugs, medication, implants (including penile prosthetic implants), hormone therapy, surgery, medical or psychiatric care or treatment.
  65. **Travel expenses** of a physician attending a covered person or travel expenses of a covered person, although recommended by a physician, except as specifically indicated as a covered medical expense.
  66. Any expenses which exceed the **usual, customary, and reasonable** expenses for the care rendered.
  67. **Vision therapy or orthoptic training.**
  68. **Vitamins**, minerals, nutritional supplements, appetite suppressants, dietary supplements, and formulas whether or not prescribed by a physician, except as specifically indicated as a covered expense.
  69. Any charges for any condition, disability or expense resulting from or sustained as a result of **voluntary participation in or being engaged in an illegal occupation, riot, commission of or attempted commission of an assault or a felonious act.**
  70. Any charges for any condition, disability or expense resulting from or sustained as a result of **war or act of war, declared or undeclared, civil war, insurrection, rebellion or revolution**, or to any act or condition incident to any of the foregoing, unless as a result of a random act.
  71. **Weekend hospital admission** unless due to an emergency or unless surgery is scheduled within twenty-four (24) hours.

Admissions prior to surgery. If the employee or his/her dependent is admitted to the hospital prior to the day of surgery, no benefits will be paid for expenses incurred during that period prior to surgery unless the admission is medically necessary due to: (a) an emergency situation; or (b) complications which require admission prior to the day of surgery.

72. Expenses for treatment, supplies, instruction or activities for **weight reduction**, weight control, weight loss programs or physical fitness even if the services are performed or prescribed by a physician. Obesity in itself is not considered an illness or disease and benefits are not allowed solely for its evaluation and treatment.

Benefits will be allowed for services, supplies or surgery when required due to **morbid obesity**. Morbid obesity is defined as a condition in which persistent and uncontrollable weight gain causes a threat to life because the covered person is either:

- a. twice or more the ideal weight; or
- b. sixty percent (60%) or one hundred (100) pounds or more above the ideal weight, whichever is greater. Ideal weight is determined by accepted standard weight tables for frame, age, height and sex.

Surgical benefits will not be authorized unless:

- a. the condition of morbid obesity has existed for at least five (5) years; and
- b. nonsurgical methods of accomplishing weight reduction have been tried under physician supervision for at least three (3) years; and
- c. conditions such as high blood pressure, pulmonary insufficiency (lung disease), arteriosclerosis (hardening of the arteries), diabetes, coronary artery disease, and the like indicate a need for surgery.

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

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

73. **Wigs**, artificial hairpieces, hair transplants, implants or drugs even if there is a physician's prescription and medical reason for the hair loss.
74. Any expenses for any condition or disability which is due to injury or illness arising out of or in the course of any occupation or employment for wage or profit or which would entitle the covered person to any benefit under a **workers' compensation act, law or similar legislation**, including those situations whereby the covered person lawfully chose not to be covered or waived or failed to assert his/her rights under a workers' compensation law, act or similar legislation.

## **PRE-EXISTING CONDITION EXCLUSION**

A pre-existing condition must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the enrollment date.

The pre-existing condition exclusion does not apply to:

1. Genetic information in the absence of a diagnosis of the condition related to the genetic information.
2. Pregnancy.
3. A newborn child or newly adopted child under age eighteen (18) if the child is covered within thirty (30) days of the date of birth, adoption, or placement for adoption (or who has creditable coverage from birth, adoption, or placement for adoption without a significant break in coverage).
4. Conditions first discovered during the waiting period.
5. Prescriptions purchased using the Prescription Drug Card Program.

Expenses resulting from pre-existing conditions will be considered for payment to a maximum paid of \$1,000 for all conditions combined; and/or

Expenses resulting from pre-existing conditions will be considered for payment if, beginning on the covered person's enrollment date:

1. A covered person does not receive medical care or services, including prescription drugs or other medical supplies either recommended or actually received, and is not under a physician's care with respect to the pre-existing condition for a period of ninety (90) consecutive days; or
2. A period of twelve (12) consecutive months has elapsed.

A pre-existing condition must be reduced by the period of creditable coverage an individual has under any previous plan as of their enrollment date. This Plan utilizes the standard method of determining creditable coverage. A pre-existing condition exclusion will apply if documentation of prior creditable coverage indicates there is a sixty-three (63) consecutive day break in coverage from your last date of coverage to your enrollment date.

## DEFINITIONS

The terms as used herein shall be deemed to define terms that may be used in the wording of the Plan Document. These definitions shall not be construed to provide coverage under any benefit unless specifically provided.

**"Accident"** means a bodily injury sustained independently of all other causes, that is sudden, direct and unforeseen, and is exact as to time and place.

**"Administrator"** shall mean as defined by federal law, the Plan Administrator (San Luis Valley Combined Educators Board of Directors).

**"Alcoholism"** means a morbid state caused by excessive or compulsive consumption of alcohol.

**"Alcoholism and Chemical Dependency Treatment Center"** means a detoxification and/or rehabilitation facility licensed by the state to treat alcoholism and/or chemical dependency.

**"All Day"** shall be considered to begin at 12:01 a.m., and to end immediately prior to 12:01 a.m. standard time at the residence of the employee, as stated in his/her application/ request for coverage under the Plan; or if none is stated, at the address of the district.

**"Ambulance"** shall mean a specially designed or equipped vehicle which is licensed for transferring the sick or injured. It must have customary patient care, safety, and life-saving equipment, and must utilize trained personnel.

**"Ambulatory Surgical Center"** means an institution or facility, licensed by the jurisdiction in which it is located, either free standing or as part of a hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from within a twenty-four (24) hour period and licensed by the jurisdiction in which it is located. An office maintained by a physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, shall not be considered to be an ambulatory surgical center.

**"Amendment"** means a formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by San Luis Valley Combined Educators Board of Directors.

### Plan Amendment/Modification/Termination

The employer intends to provide benefits under the Plan indefinitely. However, the employer may without prior notice:

1. Change the contributions you must make under the Plan; or
2. Amend or terminate the Plan. In order to do this, the participating school districts of the San Luis Valley Combined Educators Health Plan have adopted the Intergovernmental Agreement which establishes the initial Plan amendment and termination procedures by means of a board resolution. This board resolution must:
  - a. be passed by the San Luis Valley Combined Educators Board of Directors; and
  - b. adhere to the provisions adopted under the Intergovernmental Agreement.

If the Plan is amended or terminated, this will not affect the payment of any claims for expenses incurred prior to the time the change is made.

**"Anesthesia"** means general anesthesia which produces unconsciousness in varying degrees with muscular relaxation and a reduction or absence of pain. Regional or local anesthesia produces similar effects to a limited region of the body without causing loss of consciousness. Anesthesia is administered by a physician or certified registered nurse anesthetist (CRNA).

**"Calendar Year"** means a period of time commencing on January 1 and ending on December 31 of the same year.

**"Chemical Dependency/Substance Abuse"** means physiological and psychological addition to a controlled drug or substance, or to alcohol. Dependence upon tobacco, nicotine and caffeine are not included in this definition.

**"Child"** - Refer to "Dependents Eligible for Coverage."

**"Claims Administrator"** shall mean the person or firm employed by the San Luis Valley Combined Educators Board of Directors who is responsible for the processing of claims and payment of benefits, administration, accounts, reports, and other services contracted for by the San Luis Valley Combined Educators Board of Directors.

**"Cleft Lip"** means a birth deformity in which the lip fails to close.

**"Cleft Palate"** means a birth deformity in which the palate (the roof of the mouth) fails to close.

**"Close Relative"** means the spouse, parent, brother, sister, child, or spouse's parent, brother, or sister of the covered person.

**"College"** - See definition of University.

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

**"Condition"** means a medical condition. Refer to the definition of "Medical Condition."

**"Consultation"** means a service provided by another physician at the request of the physician in charge of your case. The consulting physician often has specialized skills that are helpful in diagnosing or treating the illness or injury.

**"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.

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

**"Covered Expense/Covered Service"** means any necessary usual, customary, and reasonable item of expense at least a portion of which is covered under the Plan.

**"Covered Person"** means any employee or dependents of an employee and/or a person and his/her dependents who are included in a class or group of persons to which the Plan has been extended, meeting the eligibility requirements for coverage as specified in the Plan, and are properly enrolled in the Plan.

**"Creditable Coverage"** means coverage of an individual under any of the following:

1. A group health plan (see definition below);
2. Health insurance coverage as defined below (without regard to whether the coverage is offered in the group market, the individual market, or otherwise);
3. Part A or Part B of Medicare;
4. Medicaid, other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines;
5. Medical and dental care for members and certain former members of the uniformed services, and for their dependents.

6. A medical care program of the Indian Health Service or of a tribal organization;
7. A State health benefits risk pool;
8. A health plan offered under the Federal Employees Health Benefits Program;
9. A public health plan, which means any plan established or maintained by a State, county, or other political subdivision of a State that provides health insurance coverage to an individual who are enrolled in the plan; and
10. A health benefit plan under the Peace Corps Act.

Creditable coverage does not include:

1. Accident only coverage including accidental death & dismemberment;
2. Disability income insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Coverage issued as a supplement to liability insurance;
5. Workers' compensation or similar insurance;
6. Automobile medical payment insurance;
7. Credit-only insurance (for example, mortgage insurance); and
8. Coverage for on-site medical clinics.
9. Limited Scope Benefits. Refer to the definition of "Limited Scope Benefits."
10. Long-term care benefits.
11. Supplemental benefits. Refer to the definition of "Supplemental Benefits."
12. Non-coordinated benefits such as: a) coverage for only a specific disease or illness (for example, cancer only policies) or hospital indemnity or other fixed dollar indemnity insurance (for example, \$100/day) which are provided under a separate policy, certificate, or contract of insurance; b) there is no coordination between the provision of benefits and an exclusion of benefits under any group health plan maintained by the same plan administrator; and c) the benefits are paid with respect to an event without regard to whether benefits are provided under any group health plan maintained by the same plan administrator.

**"Custodial Care"** means that type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist in meeting the needs of daily living of a covered person, whether or not totally disabled, in the activities included, but not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

**"Dentist"** shall mean a person duly licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered.

**"Dependent"** - Refer to the Eligibility section, Dependents Eligible for Coverage.

**"District"** means San Luis Valley Combined Educators participating school districts, and any subsidiary or affiliate which adopts the Plan and business and becomes a party to the Plan.

**"Drug Abuse"** shall mean the consumption, injection, or other utilization of any drug or other controlled substance not medically prescribed or administered or the over utilization of any drug which is medically prescribed or administered.

**"Durable Medical Equipment"** means equipment which is able to withstand repeated use, used to serve a medical purpose, and not generally useful to a person in the absence of illness or injury.

**"Effective Date"** means the date as of which the employer and any subsidiary or affiliate adopts the Plan; or the date the employee and his/her eligible dependent are properly enrolled in the Plan as specified in the eligibility requirements for coverage.

**"Emergency Care"** means care for a condition which in the absence of immediate medical treatment would result in the condition's becoming significantly worse, or result in the death of the covered person.

**"Employee"** shall mean a person employed by the district and/or who is included in a class or group of persons to which the Plan has been and continues to be extended, and who are properly enrolled in the Plan.

**"Employer"** means San Luis Valley Combined Educators participating school districts and any subsidiary or affiliate which adopts the Plan and business and becomes a party to the Plan in accordance with the Intergovernmental Agreement.

**"Employer's Previous (Prior) Group Plan"** means the employer's group plan of benefits which was replaced by similar benefits under the Plan, and was in effect up to the day before the effective date of the Plan.

**"Enrollment Date"** (enrollment date and first day of coverage) are the following:

1. Enrollment date means the first day of coverage or, if there is a waiting period, the first day of the waiting period (typically the date employment begins).
2. First day of coverage means, in the case of an individual covered for benefits under a group health plan in the group market, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy.

**"ERISA"** refers to the Employee Retirement Income Security Act of 1974 or any provision or section thereof which is herein specifically referred to as such act, provision or section which may be amended from time to time.

**"Exclusion"** means any provision of the Plan whereby coverage for a specific service or condition is entirely eliminated regardless of medical necessity.

**"Experimental or Investigational Services"** means:

1. Care, procedure, treatment or technology which: (a) is not widely accepted as safe, effective and appropriate for the injury or sickness throughout the recognized medical profession and established medical societies in the United States; or (b) is experimental, in the research or investigational stage, or conducted for research or similar purposes.
2. Drugs and tests which: (a) the Federal Food and Drug Administration has not approved for general use; (b) are considered experimental; or (c) are for investigational use. Drugs and tests approved for a specific medical condition but which are used for another condition, will be considered experimental.

In determining any of the above, the Plan will rely on recognized medical sources such as, but not limited to, the Data Project of the American Medical Association, the National Institute of Health, the U.S. Food and Drug Administration, the Health Care Finance Administration (HCFA) and other broadly accepted medical authorities and sources.

**"Family"** means a covered employee and his/her eligible dependents.

**"Full-Time Employment"** means a basis whereby an employee is employed by the district and scheduled to work an average of twenty (20) hours per week. Such work may occur either at the usual place of business of the district or at a location to which the business of the district requires the employee to travel, and for which he or she receives regular earnings from the district.

**"Full-Time Student"** means an employee's dependent child who is enrolled in and regularly attending an accredited college or university, high school or vocational school for the minimum number of credit hours required by that school, college or university in order to maintain full-time student status.

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

**"Group Health Insurance Coverage"** means health insurance coverage offered in connection with a group health plan.

**"Group Health Plan"** means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

**"Health Insurance Coverage"** means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.

**"Health Insurance Issuer"** means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of Section 514(b)(2) of ERISA). Such term does not include a group health plan.

**"Hemodialysis"** means the treatment of an acute or chronic kidney ailment during which impurities are removed from the blood with dialysis equipment.

**"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), significantly expanding employee access to health care coverage.

**"Home Health Care Agency"** means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

1. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services.
2. It has policies established by a professional group associated with the agency or organization. This professional group must have at least one (1) physician and at least one (1) graduate registered nurse (R.N.) to govern the services provided and it must provide full-time or part-time supervision of such services by a physician or graduate registered nurse (R.N.).

3. It maintains a complete medical record on each patient.
4. It has a full-time or part-time administrator.
5. It is a provider of services under Medicare.

In rural areas where there are no agencies which meet the above requirements or areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.

**"Home Health Care Plan"** means a program for continued care and treatment of the covered person established and approved in writing by the covered person's attending physician. The attending physician must certify that the proper treatment of the illness or injury would require convalescent confinement as a resident inpatient in a hospital or skilled nursing facility in the absence of the services and supplies provided as part of the home health care plan.

**"Hospice"** means a health care program providing a coordinated set of services rendered at home, in outpatient settings or in institutional settings for covered persons suffering from a condition that has a terminal prognosis. A hospice must have an interdisciplinary group of personnel which includes at least one (1) physician and one (1) graduate registered nurse (R.N.), and it must maintain central clinical records on all patients. A hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

**"Hospice Benefit Care Period"** means a specified amount of time during which the covered person undergoes treatment by a hospice. Such time period begins on the date the attending physician of a covered person certifies a diagnosis of terminally ill, and the covered person is accepted into a hospice program.

**"Hospital"** means an institution which meets all of the following conditions:

1. It is licensed and operated in accordance with the laws of jurisdiction in which it is located which pertain to hospitals; is engaged primarily in providing medical care and treatment to ill and injured persons on an inpatient basis at the patient's expense; maintains on its premises all the facilities necessary to provide for diagnosis and medical and surgical treatment of an illness or an injury; and such treatment is provided by or under the supervision of physicians with continuous twenty-four (24) hour nursing services by graduate registered nurses (R.N.s).
2. It qualifies as a hospital, a psychiatric hospital, or a tuberculosis hospital and is accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO).
3. It is a provider of services under Medicare.

4. It is not, other than incidentally, a place for rest, a place for the aged or a nursing home.
5. A free-standing facility which is licensed to treat alcohol and substance abuse will meet the definition of a hospital.

**"Hospital Miscellaneous Expenses"** means the actual charges made by a hospital in its own behalf for services and supplies rendered to the covered person which are medically necessary for the treatment of such covered person. Hospital miscellaneous expenses do not include charges for room and board or for professional services of a physician and drugs or supplies not consumed or used in the hospital.

**"Illness/Sickness"** means a bodily disorder, disease, physical sickness, bodily infirmity, hernia of any kind, or bacterial infection other than occurring with and as a result of an injury, or functional nervous disorder of a covered person. A recurrent illness will be considered one (1) unless the concurrent illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one (1) illness.

**"Incurred Expenses/Services"** means those treatments, services and supplies rendered to a covered person. Such expenses shall be considered to have occurred at the time or on the date the treatment, service or purchase is actually provided.

**"Injury"** means sudden and instant damage to the body, which is unintended and undesigned by the individual and which results directly from and independently of all other causes of loss covered by the Plan.

**"Inpatient"** refers to the classification of a covered person when that person is admitted to a hospital, hospice, or convalescent facility for treatment, and charges are made for room and board to the covered person as a result of such treatment, upon the recommendation of a physician.

**"Intensive Care Unit"** means a section, ward, single room or coronary care unit within the hospital which is separated from other facilities and:

1. is operated exclusively for the purpose of providing professional medical treatment for critically ill patients; and
2. has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and
3. provides constant observation and treatment by registered nurses (R.N.s) or other highly trained hospital personnel.

**"Laboratory, Pathology Services, X-Ray and Radiology Services"** means:

Laboratory and pathology services - testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material which has been removed from the body. Diagnostic medical procedures requiring the use of technical equipment for evaluation of body systems are also considered laboratory services. Examples: electrocardiograms (EKGs) and electroencephalograms (EEGs).

X-ray and radiology services - services including the use of radiology, nuclear medicine, and ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.

**"Late Entrant"** means an employee or dependent who does not enroll during the initial period in which he or she is eligible to enroll, or during a special enrollment period when there is a change in family status or loss of group health coverage under another plan.

**"Life- or Limb-Threatening Emergency"** means an event or condition which the covered person reasonably believes threatens his or her life or limb in such a manner that a need of immediate medical care is created to prevent death or serious impairment of health.

**"Limitation"** means any provision other than an exclusion, which restricts coverage under the Plan, regardless of medical necessity.

**"Limited Scope Benefits"** are dental, vision or other types of benefits which are not deemed an integral part of the Plan and the participant has the right to elect to receive such coverage and pay an additional contribution for such coverage; or a benefit provided under a separate plan or policy. They are limited in scope to a narrow range or type of benefits that are generally excluded from hospital/medical/surgical benefit packages.

**"Maintenance Drugs"** - means prescription drugs that are consistently prescribed and taken long term or for life. There are some Food and Drug Administration (FDA) restricted drugs that can only be issued by a certain dosage amount on a monthly basis, i.e. narcotic drugs.

**"Maternity"** means that physical state which results in childbirth, abortion, or miscarriage, and any medical complications arising out of or resulting from such state.

**"Medicaid"** - Title XIX (Grants to states for Medical Assistance Programs) of the United States Social Security Act as amended.

**"Medical Condition"** means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

**"Medically Necessary"** means health care services, supplies or treatment which, in the judgment of the attending physician, are appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

**"Medicare"** means the programs established by Title I of Public Law 89-98 (79 Statute 291) as amended entitled "Health Insurance for the Aged Act," and which includes Parts A and B and Title XVIII of the Social Security Act (as amended by Public Law 89-97, 79) as amended from time to time.

**"Mental Health Disorder"** means neurosis, psychoneurosis, psychopathy, personality disorder, psychosis, or mental or emotional diagnosed disease or disorder of any kind. Anorexia nervosa, bulimia nervosa, and eating disorders are classified as manifest mental disorders.

**"Mental Retardation and/or Physical Disability"** means the inability of a person to be self sufficient as a result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder and diagnosed by the physician as permanent and continuing.

**"Midwife"** means a licensed or registered midwife who has completed the academic and clinical requirements set forth by specific states who provide this license. It is issued upon passing a state board exam and a practical exam, and by meeting a set number of supervised experiences and births. The midwife provides prenatal, delivery, and immediate newborn and post-partum care either at home or in a birth center.

**"Minor Emergency Medical Clinic"** means a freestanding facility which is engaged primarily in providing minor emergency and episodic medical care to a covered person. A board-certified physician, a registered nurse (R.N.) and a registered x-ray technician must be in attendance at all times that the clinic is open.

The clinic's facilities must include x-ray and laboratory equipment and a life support system. For the purposes of the Plan, a clinic meeting these requirements will be considered to be a minor emergency medical clinic, by whatever actual name it may be called. However, a clinic located on or in conjunction with or in any way made a part of a regular hospital shall be excluded from the terms of this definition.

**"Missionary"** means a dependent child who meets all of the qualifications of an eligible dependent and who is serving on an approved full-time mission for a recognized religious organization. The full-time or part-time student requirement will be waived while serving on the mission.

**"Named Fiduciary"** means San Luis Valley Combined Educators Board of Directors, which has the authority to control and manage the operation and administration of the Plan.

**"Network"** means the physicians, hospitals, and other medical service providers who are members of the provider Network.

**"Newborn"** refers to an infant from the date of his/her birth until initial discharge from the hospital.

**"Non-Network Provider"** means a legally licensed health care provider which provides, within the scope of its authority, services and supplies that are covered under the Plan, but which has not entered into a contract with the Network.

**"Nurse"** means a graduate registered nurse (R.N.), a licensed practical nurse (L.P.N.) who is licensed in the state in which the services are performed.

**"Nurse Practitioner"** means a registered nurse (other than an immediate family member or employee of the employer) who: (a) completes a program of study affiliated with a college or university; (b) passes a nurse practitioner certification examination given by the American Nurses Association; (c) acts within the scope of that certification in treating the injury or sickness; and (d) who is licensed by the law of the state in which services are rendered.

**"Office Visit"** means a face to face meeting between a physician and a patient for the purpose of medical treatment or service.

**"Orthopedic Appliance"** means any rigid, or semi-rigid support used to restrict, eliminate, or support motion in a part of the body that is diseased, injured, weak or deformed.

**"Outpatient"** refers to the classification of a covered person when that covered person receives medical care, treatment, services or supplies at a clinic, a physician's office, or at a hospital if not a registered bed-patient at the hospital, an outpatient psychiatric facility or an outpatient alcoholism, or drug abuse facility.

**"Outpatient Psychiatric Facility"** means an administratively distinct governmental, public, private or independent unit or part of such unit that provides outpatient mental health services and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients. This includes alcohol and drug abuse facilities.

**"Participant"** as defined in ERISA Section 3(7), means "any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or member of such organization, or whose beneficiaries may be eligible to receive any such benefit."

**"Participant Coverage"** means coverage as stated in the Plan Document and as amended to a covered participant and his or her eligible dependents.

**"Physician"** means a legally licensed physician who is acting within the scope of his/her license and any other professional provider required to be recognized for benefit payment purposes under the law of the state in which the employee receives treatment and is acting within the scope of his/her license, but is not related to the employee.

**"Placement for Adoption"** is defined under ERISA Sec. 609(c)(3)(B) as follows:

The term "placement," or being "placed," for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child.

For group health plan purposes, these provisions override state laws requiring the legal guardianship of a child placed for adoption to remain with the appropriate agency until the adoption is finalized.

**"Plan"** means without qualification the Plan Document.

**"Plan Administrator/Plan Sponsor"** means San Luis Valley Combined Educators Board of Directors which is responsible for the day-to-day functions and management of the Plan. San Luis Valley Combined Educators Board of Directors may employ persons or firms to process claims and perform other Plan related services.

**"Pre-Existing Condition"** must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the enrollment date.

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

**"Private-Duty Nursing Services"** means services that require the training, judgment, and technical skills of an actively practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.). Such services must be prescribed by your attending physician for the continuous medical treatment of your condition.

**"Prosthesis"** means any device that replaces all or part of a missing body organ or body member.

**"Provider"** means a person or facility that is recognized by the Plan as a health care provider, and fits one (1) or more of the following descriptions:

1. Professional Provider. A physician or other professional provider who is recognized by the Plan.
2. Other Professional Provider. A professional provider (except a physician) who is recognized by the Plan and licensed, certified, or registered by the state or jurisdiction

where services are provided to perform designated health care services. Services of such a provider must be among those covered by the Plan and are subject to review by a medical authority appointed by the Plan. A professional supplier of medical supplies and equipment is considered an other professional provider.

3. Facility Provider. An alcoholism treatment center, home health agency, hospice agency, hospital, or other facility, which the Plan recognizes as a health care provider.
4. Other Facility. A facility provider (except a hospital, alcoholism treatment center, home health agency, or hospice agency) that the Plan recognizes as a provider and that is licensed or certified to perform designated health care services by the state or jurisdiction where services are provided. Services of such a provider must be among those covered by the Plan and are subject to review by a medical authority appointed by the Plan. Examples: ambulatory surgery center, dialysis center, Veteran's Administration, or Department of Defense Hospital.

**"Psychiatric Care"** also known as psychoanalytic care, means treatment for a mental illness or disorder, or a functional nervous disorder.

**"Psychiatric Hospital"** means an institution which meets the following requirements:

1. maintains diagnostic and medical facilities on its premises or in facilities under its control; and
2. primarily provides care and treatment to registered inpatients for mental illness, emotional or nervous disorder, psychosis, neurosis, character or personality disorder or other mental or emotional disease or disorder; and
3. is supervised by a staff of one (1) or more physicians; and
4. has twenty-four (24) hour nursing service by registered nurses (R.N.s) on duty or call; and
5. complies with all licensing or legal requirements; and
6. is not primarily a nursing, convalescent or rest home or a place for the aged or custodial care.

A part of an institution operated as a nursing, convalescent, rehabilitation or geriatric unit primarily for nursing care is not considered a psychiatric hospital.

**"Psychologist"** means an individual holding the degree of Ph.D., Ed.D and Psy.D. acting within the scope of his/her license.

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

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

**"Qualifying Beneficiary (under Public Health Services Act)"** is a covered employee and/or the spouse and/or child of a covered employee who, on the date before a qualifying event occurred, was eligible for benefits under this group health plan. Effective January 1, 1997, a qualified beneficiary includes a child who is born to or placed for adoption with the covered employee during the period of Public Health Services Act coverage.

**"Rehabilitation Facility"** means a distinct organizational entity, either separate or within a larger institution or agency which meets the following requirements:

1. provides individualized, goal-oriented, comprehensive and coordinated services designed to minimize the effects of physical, mental, social and vocational disadvantages and to effect a realization of the individual's potential; and
2. is accredited for its stated purpose by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF); and
3. is certified for its stated purpose by Medicare for Medicare reimbursement; and
4. is licensed and complies with its stated purpose under all relevant state and local laws.

**"Rehabilitation Services"** means the process of providing, in a coordinated manner, those comprehensive services deemed appropriate to the needs of a person with a disability, in a program designed to achieve objectives of improved health, welfare and the realization of one's maximum physical, social, psychological and vocational potential for useful and productive activity.

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

**"Room and Board"** refers to all charges by whatever name called which are made by a hospital, hospice, or convalescent nursing facility as a condition of occupancy. Such charges do not include the professional services of physicians nor intensive nursing care by whatever name called.

**"Schedule of Benefits"** means the outline of benefits.

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

**"Semiprivate"** refers to a class of accommodations in a hospital or convalescent nursing facility in which at least two (2) patient beds are available per room.

**"Significant Break in Coverage"** means a period of sixty-three (63) consecutive days during all of which the individual does not have any creditable coverage, except that a waiting period is taken into account in determining a significant break in coverage.

**"Skilled Nursing Care Facility"** means an institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing on an inpatient basis, for persons convalescing from injury or illness, professional nursing services rendered by a graduate registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) and physical restoration service to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
2. Its services are provided for compensation from its patients and under the full-time or part-time supervision of a physician or graduate registered nurse (R.N.).
3. It provides twenty-four (24) hour per day nursing service by licensed nurses, under the direction of a full-time or part-time graduate registered nurse (R.N.).

4. It maintains a complete original record on each patient.
5. It has an effective organization review plan.
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care, or care of mental disorders.
7. It is approved and licensed by Medicare.

This term shall also apply to expenses incurred in an institution referring to itself as a convalescent nursing facility, extended care facility, convalescent nursing home, or any such other similar nomenclature.

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

**"Subrogation/Third Party Liability"** means the transfer of one's liabilities for another; in this case the temporary assumption of the claimant's liabilities by the Plan prior to repayment by the party of primary liability. The Plan contains a subrogation clause and the claimant is obligated to obtain any monies available from third parties to reduce the Plan's losses.

**"Substance Abuse"** means addiction or abuse of alcohol, legal or illegal drugs, or any other substance used in a way which results in producing abnormal behavior and/or a mind-altered state.

**"Supplemental Benefits"** means benefits that are provided under a separate policy, certificate, or contract of insurance, such as: a) Medicare supplemental health insurance, also known as Medigap or MedSupp insurance; b) coverage supplemental to that provided under the Civilian Health & Medical Program of the Uniformed Services (also known as CHAMPUS supplemental programs); and c) similar supplemental coverage provided to coverage under a group health plan.

**"Surgery"** shall mean any operative or diagnostic procedures performed for the treatment of illnesses or injuries by an instrument or cutting procedure through any natural body opening or incision, including the necessary treatment of fractures and dislocations, severe sprains and casting thereof, but not including simple sprains or bruises.

**"TEFRA"** refers to the Tax Equity and Fiscal Responsibility Act of 1982, as amended from time to time.

**"Therapies: Chemotherapy, Radiation, Occupational, Physical and Speech"** mean:

Chemotherapy - drug therapy administered as treatment for malignant conditions and diseases of certain body systems.

Radiation therapy - x-ray, radon, cobalt, betatron, telocobalt, and radioactive isotope treatment for malignant diseases and other medical conditions.

Occupational therapy - the use of educational, vocational, and rehabilitative techniques to improve a patient's functional ability to live independently.

Physical therapy - the use of physical agents to treat disability resulting from disease or injury. Physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet radiation, massage, and therapeutic exercise.

Speech therapy (also called speech pathology) - services used for diagnosis and treatment of speech and language disorders.

**"Timely Entrant"** means a person who enrolls for coverage at the time they initially meet the eligibility provisions of an employee or dependent as defined.

**"Total Disability (Totally Disabled)"** means the physical state of a covered person resulting from an illness or injury which wholly prevents that individual from performing the duties pertaining to his/her customary employment. That individual must be under the continuous care of a physician. All determinations of a final definition of a disability are the decision of the San Luis Valley Combined Educators Board of Directors. In the case of a dependent, "Total Disability (Totally Disabled)" means unable to perform the normal activities of a person of same age and sex in good health. The dependent must be under the continuous care of a physician.

**"University"** means an accredited institution of higher education.

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

**"Usual, Customary, and Reasonable"** refers to the designation of a charge as being the usual charge made by a physician or other provider of services, supplies, medications, or equipment that is deemed medically necessary, is not experimental, and that does not exceed the general level of charges made by other providers rendering or furnishing such care or treatment within the same area. The term "area" in this definition means a county or such other area as is necessary to obtain a representative cross section of such charges.

Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill or expertise.

**"Waiting Period"** means the period of time that must pass before an employee or dependent is eligible to enroll under the terms of a group health plan. If an employee or dependent enrolls as a late entrant or on a special enrollment date, any period before such late or special enrollment is not a waiting period.

**"Well-Baby Care"** means medical treatment, services or supplies rendered to a child or newborn solely for the purpose of health maintenance and not for the treatment of an illness or injury.

**"You, Your"** means any covered person, unless the language specifically refers only to the employee or only to the dependents.

**GENERAL INFORMATION**  
**IMPORTANT FACTS ABOUT YOUR PLAN**

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)**

If your coverage terminates under this Plan, recent changes in Federal law may affect your health coverage if you become eligible to enroll in another health plan which limits or excludes coverage for pre-existing conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for conditions which exist before you enroll in a new Plan. Under the law, beginning with healthcare plans with "plan year" dates of July 1, 1997 and after, a pre-existing condition exclusion period may be reduced under certain circumstances by the period you were covered under this Plan. To assist you in verifying coverage, the Plan will issue a certificate to you (and your eligible dependents) that will provide evidence of your coverage under this Plan at the time your coverage terminates.

You have the right to receive such a certificate for any period of health coverage since July 1, 1996. If you were not covered under this Plan consecutively for a period of at least eighteen (18) months, you may need to provide documentation for earlier periods of health care coverage, not covered by the certificate issued by this Plan. This will require that you contact previous providers of health coverage.

It is the intent of the Plan to comply with all existing HIPAA regulations. If for some reason the information presented in the Plan differs from actual HIPAA regulations, the Plan reserves the right to administer HIPAA in accordance with such actual regulations.

**CONTINUATION OF COVERAGE (PUBLIC HEALTH SERVICES ACT)**

As mandated by Federal law, the Plan offers optional continuation coverage to the employee and/or his/her dependents if coverage would otherwise end due to one (1) of the following events:

1. Termination of the employee's employment for any reason except gross misconduct. Coverage may continue for the employee and his/her eligible dependents.
2. A reduction in hours worked by the employee which results in loss of Plan eligibility. Coverage may continue for the employee and his/her eligible dependents.
3. The employee's death. Coverage may continue for his/her eligible dependents.
4. Divorce or legal separation from his/her spouse. Coverage may continue for that spouse and his/her eligible dependents.

5. The employee becomes entitled to Medicare. Coverage may continue for eligible dependents who are not entitled to Medicare.
6. Loss of eligibility of a covered dependent child due to Plan eligibility requirements. Coverage may continue for that dependent.
7. The employer files a Chapter 11 bankruptcy petition and the employee was covered as a qualified retiree at the time of the filing. Coverage may continue for qualified retirees and their beneficiaries if coverage ends or is substantially reduced within one (1) year before or after the filing for bankruptcy.

**Note:** To choose this continuation coverage, an individual must be a covered person under the Plan on the day before the qualifying event. In the case of bankruptcy, an individual must have retired on or before the date coverage was substantially reduced, or be a beneficiary of the retired employee on the day before the bankruptcy.

### **Notification Requirement**

The qualifying individual has the responsibility to inform San Luis Valley Combined Educators District's Benefit Administrator of a divorce, legal separation, or a child losing dependent status under the Plan within sixty (60) days of the qualifying event. Failure to provide this notification within sixty (60) days will result in the loss of continuation coverage rights.

The employer has the responsibility of notifying InterCare Health Plans of the employee's death, termination of employment, reduction in hours, entitlement to Medicare, or the employer's bankruptcy within thirty (30) days of the qualifying event.

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

### **Maximum Period of Continuation Coverage**

The maximum period of continuation coverage for individuals who qualify due to termination of employment or reduction in hours worked is eighteen (18) months from the date of the qualifying event.

If a qualified beneficiary is disabled (as determined under the Social Security Act) at the time of termination or reduction in hours, continuation coverage for the qualifying individual may be extended to twenty-nine (29) months, provided the qualifying individual notifies InterCare either within the eighteen (18) month continuation coverage period, or within sixty (60) days after receiving notification of disability. The covered person must notify InterCare of a determination by Social Security that the individual is no longer disabled within thirty (30) days of such determination.

A qualified beneficiary may be able to extend existing coverage from eighteen (18) months to twenty-nine (29) months if the Social Security Administration determines that you, or a covered dependent, were or became totally disabled at any time during the first sixty (60) days of Public Health Services Act continuation coverage. To qualify for the extension, the qualified beneficiary must submit a copy of the Social Security disability determination notice within sixty (60) days of the date of such notice to InterCare. This paragraph applies only if you have health coverage under the Public Health Services Act on or after January 1, 1997.

The maximum period of continuation coverage for individuals who qualify due to any other described qualifying event, except bankruptcy, is thirty-six (36) months from the date of the qualifying event.

Qualifying retirees, widows and widowers of retirees who died before bankruptcy are entitled to lifetime continuation coverage. However, if a retiree dies after bankruptcy, the surviving spouse and dependent children may only elect an additional thirty-six (36) months of continuation coverage after the death.

If an individual experiences more than one (1) qualifying event, the maximum period of coverage will be computed from the date of the earliest qualifying event, but will be extended to the full thirty-six (36) months if required by the subsequent qualifying event.

However, if the employee's spouse and dependent children would otherwise lose coverage because of a qualifying event, they will be entitled to thirty-six (36) months of continuation coverage from the date the employee become entitled to Medicare even if the employee's entitlement to Medicare does not cause loss of coverage either because he/she is still employed or because he/she had already terminated employment.

### **Cost of Continuation Coverage**

The cost of continuation coverage is determined by San Luis Valley Combined Educators Board of Directors and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable premium cannot exceed 102% of the Plan's cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150% of the Plan's cost of coverage.

The qualified individual must make the first payment within forty-five (45) days of notifying the Plan of selection of continuation coverage. Future payments can be made in monthly installments within thirty (30) days of the due date. Rates and payment schedules

are established by San Luis Valley Combined Educators Board of Directors and may change when necessary due to Plan modifications.

The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event.

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

### **When Continuation Coverage Ends**

Continuation of coverage ends on the earliest of:

1. The date the maximum continuation period expires.
2. The date the qualifying individual becomes entitled to coverage under Medicare.
3. The last period for which payment was made when coverage is canceled due to non-payment of the required cost.
4. The date the employer no longer offers a group health plan to any of its employees.
5. The date the qualifying individual becomes covered under any other group health plan that does not exclude or limit coverage for a pre-existing condition the qualifying individual may have.

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

### **CONVERSION PRIVILEGE**

There are no conversion benefits for medical coverage when Public Health Services Act participation ends.

### **MEDICARE**

Health insurance protection is provided in two (2) forms under the Federal Medicare Program.

Part A: Hospital Insurance

1. Hospital costs for semiprivate room in an accredited hospital up to a limited number of days.

2. Nursing home care after hospital confinement.
3. Home health visits after hospital discharge.

#### Part B: Medical Insurance Plan and Supplemental Plan.

The supplementary plan provides protection that is not given under the Part A, Hospital Insurance Program; with the primary function of providing coverage for the cost of physicians' services.

The above Medicare programs, both Parts A and B, will assist in paying part of the health care cost for individuals age sixty-five (65) or older.

If your employer has less than twenty (20) employees in the current calendar year, Medicare coverage is primary (and the Plan will be secondary) for active employees age sixty-five (65) or older and their dependents age sixty-five (65) or older. The Plan will reduce payment by the amount paid or payable by Medicare.

If your employer had twenty (20) or more employees in the current or preceding calendar year, federal law requires that Medicare coverage be secondary to the Plan. You have the option of rejecting the Plan thereby retaining Medicare as your primary coverage. If you choose Medicare as primary, you will have no coverage under the Plan. If you reject coverage under the Plan, that choice must be made in writing to your employer. When your coverage under the Plan terminates, you will have a seven (7) month period, beginning on the termination date, to enroll in Medicare Part B.

Federal law also mandates which plan is primary in the case of certain persons who are totally disabled or have end stage renal disease.

It is the intent of the Plan to comply with all existing Medicare regulations. If for some reason the information presented in the Plan differs from actual Medicare regulations, the Plan reserves the right to administer Medicare in accordance with such actual regulations.

#### **COORDINATION OF BENEFITS (COB)**

The coordination of benefits provision is intended to prevent the payment of benefits which exceed expenses. It applies when the employee or any eligible dependent who are covered by the Plan are also covered by any other plan or plans, excluding an individual insurance policy. When more than one (1) coverage exists, one (1) plan normally pays its benefits in full and the other plan pays a reduced benefit. When spouses are employees covered under the Plan, benefits will not be coordinated within the Plan. The Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of total allowable expenses.

Allowable expense means a necessary, reasonable and customary item of expense for health care when the item of expense is covered, at least in part, by one (1) or more plans covering the individual for whom the claim is made.

The coordination of benefits provision applies whether or not a claim is filed under the other plan or plans.

### **Definitions**

The term "Plan" as used in this section of Coordination of Benefits will mean any plan providing benefits or services for or by reason of medical, vision, or dental treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for covered persons in a group whether on a covered or uncovered basis, including but not limited to:
  - a. hospital indemnity benefits; and
  - b. hospital reimbursement-type plans which permit the covered person to elect indemnity at the time of claims.
2. Hospital or medical service organizations on a group basis, group practice and other group prepayment plans.
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision.
4. Any coverage for students which is sponsored by, or provided through a school or other educational institution.
5. Any health maintenance organization (HMO).
6. Any coverage under a governmental program, and coverage required or provided by any statute.
7. Group automobile insurance.
8. Group, blanket or franchise insurance coverage.
9. Individual automobile insurance coverage on an automobile leased or owned by the district.
10. Individual auto insurance, by whatever name called.

**Note:** The Plan is always a secondary plan to benefits provided under any mandatory no-fault auto insurance act in the state in which the covered individual resides.

If a no-fault policy provides coverages in excess of the minimum required by state law, the Plan will coordinate benefits with those coverages in effect.

The benefits of the Plan will not be available to you to the extent of minimum benefits required by the no-fault law for injuries suffered by you while operating or riding in a motor vehicle owned by you if said vehicle is not covered by no-fault automobile insurance as required by law. This denial of benefits does not apply to any other person injured in a motor vehicle accident if the injured person is a non-owner operator, passenger or pedestrian and such other person is not covered by no-fault automobile insurance.

The term "Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such 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.

The term "Claim Determination Period" means a calendar year during which the covered person for whom claim is made has been covered under the Plan.

### **Coordination Procedures**

If a covered person is covered under more than one (1) plan, this coordination of benefits section will apply. This section will be used to determine the amount of benefits payable under the Plan for a covered person.

One plan is the primary plan, and all the other plans are secondary, in the order described below. The primary plan pays its benefits first, without taking the other plans into consideration. The secondary plans then pay benefits up to the extent of their liability after taking into consideration the benefits provided by the other plans. Benefits under other plans include benefits which a covered person could have received if such benefits had been claimed.

1. If a plan has no coordination of benefits provision (or similar provision), it is automatically the primary plan.
2. If all the plans have coordination of benefits provisions, a plan is primary if it covers the person as an employee, and secondary if it covers the person as a dependent.
3. If a person is covered as a dependent child under more than one (1) plan:
  - a. the plan of the parent whose birthday falls earlier in the year is the primary plan (month and day only);
  - b. if the father and mother have the same birthday, the plan covering the parent longer is the primary plan;
  - c. if the other plan coordinates benefits based upon the sex of the parents, then the plan that covers such person as a dependent of a male person is the primary plan;

d. if the parents are separated or divorced, the rules below will apply:

- 1) The plan covering the child as a dependent of the parent with legal custody of the child would be the primary plan; unless
  - 2) a court decree sets the obligation for medical expenses of such child. The plan which covers the child as a dependent of the parent with such obligation will be the primary plan.
  - 3) If the specific terms of a court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plan covering the child shall follow the order of benefits determination rules for dependent children of parents who are not separated or divorced.
4. If a plan is "no-fault" auto insurance or third party liability insurance, it is the primary plan.

If the primary plan is still not established by 1, 2, 3, or 4 above then the plan that covers such person for the longest, continuous period of time will be the primary plan. Regardless of 1 through 4, **a plan which covers the person as an active employee (or a dependent of an active employee) will be primary to the plan which covers the person as:**

1. a laid-off or retired employee;
2. the dependent of a laid-off, retired or deceased employee; or
3. a Public Health Services Act beneficiary who is continuing coverage in accord with federal law.

### **Payments**

Whenever payments which should have been made under the Plan in accordance with this provision have been made under any other plan or plans, the district will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under the Plan and to the extent of such payments, the district will be fully discharged from liability under the Plan. The benefits that are payable will be charged against any applicable maximum payment or benefit of the Plan rather than the amount payable in the absence of this provision.

### **Rights of Recovery**

Whenever payments have been made by the district, with respect to allowable expenses, in a total amount, at any time, in excess of the maximum amount of payment necessary at this time to satisfy the intent of this provision, the district shall have the right, exercisable alone and at its sole discretion, to recover such payments to the extent of such excess from among

one (1) or more of the following, as the district shall determine: any persons, companies or other organizations to, or for, or with respect to whom payments have been made.

### **Right to Receive and Release Necessary Information**

For the purpose of determining the applicability of and implementing the terms of this provision of the Plan or any provision of similar purpose of any other plan, the Plan may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under the Plan shall furnish to the Plan such information as may be necessary to implement this provision.

### **SUBROGATION/THIRD PARTY LIABILITY**

Third party liability exists when someone else is legally responsible for the condition or injury of an employee or his/her dependent while covered for benefits under the Plan. No benefits will be payable under the Plan for any services or supplies related to such a condition or injury for which a third party is determined to be liable until benefits afforded under any third party coverage have been exhausted.

The Plan may, however, provide benefits if:

1. it is established that a third party liability does not exist; or
2. the employee or his/her dependent provides the Plan with a written lien to reimburse the Plan the amount of all benefits paid on behalf of such person, if such person later receives, or settles, or recovers in court, any benefits or damages from a third party which are/were related to the condition or injury for which benefits are being or were paid while such person was covered under the Plan.

### **Plan Rights When Third Party Liability Exists**

1. When a third party is or may be liable for the costs of any covered expenses payable to the employee or his/her dependent, or on behalf of the employee or his/her dependent under the Plan, the Plan has subrogation rights. This means that the Plan has the right, either as co-plaintiffs or by direct suit, to enforce the employee or his/her dependent claim against a third party for any benefits paid under the Plan on behalf of such person for the related condition or injury; and
2. When the employee or his/her dependents fails to cooperate in satisfying the Plan's subrogation interest, and the Plan must file a lawsuit against such person or the third party in order to enforce the Plan's rights under this provision, the employee or his/her dependent for which benefits are being paid or were paid under the Plan shall be responsible for attorney's fees and costs incurred by the Plan.

### **Employee's Obligations When Third Party Liability Exists**

If a third party is or may be liable for the costs of any expenses payable to or on behalf of the employee or his/her dependents under the Plan, the employee and/or his/her dependents must do the following:

1. promptly notify the Plan of a claim involving or against a third party; and
2. the employee or his/her dependents and his/her attorney must provide a written lien to the Plan to reimburse the amount of any benefits paid by the Plan on behalf of such employee or his/her dependents in any action with or against the third party or the third party's insurance carrier; and
3. if the employee or his/her dependents receives money for the claim by suit, settlement, or otherwise, the employee or his/her dependents must fully reimburse the Plan the amount of any benefits provided under the Plan on his/her behalf which are or were related to a condition or injury for which the third party is liable. The employee or his/her dependents may not exclude recovery of benefits paid under the Plan on his/her behalf from any type of damages or settlement recovered by the employee or his/her dependents; and
4. cooperate in every way necessary to help the Plan enforce its subrogation rights; and
5. the employee and his/her dependents may not take any action that might prejudice the Plan's subrogation rights.

### **CLAIMS PAYMENTS MADE IN ERROR**

If payments in excess of the correct amount due are made, the Plan may recover all excess amounts paid. Recovery will be made by reducing or suspending future Plan payments, or by requiring the covered person to pay back the overpayment in full, or in installments, until the overpayment is recovered.

### **ALTERNATE PAYEE PROVISION**

The Plan must make payments to the employee's separated/divorced spouse, state child support agencies or Medicaid agencies if required by a qualified medical child support order (QMCSO) or state Medicaid law.

### **ASSIGNMENT OF BENEFITS**

Payments will also be made in accordance with any assignment of rights required by a state Medicaid plan.

## **REPLACEMENT PROVISION**

### **Applicability**

The replacement provision applies when the employer's prior group medical plan is terminated and replaced by coverage under the Plan, and

1. the employee and his/her dependents are eligible for coverage on the effective date of the Plan; or
2. the employee and his/her dependents were validly covered under the employer's prior group medical plan on the day before the effective date of the Plan.

Benefits are **not** payable under the Plan for medical expense due to any bodily injury or sickness for which the employee and/or his/her dependents are entitled to receive benefits during any extension period provided by the prior group medical plan.

### **Deductible Amount and Out-of-Pocket Amount**

Expenses incurred while the employee and his/her dependents were covered under the prior group medical plan may be used to satisfy the deductible and the out-of-pocket amount under the Plan, if the expense incurred was applied to the deductible or out-of-pocket amount under the prior group medical plan.

### **Pre-Existing Conditions**

If a bodily injury or sickness is a pre-existing condition but would not have been a pre-existing condition under the prior group medical plan had it remained in force, it will not be a pre-existing condition under the Plan. If a bodily injury or sickness is a pre-existing condition under both the prior group medical plan and the Plan, benefits payable are applicable only to medical expenses which were incurred after the date such bodily injury or sickness would no longer have been a pre-existing condition under the prior group medical plan, had it remained in force.

## **HOW TO FILE A CLAIM**

### **STANDARD CLAIMS PROCEDURES**

1. Each employee has been issued an ID card which instructs the provider of the service where to bill directly for expenses incurred. This ID card also provides a brief outline relative to the procedure for submitting claims.
2. If the provider has not submitted their bill and you have an itemized statement or billing, it is important to secure a claim form, complete it in full, attach all itemized statements and charges (not canceled checks or balance forward bills) and mail to:

### **INTERCARE HEALTH PLANS**

P.O. Box 3559  
Englewood, CO 80155-3559  
(800) 426-7453  
(303) 770-5710

3. Every attempt will be made to help covered persons understand their benefits; however, any statement made by an employee of the claims administrator or the employer will be deemed a representation and not a warranty. Actual benefit payment can only be determined at the time the claim is submitted and all facts are presented in writing.

If a definite answer to a specific question is required, please submit a written request, including all pertinent information, and a statement from the attending physician (if applicable), and a written reply (which will be kept on file) will be sent.

4. Benefits may be assigned to the hospital, doctor or any provider of service.
5. First notice of claim must be filed within ninety (90) days of occurrence. All claims should be submitted within a reasonable time frame for prompt processing. Claims fifteen (15) months or older may be denied.
6. All persons making a claim shall be notified in writing whether or not the claim will be paid. This notice will be given or mailed to the claimant within ninety (90) days of receipt by InterCare Health Plans of a properly filed claim. Under certain circumstances, additional time may be needed to process the claim. If additional time is needed, the claimant will be notified in writing. If notice of the claim is not received by the claimant as stated above, the claim should be considered denied for purposes of proceeding to the review procedure.

If any part of the claim is denied, the notice will explain the specific reason(s) for the denial and will include a specific reference to the Plan provision(s) upon which the denial was based. If applicable, the claimant will be given a description of any additional information necessary to process the claim, an explanation of why such

information is necessary, and the steps which may be followed to request a review of the decision.

If the claim is denied in whole or in part, the claimant is entitled to:

- a. request a review of the decision;
- b. review pertinent documents used in the claim determination;
- c. submit any issues and comments in writing.

To request a review, the claimant must file a written request with San Luis Valley Combined Educators Board of Directors within sixty (60) days of receiving the original claim determination. The claimant may request, within that sixty (60) day period an extension if more time is needed to prepare an appeal.

A final decision on the review will be made by the San Luis Valley Combined Educators Board of Directors, or its designee, though the San Luis Valley Combined Educators Board of Trustees may, at its discretion, make an interim review of the initial claim decision. The San Luis Valley Combined Educators Board of Directors decision will be made within sixty (60) days after its receipt of the request for appeal. Under certain circumstances, additional time may be required to complete the review, but in no event will such period extend beyond one hundred twenty (120) days following receipt of the request. If additional time is needed, the claimant will be notified in writing.

The decision upon review will be final. It shall be in writing and contain the specific reason(s) for the decision, contain references to the pertinent Plan language upon which the decision was based, and be written in a manner to be understood by the claimant.

### **LARGE CLAIM MANAGEMENT**

The employee may be asked to assist in the investigation and review of large claims over \$5,000. InterCare provides a special large claim management service to help assure that the charges made for large claims are appropriate and reasonable and customary.

## **GENERAL PROVISIONS**

### **FREE CHOICE OF PHYSICIAN**

The covered person has free choice of any provider of services; not all providers or services may be considered covered or recognized under the Plan.

### **DEDUCTIBLE**

The amount of covered expense already defined, which must be incurred and paid before any medical benefits are available hereunder, shall be known as the "Deductible." The "Deductible" shall be the applicable amount specified in the Schedule of Benefits and must be incurred within the accumulation period January 1 to December 31.

### **ALLOCATION AND APPORTIONMENT OF BENEFITS**

The employer reserves the right to allocate the deductible amount to any eligible charges and to apportion the benefits to the covered person and any assignees. The determination by the Plan as to which charges are used for the deductible and the distribution of the benefits is final and binding upon the covered person and all assignees.

### **MAXIMUM AMOUNT**

The maximum payable for all covered expenses for each covered person shall not exceed in the aggregate the maximum amount shown in the Schedule of Benefits hereof. All claims paid which reduce a specific coverage area will also reduce the lifetime maximum.

### **EXAMINATION**

The employer shall have the right and opportunity to have the covered person examined whose injury or sickness is the basis of a claim hereunder when and so often as it may reasonably require during pendency of claim hereunder.

### **RECORDS**

Each covered person authorizes and directs any provider that has attended, examined or treated them to furnish to the claims administrator, at any time upon its request, any and all information, records or copies of records relating to the attendance, examination or treatment rendered to the covered person; and the claims administrator agrees that such information and records will be considered confidential. Further, any charges imposed relative to the acquisition of such information will be absorbed by the covered person.

### **CHANGE IN AMOUNT OF COVERAGE FOR YOU**

Any change in the amount of your coverage resulting from a change of the factors on which these amounts are based (such as employee classification) will take effect on the date of the change. Any change in the amount of your coverage resulting from an amendment which revises the amounts or benefits provided under the Plan will become effective on the date of the amendment.

### **CHANGE IN AMOUNT OF COVERAGE FOR YOUR DEPENDENTS**

Any change in the amount of a dependent's coverage as a result of the employee's coverage change, will take effect on the date of the change. Any change in the amount of a dependent's coverage resulting from an amendment which revises the amounts or benefits provided under the Plan will become effective on the date of the amendment.

### **MISSTATEMENT OF AGE OR CLASSIFICATION**

If the age or classification of a covered person is misstated or omitted, the correct age or classification will decide whether and what amount of coverage is payable. The contribution will also be adjusted as required.

### **TIME LIMIT ON CERTAIN DEFENSES/STATEMENTS**

After the employee or his/her dependent has been covered under the Plan for two (2) years, no statement, except fraudulent misstatements the employee made about his/her or his/her dependent's health, will be used to void coverage or to deny a claim for loss beginning after the end of that two (2) year period. No statement the employee makes will be used in any contest unless it is in writing and a copy is given to the employee, his/her beneficiary or the representative of the employee's estate.

### **STATEMENTS**

In the absence of fraud, all statements made by a covered person will be deemed representations and not warranties. No such representations will void the Plan benefits or be used in defense to a claim hereunder unless a copy of the instrument containing such representation is or has been furnished to such covered person.

### **CLERICAL ERROR**

If a clerical error is made, it will not affect the coverage to which the covered person is entitled. Delay or failure to report termination of any coverage will not continue the coverage in force beyond the date it terminates according to the Plan.

## **PERIODIC REPORT**

Within one (1) month following the date of any change in the group of employees and dependents covered, the employer shall furnish the claims administrator the names of all employees who have become covered or cease to be covered since the date of the previous reports.

Failure on the part of the employer to report the name of any employees or dependents who are eligible for coverage shall not deprive such persons of their benefits under the Plan; nor shall failure on the part of the employer to report any termination of any employee or dependent obligate the Plan to continue such benefits beyond the date of termination.

## **AFFILIATED DISTRICTS**

Any of the employer's affiliated districts may be deleted or added to the Plan upon written notice by the employer on or before the date such deletion or addition is effective.

## **NOTICE AND PROOF OF CLAIM**

Written notice of injury or of illness upon which a claim may be based must be given to the employer within ninety (90) days of the date of the commencement of the first loss of which benefits arising out of such injury or illness may be claimed.

Notice given by or on behalf of the claimant to the employer with particulars sufficient to identify the covered person, shall be deemed to be notice to the employer. Failure to furnish notice within the time provided in the Plan shall not invalidate any claim if it shall be shown not to have been reasonably possible to furnish such notice and that such notice was furnished as soon as was reasonably possible.

The employer, upon receipt of the notice required by the Plan, will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not so furnished within fifteen (15) days after the employer receives such notice, the claimant shall be deemed to have complied with the requirements of the Plan as to proof of loss upon submitting, within the time fixed in the Plan for filing proofs of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

Affirmative proof of loss of time on account of disability or of hospital confinement for which a claim is made must be furnished to the employer within ninety (90) days after the termination of the period for which claim is made. Affirmative proof of any loss on which a claim is made must be furnished to the employer within ninety (90) days after the date of such loss. Claims fifteen (15) months or older may be denied. Failure to furnish proof within the time provided in the Plan shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible. However, when a covered person's coverage terminates for any reason, written proof of claim must be given to the employer within ninety (90) days of the date of termination of coverage, provided that the Plan remains in

force. However, upon termination of the Plan, final claims must be received within ninety (90) days of termination.

### **FACILITY OF PAYMENT OF CLAIMS**

All Plan benefits are payable to the participant, or subject to any written direction of the participant. All or a portion of any indemnities provided by the Plan on account of hospital, nursing, medical or surgical services may, at the participant's option and unless the participant requests otherwise in writing not later than the time of filing proofs of such loss, paid not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services. However, if any such benefit remains unpaid at the death of the participant or if the participant is a minor or is, in the opinion of the employer, legally incapable of giving a valid receipt and discharge for any payment, the employer may, at its option, pay such benefits to any one or more of the following relatives of the participant: wife, husband, mother, father, child or children, brother or brothers, sister or sisters. Any payment so made will constitute a complete discharge of the employer's obligation to the extent of such payment and the employer will not be required to see the application of the money so paid.

If the claim is not paid in full, the employer will furnish notice to the participant which will specify the reason or describe the additional information required to perfect the claim. Upon written request by the participant within sixty (60) days after notice is received, the employer will review the claim in question and give a final written decision on the review within sixty (60) days, or one hundred twenty (120) days under special circumstances, after such request is received.

### **NOTICE OF DENIAL OF CLAIM**

If your claim has been denied, in whole or in part, you will be furnished with written notice stating the specific reasons for the denial, a specific reference to pertinent plan provisions on which the denial is based, a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary. Also, information will be provided as to the steps to be taken if you wish to submit your claim for review.

This notice will be provided to you within ninety (90) days after you file the claim. If an extension of time for processing the claim is required by special circumstances, an additional ninety (90) days will be allowed in order to act on the claim, in which case you will be given written notice of the extension before the end of the initial 90-day period. If notice of the denial of the claim is not given as stated above, the claim is decreed denied for the purpose of proceeding to the Review Procedure.

## **REVIEW PROCEDURE**

If your claim has been denied, you or your authorized representative may request a review upon written application to the Claims Administrator, review pertinent documents, and submit issues and comments in writing to the Claims Administrator. In order to appeal a denial of a claim, you must make written application for review within sixty (60) days after receipt by you of written notification of denial of the claim. A decision shall be made regarding such application for review promptly.

## **RETROSPECTIVE REVIEW**

San Luis Valley Combined Educators Board of Directors will have the right to allow benefit payments under the Plan on a previously denied claim when there are extenuating circumstances.

## **LEGAL PROCEEDINGS**

No action at law or in equity shall be brought to recover under the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, nor shall such action be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Plan.

## **TIME LIMITATION**

If any time limitation of the Plan with respect to giving notice of claim or furnishing proof of loss, or the bringing of an action at law or in equity, is less than that permitted by ERISA, such limitation is hereby extended to agree with the minimum period permitted by such law.

## **WORKERS' COMPENSATION NOT AFFECTED**

This Plan is not in lieu of, and does not affect any requirement for coverage by workers' compensation insurance.

## **CONFORMITY WITH LAW**

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

## **MISCELLANEOUS**

Section titles are for conveniences of reference only, and are not to be considered in interpreting this Plan. No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of this Plan.

**SIGNATURE**

The effective date of this Plan Document is June 1, 1994, and as restated June 1, 2001.

IT IS AGREED BY San Luis Valley Combined Educators that the provisions contained in this Plan Document are acceptable and will be the basis for the administration of said Employee Medical Plan described herein.

SIGNED at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 2001.

**SAN LUIS VALLEY COMBINED EDUCATORS**

BY: \_\_\_\_\_  
(Authorized Representative's Signature)

\_\_\_\_\_  
(Authorized Representative's Printed Name)

TITLE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

**PLAN DESIGNED BY  
GALLAGHER BYERLY, INC.**

**SIGNATURE PAGE**  
**FOR THE**  
**SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT**  
**EFFECTIVE JUNE 1, 2001**

Each provision, each benefit, each page in this Summary Plan Description has been reviewed and approved by the undersigned.

Any changes to this Summary Plan Description/Plan Document shall be made by amendment to the master Plan Document.

With this approval, the client will print the Summary Plan Description. InterCare will furnish a copy on a disk to the client.

CLIENT: **SAN LUIS VALLEY COMBINED EDUCATORS**

APPROVED BY:

\_\_\_\_\_  
(Authorized Representative's Signature)

\_\_\_\_\_  
(Authorized Representative's Printed Name)

DATE:

\_\_\_\_\_