
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

CU GME HEALTH BENEFITS PLAN

EFFECTIVE July 1, 2020

It is the Member's responsibility to know the provisions of coverage for the medical, dental and prescription drug benefits set forth in this document.

The CU GME Health Benefits Plan is a Preferred Provider Organization (PPO). Benefits are maximized when Plan Participants access Network Providers.

***Website for CU GME medical, dental and prescription drug information, updates and announcements including Plan Document and access to Provider Networks:
medschool.cuanschutz.edu/GMEBenefits.**

This document does not constitute a contract for benefits, either expressed or implied, with the University of Colorado School of Medicine Graduate Medical Education program. Rights are reserved to change, delete or add to the Plan provisions as outlined herein.

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INTRODUCTION

This document is your Summary Plan Description of the medical, prescription drug and dental benefits provided by the CU GME Health Benefits Plan (the Plan) as revised July 1, 2020. From time to time, the CU GME Health & Welfare Trust Committee may amend this document, or it may be revised for clarification. This document, along with all approved amendments, is the controlling document.

Any oral statement or representation made by the University of Colorado, its members or its representatives that alters, modifies, or amends, or is inconsistent with the written terms of the Plan is invalid and unenforceable.

The University of Colorado fully intends to maintain this Plan indefinitely; however, it reserves the right to terminate, suspend, discontinue or amend the Plan in whole or in part at any time and for any reason. Such actions may include but are not limited to changes in benefit coverage, Deductibles, maximums, Copayments, exclusions, limitations, definitions, and eligibility. Should any such action occur, the rights of Plan Participants are limited to payment of applicable benefit for Covered Charges on the date services were rendered.

All amendments or a termination of the Plan must be in writing, name an effective date and be approved by the Trust Committee and signed by the Chancellor of the University of Colorado or designee. Any such action will be communicated to Members in writing as soon as reasonably possible.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, Injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

Coverage under the Plan will take effect for an eligible Member and designated Dependents when the Member and such Dependents satisfy all the eligibility and enrollment requirements of the Plan. Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, including but not limited to, coordination of benefits, subrogation, exclusions, timeliness of COBRA continuation elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document.

Many of the sections in this document are related to other sections. Reading only one section may not provide all of the necessary information on each topic.

PLAN CONTACT INFORMATION

PRE-CERTIFICATION AND UTILIZATION REVIEW ADMINISTRATOR

For a list of services requiring Pre-certification, see page 42 of this document.

CAUTION: It is the responsibility of the Plan Participant to assure Pre-certification is obtained when required. If a service requires Pre-certification and it is not obtained, all related charges will be denied and will become the responsibility of the Plan Participant.

Pre-certification is a type of utilization review by which services such as Hospital admissions, proposed length of stay, home health care and certain Outpatient Services such as surgeries, scans, and therapies must be approved as Medically Necessary. Based on information submitted by you and your doctor, medical professionals (Registered Nurses and board-certified Physician consultants) review the medical appropriateness for services requiring Pre-certification. Certification assessment is based on standards widely used and accepted in the medical community with full consideration given to medical complications and extenuating circumstances.

For MEDICAL/SURGICAL Pre-certification, contact:
CU Health Plan Medical Management
Phone (303) 493-7507
Fax (303) 493-7501

For MENTAL HEALTH/SUBSTANCE ABUSE Pre-certification, contact:
MINES & ASSOCIATES (800) 873-7138

MEDICAL/DENTAL CLAIMS ADMINISTRATOR and COBRA Continuation Administrator

The CU GME Health Benefits Plan has appointed an independent third party administrator (TPA) as the Claims and COBRA Continuation Administrator of the Plan. As such, the Claims Administrator has full discretion to determine initial Plan benefits (process claims), interpret the terms of the Plan and to determine the answers to any questions arising under the Plan. The Claims Administrator shall exercise its powers with complete independence from any interest of the CU GME Health Benefits Plan. The Claims Administrator is:

AmeriBen
PO Box 7186
Boise ID 83707
www.myameriben.com

Toll-Free Phone: (866) 955-1498
Fax: (208) 424-0595

CU GME BENEFITS OFFICE

OFFICE OF GRADUATE MEDICAL EDUCATION
Contact: CU GME Benefits (303) 724-6024
Access to Provider Networks and Plan Document
www.medschool.ucdenver.edu/gme/healthdental

PHARMACY BENEFITS MANAGER

Prescriptions should be obtained at participating pharmacies using your Benefits ID card. A list of participating pharmacies may be obtained by calling Navitus Health Solutions Customer Care or from the Navitus Health Solutions website.

Claim forms for reimbursement of prescriptions purchased at non-participating pharmacies or a Physician's office can be found on the Navitus Health Solutions website or by calling Navitus Customer Care.

Forms for the mail order program may be obtained directly from NoviXus Healthcare Services.

Navitus Health Solutions
P.O. Box 999
Appleton, WI 54912-0999
Customer Care: 1-866-333-2757
Website: www.navitus.com

Mail Order Pharmacy: NoviXus Healthcare Services
P.O. Box 8004
Novi, MI 48376-8004
Customer Service: 1-888-240-2211
Website: www.novixus.com

Specialty Pharmacy: Lumicera Health Services
2601 West Beltline Highway; Suite 302
Madison, WI 53713
Customer Care: 1-855-847-3553
Website: www.lumicera.com

PLAN ADMINISTRATOR

OFFICE OF GRADUATE MEDICAL EDUCATION
Contact: CU GME Benefits (303) 724-6024

IMPORTANT NOTES

This Plan does not cover any treatment or service prescribed or *furnished by a Provider or Physician who is a Member of this Plan*. This includes treatment or services prescribed by the Member for him/herself, a family member, or any participant covered under this Plan.

This Plan also excludes psychoanalysis or psychotherapy that can be credited towards earning a degree or furtherance of the education or training of a Participant, regardless of diagnosis or symptoms that may be present.

ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS

The Plan Year is from July 1-June 30.

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

Member's Effective Date. Coverage begins on the Member's individual training agreement effective date with the University of Colorado Graduate Medical Education Programs.

Dependents' Effective Date. Dependents who are eligible for coverage on the Member's Effective Date, and for whom the Member has completed the required enrollment process including timely submission of Enrollment and Change Form and required documentation, will be covered as of the Effective Date of the Member. The Effective Date of a newly acquired Dependent's coverage will be the date as described in the "Special Enrollment Periods" section of this document providing the Member submits an updated Enrollment & Change Form and required documentation to the Plan Administrator within 31 days of a qualifying event. Otherwise, Dependents must wait until the open enrollment period to be eligible. (See Special Enrollment Periods.)

ELIGIBILITY

Eligible Members include:

- (1) Interns (individuals in first year of training in a graduate medical education [GME] program);
- (2) Residents (individuals in training in a GME program); and
- (3) Fellows (residents in training in a designated subspecialty GME program) of the University of Colorado School of Medicine and Affiliated Hospitals.
- (4) Residents in a dentistry or pharmacy training program designated as eligible by training program and Plan Administrator.

For the purposes of this document and per ACGME definition, the word "resident" refers to interns, residents and fellows. To be eligible for coverage, resident must be participating in a CU GME training program and have a fully executed training agreement with a 50% or greater full time equivalent appointment. Residents participating in the CU GME program who have alternate funding sources may not be eligible for medical or dental benefits under this program.

Eligible Dependents include:

- (1) A covered Member's legal Spouse, Civil Union Partner, or Domestic Partner.

The Plan Administrator may require submission of documentation and applicable forms including but not limited to proof of a legal marital relationship (marriage certificate or common-law affidavit), a copy of the Civil Union Certificate received from the County Clerk and Recorder or a record of the Civil Union received from the State Registrar as presumptive evidence of Civil Union for Civil Union Partners, or a Domestic Partner Affidavit.

There may be tax consequences to the Member when enrolling a Civil Union Partner a Domestic Partner or child(ren) of a Civil Union Partner or Domestic Partner.

See enrollment requirements on page 6.

- (2) A covered Member's Dependent Child. The term "Dependent Child" shall include a child to the limiting age of 26 without regard to student status, marital status, financial dependency or residency status with the Member or any other person.

When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month. Dependent Child includes:

- (a) a natural child of the Member;
- (b) a child in Placement for Adoption;
- (c) a legally adopted child;
- (d) a stepchild for whom the Spouse is the Legal Guardian may also be included as long as a natural parent remains married to the Member;
- (e) a child of an eligible Civil Union Partner or Domestic Partner for whom the Civil Union Partner or Domestic Partner is the Legal Guardian, and as long as the Civil Union Partner or Domestic Partner remains covered under the Plan;
- (f) a child for whom the Member has assumed Legal Guardianship and has provided documentation of Legal Guardianship to the Plan Administrator;
- (g) a newborn child whose mother is an eligible dependent child of the Member if the Member has assumed Legal Guardianship and has provided documentation to the Plan Administrator;
- (h) a covered dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, Primarily Dependent Upon the covered Member for support and maintenance, and unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.
- (i) a dependent of a Plan Member covered by a Qualified Medical Child Support Order (QMCSO). Any such dependent is required to be covered under this Plan as of the date of the QMCSO or the Effective Date of coverage for the enrolled Member, whichever is later. If the coverage is for a stepchild of a Plan Member or child of an eligible Civil Union Partner and the parent named in the QMCSO is covered under the health Plan, the Plan will enroll that stepchild or child of the eligible Civil Union Partner or Domestic Partner. All Plan limitations will apply. A QMCSO is a judgment or decree by a court of "competent jurisdiction" that requires a group health plan to provide coverage to the children of a Plan Participant, pursuant to a state domestic relations law. The child is termed an "alternate recipient" and is entitled to coverage.

The Plan or Claims Administrator may require documentation proving dependency, including birth certificates, tax records, divorce decree, or initiation of legal proceedings to sever parental rights.

If a person covered under this Plan changes status from Member to Dependent or Dependent to Member, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for Deductibles and all amounts applied to maximums. If both mother and father are Members, their children will be covered as Dependents of the parent whose birthday occurs earlier in the calendar year.

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

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

These persons are excluded as Dependents:

- (1) A person on active duty in any military service of any country.
- (2) Any dependent who is covered under this Plan as a Member.
- (3) Any dependent who is covered under this Plan as a dependent of another Member.

In no event may a dependent child be covered by more than one Member. If the child is an eligible dependent of more than one Member the child may only be covered by the Member with the earliest birthday in the calendar year.
- (4) Other individuals living in the covered Member's home, but who are not eligible as defined.
- (5) The legally separated or divorced former Spouse of the Member.
- (6) A Domestic Partner for whom the Member has submitted an Affidavit of Termination of Domestic Partnership
- (7) A Civil Union Partner for whom the Member has submitted documentation of Civil Union dissolution.

ENROLLMENT

Enrollment Requirements. A Member must enroll for coverage by completing the enrollment process, including timely submission of Enrollment and Change Form, listing all eligible dependents for whom coverage is to be considered, and required documentation. Members are required to contribute towards the cost of coverage. Information for coordination of benefits for Dependents may be requested at any time.

Dental Coverage is an excepted benefit. Member and eligible Dependents enrolling in medical coverage will automatically be enrolled in dental coverage. The Member may choose to opt out of (waive) dental coverage and enroll for medical coverage only. When the Member chooses to waive dental coverage, enrollment in dental coverage will not be allowed until the annual open enrollment period unless Member experiences a qualifying event.

Enrollment Requirements for Newly Acquired Dependents. Outside of the Open Enrollment Period, a newly acquired Dependent's (e.g. newborn, new Spouse, Domestic Partner, Civil Union Partner or child Placed for Adoption) coverage will be the date they are acquired providing the Member submits the updated Enrollment and Change Form and required documentation to the Plan Administrator within 31 days of a qualifying event. Otherwise, Dependent must wait until the open enrollment period to be eligible. (See Special Enrollment Periods.)

Timely or Late Enrollment

- (1) Timely Enrollment - The enrollment will be "timely" if the completed Enrollment & Change Form and documentation is received by the Plan Administrator no later than within 31 days of when the person becomes eligible for the coverage either initially or under a Special Enrollment Period.

If two Members (Spouses, Civil Union Partners, or Domestic Partners) are covered under the Plan and the Member who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Member.

- (2) Late Enrollment - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who

are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

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

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

Special Enrollment Periods

Special enrollment rights may apply with respect to a Member, a Dependent of a Member, or both.

The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage.

Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

- (1) Individuals losing other coverage.** A Member or Dependent who is eligible, but not enrolled in this Plan, may enroll if all of the following conditions are met:
 - (a)** The Member or Dependent was covered under a group health plan or governmental plan such as Medicare or TRICARE at the time coverage under this Plan was previously offered to the individual.
 - (b)** If required by the Plan Administrator, the Member stated in writing at the time that other health coverage was the reason for declining enrollment.
 - (c)** The coverage of the Member or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated.
 - (d)** The Member or Dependent requests enrollment in this Plan not later than within 31 days of the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above. If the Member or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

The Effective Date of coverage for individuals enrolled during a Special Enrollment Period due to case of loss of eligibility under a group health plan, another group health insurance issuer offering group health insurance coverage, or a governmental plan such as Medicare or TRICARE coverage is the first day of the month following the loss of eligibility.

- (2) New eligible Dependent.** A new Dependent may be enrolled in the Plan if all of the following conditions are met:
 - (a)** The Member is a participant under this Plan (or is eligible to be enrolled under this Plan but failed to enroll during a previous enrollment period);

- (b) A person becomes a Dependent of the Member through marriage, civil union, or domestic partnership, birth, adoption or Placement for Adoption;
- (c) The Dependent is enrolled during the 31 day period beginning on the date of the marriage, civil union, domestic partnership, birth, adoption or Placement for Adoption. If written request for coverage is not made within the 31-day Special Enrollment Period, the Member and/or affected dependents will be considered late entrants.

If not otherwise enrolled, the Member may be enrolled during the Special Enrollment Period.

In the case of the birth or adoption of a child, the Spouse, Civil Union Partner, or Domestic Partner of the covered Member may be enrolled as a Dependent of the covered Member if otherwise eligible for coverage.

The effective date of coverage for dependents enrolled during a Dependent Special Enrollment Period

- in the case of marriage, the date of the marriage;
- in the case of a civil union, the date the civil union is certified; in the case of a Domestic Partnership, the effective date of the Domestic Partnership
- in the case of a Dependent's birth, the date of birth; or
- in the case of a Dependent's adoption or Placement for Adoption, the date of the adoption or Placement for Adoption.
- in the case of a court order, the date of the court order coinciding with the Member's Effective Date, whichever is later.

(3) **Member or Dependent** eligible for coverage or premium assistance through a Medicaid plan or State Child Health Plan (SCHIP). A Member or Dependent who is eligible, but not enrolled in this Plan, may enroll in the Plan if:

- (a) The Member or Dependent is covered under a Medicaid plan or SCHIP and coverage of the Member or Dependent under such a plan is terminated as a result of loss of eligibility; or
- (b) The Member or Dependent becomes eligible for premium assistance under Medicaid or SCHIP, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than direct enrollment in a state Medicaid program; and
- (c) The individual is enrolled for coverage in the CU GME Health Benefits Plan within 60 days after the date the Member and/or Dependent's Medicaid or state-sponsored SCHIP coverage ends or the date the Member or Dependent becomes eligible for premium assistance under Medicaid or SCHIP.

The Effective Date of coverage for Members and Dependents enrolled during a Special Enrollment Period due to termination of Medicaid or SCHIP coverage or eligibility for premium assistance under Medicaid or SCHIP is the first day of the month following the loss of eligibility.

Annual Open Enrollment

Every April/May, during the annual open enrollment period, Members and their Dependents who are Late Enrollees will be able to enroll in the Plan for coverage effective July 1 of that year.

Benefit choices for Late Enrollees made during the open enrollment period will become effective July 1st. Plan Members will receive detailed information regarding open enrollment from their Plan Administrator.

EFFECTIVE DATE

Effective Date of Member Coverage. A Member will be covered under this Plan as of the first day that the Member satisfies all of the following:

- (1) The eligibility requirements of the Plan.
- (2) The enrollment requirements of the Plan.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that:

- (1) The eligibility requirements of the Plan are met.
- (2) The Member is covered under the Plan.
- (3) All Plan enrollment Requirements are met.

TERMINATION OF COVERAGE

When Member Coverage Terminates.

Member coverage will terminate on the earliest of these dates:

- (1) The date the Plan or group coverage under the Plan is terminated.
- (2) The final day the covered Member ceases to be in one of the eligible classes. This includes the final day a Member's training terminates according to their training agreement, or death of the Member.
- (3) The date any required payment for coverage under the Plan is not made.
- (4) The date the Member enters the armed forces on active duty. (When taking a qualified military leave of absence, pursuant to the Uniformed Services Employment and Reemployment Rights Act [USERRA], the Member may elect coverage subject to the COBRA Continuation, page 83.)

When Dependent Coverage Terminates.

A Dependent's coverage will terminate on the earliest of these dates:

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Member's coverage under the Plan terminates for any reason including death.
- (3) The date a covered Spouse, Civil Union Partner or Domestic Partner loses coverage due to loss of dependency status. This includes legal separation or divorce for a Spouse, dissolution of civil union or termination of Domestic Partnership.
- (4) The date that a Dependent child ceases to be a Dependent as defined by the Plan.
- (5) The date the Dependent enters the armed forces on active duty. (When taking a qualified military leave of absence, pursuant to the Uniformed Services Employment and Reemployment Rights Act [USERRA], the Dependent may elect coverage subject to the COBRA Continuation, page 83.)

HEALTH BENEFITS DURING A LEAVE OF ABSENCE

Retention of the CU GME Health Benefits Plan may be available to eligible residents during a leave of absence. The resident must complete COBRA Continuation enrollment and pay the COBRA premium.

See COBRA Continuation provisions (page 83) in this document and the current GME Leave Policy for further information.

RETENTION OF COVERAGE BETWEEN PROGRAM STOP/START DATES

When, due to the training program start and end dates, a resident enrolled in the Plan has eight or fewer days between the end of his/her current training program year with CU GME and the start of his/her next training program year with CU GME, the enrolled Member and dependent(s) will retain coverage with the Plan between the program end and start dates at no additional cost to the resident.

RESCISSION OF COVERAGE DUE TO MISREPRESENTATION

The Plan has the right to rescind any coverage of a Member or Dependents for making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage or obtaining benefits under the Plan. The Plan may either void coverage for the Member and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least thirty (30) days' advance written notice of such action. The Plan will refund all contributions paid by the Member for any coverage rescinded; however, claims paid will be offset from this amount. The Plan reserves the right to collect additional monies if claims are paid in excess of the Member's and/or Dependent's paid contributions.

The Plan's decision to rescind coverage may be appealed. Refer to "How to File an Appeal" on page 70 for detailed information about the appeal process.

PROVIDER NETWORKS

This Plan is a Preferred Provider Organization (PPO) plan.

PPO Network: CU GME Health Benefits Plan Proprietary Network

PPO Networks for Behavioral Health: Mines and Associates
CU Medicine Behavioral/Mental Health Participating

Providers

Access to information about Network Providers is available at www.medschool.ucdenver.edu/gme/healthdental. This information is updated as needed.

Benefits are based on the network status of the Provider of service on the date of service. This Plan has entered into an agreement with certain Hospitals, Physicians, Behavioral Health and other health care Providers, which are called Network (In-Network) Providers.

Therefore, when a Plan Participant uses a Network Provider, that Plan Participant may be eligible for a higher level of benefit from the Plan than when a Non-network (Out-of-Network) Provider is used. It is the Plan Participant's choice as to which Provider to use and the Plan Participant's responsibility to determine the network status of a Provider prior to receiving services.

- (1) If a Plan Participant has a Medical Emergency requiring immediate care, as certified by medical management, the Plan Participant may not be subject to Non-network Plan provisions for certain Non-network services such as ambulance services or inpatient admissions.
- (2) In the event a Medically Necessary covered service is not available from an In-Network Provider, the plan may authorize in-network benefit levels for services provided by an Out-of-Network Provider.

Pre-certification for network non-availability must occur before the service is rendered. Request must specifically state the request is for consideration of network non-availability. Post-service approval will not be made. Each situation will be reviewed on a case-by-case basis.

If authorization is received, it will be limited to a specific provider/facility (identified by name), specific services/supplies and for a specific period of time or treatment period. The network non-availability provision is **not** subject to appeal procedure allowed for other services denied because pre-certification was required but not obtained.

SUMMARY OF MEDICAL BENEFITS

To verify eligibility or clarify benefits, please call the Claims Administrator before the charge is incurred. NOTE: Final disposition of a claim is possible ONLY when the actual claim for services rendered is received and reviewed.

MEDICAL BENEFITS

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

Pre-certification:

Pre-certification of services is not a guarantee of benefits payable and will not result in payment of benefits that would not otherwise be payable under plan provisions.

Pre-certification is required for the following services. **If a service requires certification and it is not obtained, all related charges will be denied and will become the responsibility of the Plan Participant. It is the responsibility of the Plan Participant to assure certification is obtained.**

Durable Medical Equipment:

Costing more than \$500 and/or
Rented more than 60 days and
Hospital Grade Breast Pumps

(Exceptions: Pre-certification of oxygen for newborns up to one year of age is not required. Covered supplies for covered Durable Medical Equipment, for example insulin pump supplies, do not require pre-certification, but are limited to a 90 day supply.)

Genetic Testing

Hearing Aids

Home Health Care

Hospitalizations*

Emergency: Pre-certification management must be notified within forty-eight (48) hours after confinement (within 72 hours if confinement begins on a Friday or Saturday) or as soon as reasonably possible following the Emergency Admission. This includes Hospitalization for Mental Health and/or Substance Abuse.

Non-emergency: Pre-certification should be requested at least 7-10 days in advance of confinement. This includes Hospitalization for Mental Health and/or Substance Abuse.

Hospice Care

Network Non-availability

Occupational therapy (outpatient)

Outpatient surgical procedures performed at a free-standing surgical facility or in the outpatient department of a Hospital

- that require an incision, laser, use of an Operating Room or are invasive (Surgery in a Physician's office does not require Pre-certification, even if a treatment room is used)

Pediatric Dental Services: General anesthesia and Hospital or facility charges only as specified on page 26

Prosthesis/Prosthetic device
Scans, MRI, CT, PET scans (outpatient)
Skilled Nursing Facility stays
Sleep studies
Speech therapy (outpatient)

Transplants, Organ and Tissue

- * The Plan does NOT require certification for a childbirth length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

However, it is recommended that you notify the Pre-certification and Utilization Review Administrator of the approximate date of delivery. If the admission exceeds the 48 or 96 hour allowance, this information will assist in certification of additional days.

Refer to the Newborns' and Mothers' Health Protection Act of 1996 on page 92 for additional information.

Refer to the Pre-certification and Utilization Review section, beginning on page 42, for additional details of the Pre-certification process.

SUMMARY OF MEDICAL BENEFITS

Services indicated with an “*” may require Pre-certification. See page 42 for additional information.

MAXIMUM LIFETIME BENEFIT AMOUNT	Unlimited	
DEDUCTIBLE, PER PLAN YEAR	NETWORK (IN-NETWORK) PROVIDERS	NON-NETWORK (OUT OF NETWORK) PROVIDERS
Per Plan Participant	Deductible does not apply to in-network services	\$750
Per Family Unit	Deductible does not apply to in-network services	\$1,200
OUT-OF-POCKET ANNUAL (PLAN YEAR) MAXIMUM		N/A
Per Plan Participant Per Family Unit	\$800 \$1,200 The Out-of-pocket Annual Maximum for the medical and prescription drug plans are separate. See Summary of Prescription Drug Benefits for Prescription Drug Plan Out-of-pocket Annual Maximum.	N/A
COPAYMENTS		N/A
Office Visit Per Visit	\$20	N/A
Pregnancy Per Global Physician’s Charge	\$200	N/A
*MRI, CT, PET scans (outpatient) Per Scan	\$100	N/A
*Inpatient Hospital Per Confinement For Continuous Confinements, only one Copay will apply	\$200	N/A
Emergency Room Per Visit Waived if patient is admitted to the Hospital directly from the emergency room	\$200	\$200
*Outpatient Surgery Facility Per Day Waived if admitted directly from outpatient department If surgery is performed in conjunction with emergency room services, only emergency room Copay applies	\$100	N/A

COPAYMENTS (cont.)	NETWORK (IN-NETWORK) PROVIDERS	NON-NETWORK (OUT OF NETWORK) PROVIDERS
Urgent Care Facility/ER Alternative Visits Per Visit	<p>\$20</p> <ul style="list-style-type: none"> ▪ Office visit Copay will apply for Network Physician visit ▪ Urgent Care Facility/ER Alternative Visit <p>Emergency room Copay will apply for emergency room.</p>	<p>\$20</p> <p>For facility charge and related Physician charges incurred at time of presentation to an Urgent Care Facility <i>if Plan Participant is traveling greater than 50 miles from residence (for purposes other than to seek non-preapproved medical care) and/or Resident participating in “away” rotation.</i></p> <p>Emergency room Copay will apply for emergency room.</p>

See next page for Summary of Medical Benefits, Covered Services

COVERED SERVICES	NETWORK (IN-NETWORK) PROVIDERS	NON-NETWORK (OUT-OF-NETWORK) PROVIDERS <i>Benefits are subject to Usual, Customary and Reasonable Allowance</i>
Ambulance Service	100%	50% after Deductible for a condition that is not a Medical Emergency; 100% for a Medical Emergency or if authorized by the Precertification and Utilization Review Administrator
Bereavement Counseling Services	100%	50% after Deductible Maximum of 6 visits during the Bereavement Period
Chiropractic Services	Not covered	
Clinical Trials	Refer to Clinical Trials section, Detail of Medical Benefits	Refer to Clinical Trials section, Detail of Medical Benefits
*Durable Medical Equipment	100%	50% after Deductible
Breast Pump	100% Per Plan provision	Not covered. Not covered for dependent child or grandchild.
*Hearing Aid Services		
Office Visit	100% after Copay for office visits	50% after Deductible
Other Covered Services	Per Plan provision for specific services Maximum of \$4,000 per 48 months Dependent children up to their 18th birthday	50% after Deductible
*Home Health Care	100%	50% after Deductible
*Hospice care	100%	50% after Deductible
*Hospital Services		
Room and Board Ancillary Services	100% after Copay for inpatient admissions The semiprivate room rate If Hospital has only private rooms, 90% of the average private room rate Hospital's ICU Charge Hospital's reasonable charge for necessary ancillary services	50% after Deductible 100% after Copay for inpatient admissions for Emergency Admissions if certified within specified time period. Patient must be transferred to a network facility, based on bed availability, as soon as his/her condition safely permits, or benefits revert to 50%

COVERED SERVICES	NETWORK (IN-NETWORK) PROVIDERS	NON-NETWORK (OUT-OF-NETWORK) PROVIDERS <i>Benefits are subject to Usual, Customary and Reasonable Allowance</i>
*Hospital Services (cont.)		
Emergency Room (Pre-certification is not required for Emergency Room)	100% after Copay for emergency room	100% after Copay for emergency room
*Outpatient Surgery Facility (includes charges from outpatient Hospital facility and Ambulatory Surgery Center)	100% after Copay for outpatient surgery facility	50% after Deductible
Infertility	100% \$2,500 Lifetime Maximum Includes: care, supplies and services leading to the diagnosis of Infertility. Services associated with the <u>treatment</u> of Infertility are not covered.	50% after Deductible
Laboratory and X-ray *Scans MRI PET CT	100% after Copay for scans Separate Copay per scan	50% after Deductible – or-- 100% of usual, customary and reasonable for a laboratory test or tissue specimen obtained in the office of a Network Provider.
Mental Health *Inpatient	100% after Copay for inpatient admissions The semiprivate room rate If Hospital has only private rooms, 90% of the average private room rate Hospital's ICU Charge Hospital's reasonable charge for necessary ancillary service	50% after Deductible 100% after Copay for inpatient admissions for Emergency Admissions if certified within specified time period. Patient must be transferred to a network facility, based on bed availability, as soon as his/her condition safely permits, or benefits revert to 50%

COVERED SERVICES	NETWORK (IN-NETWORK) PROVIDERS	NON-NETWORK (OUT-OF-NETWORK) PROVIDERS <i>Benefits are subject to Usual, Customary and Reasonable Allowance</i>
Mental Health (cont.)		
Partial Hospitalization Intensive Outpatient Care	100%	50% after deductible
Outpatient	100% after Copay for office visits	50% after deductible
Midwifery Services	100% after Copay for global pregnancy Physician's charge Applies only to services performed by Network midwife and rendered at Network facility	Not covered.
*Occupational Therapy	100%	50% after Deductible 20 Visit Plan Year Maximum Combined with Speech Therapy/Auditory Rehabilitation
Pervasive Developmental Disorder		
Office Visit	100% after Copay for office visits	50% after Deductible
Other Covered Services	Per Plan provision for specific services	50% after Deductible \$5,000 Plan Year Maximum
Physical Therapy	100%	50% after Deductible 40 Visit Plan Year Maximum

COVERED SERVICES	NETWORK (IN-NETWORK) PROVIDERS	NON-NETWORK (OUT-OF-NETWORK) PROVIDERS <i>Benefits are subject to Usual, Customary and Reasonable Allowance</i>
Physician Services		
Inpatient Visits	100%	50% after Deductible
Office Visits	100% after Copay for office visits	50% after Deductible
Surgery	100%	50% after Deductible 100% for a pre-certified covered surgical procedure, if a Non-network Provider is used in a situation in which the Participant has no control over provider selection such Non-network services may be covered at the In-network level
Podiatric Services		
Office Visit	100% after Copay for office visits	50% after Deductible
Other Covered Services	Per Plan provision for specific services	50% after Deductible
Foot Orthotics	100% \$250 Lifetime Maximum for Foot Orthotics	50% after Deductible
Pregnancy (Pregnancy not covered for dependent child or grandchild)		
Physician	100% after Copay for global Physician's charge	50% after Deductible
Hospital	100% after Copay for inpatient admissions	50% after Deductible
Well Baby Inpatient Newborn Nursery	100% Inpatient admission Copay applies for sick baby only	50% after Deductible
Preventive Care-see next page		

COVERED SERVICES	NETWORK (IN-NETWORK) PROVIDERS	NON-NETWORK (OUT-OF-NETWORK) PROVIDERS <i>Benefits are subject to Usual, Customary and Reasonable Allowance</i>
Preventive Care Routine Well Child Care (Ages 0-2)	100%	50% after Deductible
	Includes: office visits, routine physical examination, laboratory tests and immunizations	
Routine Well Child Care (Ages 2-18)	100%	50% after Deductible Includes routine physical examination and laboratory tests up to \$150 per Plan Year Immunizations up to \$60 per Plan Year See www.HealthCare.gov/center/regulations/prevention.html for a current listing of Preventive services required by law.
Routine Well Adult Care (Ages 19 and over)	100%	50% after Deductible \$500 Plan Year Maximum <ul style="list-style-type: none"> • Frequency limits for mammogram Ages 35-40 one baseline mammogram during this period Ages 41-49 one mammogram every 2 years Age 50 and over one mammogram per Plan Year; • Frequency limits for prostatic specific antigen One exam per Plan Year for male participants age 45 and over. • Services, including immunizations, for the purpose of travel are not covered. • Preventive Care required by law is covered. See www.HealthCare.gov/center/regulations/prevention.html for a current listing of Preventive services required by law, including woman's preventive medicine.
*Prosthesis/Prosthetic device	100%	50% after Deductible
*Skilled Nursing Facility	100% after Copay for inpatient admissions	50% after Deductible The facility's semiprivate room rate 100 days Plan Year maximum
*Speech Therapy/Auditory Rehabilitation	100%	50% after Deductible 20 Visit Plan Year Maximum Combined with Occupational Therapy

COVERED SERVICES	NETWORK (IN-NETWORK) PROVIDERS	NON-NETWORK (OUT-OF-NETWORK) PROVIDERS <i>Benefits are subject to Usual, Customary and Reasonable Allowance</i>
Substance Abuse		
*Inpatient	100% after Copay for inpatient admissions The semiprivate room rate If Hospital has only private rooms, 90% of the average private room rate Hospital's ICU Charge Hospital's reasonable charge for necessary ancillary service	50% after Deductible 100% after Copay for inpatient admissions for Emergency Admissions if certified within specified time period. Patient must be transferred to a network facility, based on bed availability, as soon as his/her condition safely permits, or benefits revert to 50%
Partial Hospitalization Intensive Outpatient Care	100%	50% after deductible
Outpatient	100% after Copay for office visits	50% after deductible
*Transplants, Organ and Tissue	100%	50% after Deductible Not covered unless approved through the Alternative Care provision Meals and lodging-\$150 daily maximum Transportation, meals and lodging-\$10,000 Lifetime maximum Donor-\$10,000 Lifetime maximum
TMJ/Jaw Joint	100%	50% after Deductible \$1,500 Lifetime Maximum
Urgent Care Facility/ER Alternative Visits	Office visit Copay will apply for <ul style="list-style-type: none">▪ Network Physician visit▪ Urgent Care Facility/ER Alternative Visits Emergency room Copay will apply for emergency room.	50% after Deductible -or- 100% after Copay for office visits For facility charge and related Physician charges incurred at time of presentation to an Urgent Care Facility if Plan Participant is traveling greater than 50 miles from residence (for purposes

COVERED SERVICES	NETWORK (IN-NETWORK) PROVIDERS	NON-NETWORK (OUT-OF-NETWORK) PROVIDERS <i>Benefits are subject to Usual, Customary and Reasonable Allowance</i>
		<i>other than to seek non-preapproved medical care) and/or Resident participating in "away" rotation. Emergency room Copay will apply for emergency room.</i>
All Other Covered Services	100%	50% after Deductible

See page 47 for Prescription Plan coverage.
See page 52 for Dental Plan coverage.

DETAIL OF MEDICAL BENEFITS

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

Also consult the Plan Exclusions section of this document, beginning on page 36.

Deductible. This is the amount of Covered Charges from a Non-Network Provider for which no benefits will be paid. Before benefits can be paid in a Plan Year a Plan Participant must meet the Deductible shown in the Summary of Medical Benefits. The individual deductible applies separately to each Plan Participant. The family deductible applies collectively to all Plan Participants in the same family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of the Plan Year.

Coinsurance. For Covered Charges incurred with a Non-Network Provider, the Plan pays a specified percentage of Covered Charges at the Usual, Customary and Reasonable amount after the Plan Year Deductible amount has been reached. In these circumstances, Plan Participants are responsible for the Deductible amount and the difference between the percentage the Plan pays and 100% of the billed amount. These amounts, for which the Plan Participant is responsible, are known as Coinsurance.

Copayment/Copay. In certain cases, when seeing a Network Provider, the Plan Participant pays a specific dollar amount, as specified in the Summary of Medical Benefits. This amount for which the Plan Participant is responsible, is known as a Copayment, and is typically payable to the Provider at the time services or supplies are rendered.

Out-of-Pocket Annual (Plan Year) Maximum. This is the amount that Plan Participants will pay per Plan Year to Network Providers for Covered Charges. Once the Out-of-Pocket Annual Maximum is reached, no further Copayments will apply. The Out-of-Pocket Annual Maximum for the medical and prescription drug plans are separate. See Summary of Medical Benefits for Medical Plan Maximum and Summary of Prescription Drug Benefit for Prescription Drug Plan Out-of-Pocket Annual Maximum. The individual out-of-pocket annual maximum applies separately to each Plan Participant. The family out-of-pocket annual maximum applies collectively to all Plan Participants in the same family. When the family out-of-pocket annual maximum is satisfied, the Plan will pay 100% of Covered Charges for any covered family member during the remainder of the Plan Year.

BENEFIT PAYMENT

Each Plan Year, benefits will be paid for the Covered Charges of a Plan Participant that are in excess of the Deductible, Coinsurance and any Copayments. Payment will be made at the rate shown in the Summary of Medical Benefits. No benefits will be paid in excess of the Maximum Benefit Amounts listed for specific services. The Maximum Lifetime Benefit Amount is shown in the Summary of Medical Benefits.

COVERED CHARGES

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

- (1) **Allergy Testing and Treatment.**
- (2) **Ambulance.** Medically Necessary professional land, sea or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided, or from the nearest Hospital to the patient's home. Professional ambulance service

from one Hospital to another is a covered expense when Medically Necessary and/or when approved by the Pre-certification and Utilization Review Administrator. Charges for private automobile or commercial or public transportation are not covered.

- (3) **Anesthesia.** Anesthesia services performed by a Physician (other than the surgeon) or CRNA.
- (4) **Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD).** The following services are covered:
 - (a) Initial evaluation, to include clinical interview, administration of standard ADD scales, and psychiatric evaluation, if necessary (covered under the outpatient Mental Health benefit).
 - (b) If biologic intervention (medication) is found to be appropriate, the Plan will cover periodic evaluations for medication management (covered under the Medical Plan).
- (5) **Bereavement Counseling Services** are the services available to a Participant who experiences the death of a family member to include only the Spouse, Civil Union Partner, Domestic Partner, son, daughter, sibling or parent of the Participant Participant's Spouse, Civil Union Partner or Domestic Partner. Services must be provided within the Bereavement Period by a provider legally entitled to practice Bereavement Counseling and who customarily bills for such services. Services are separate and distinct from the Mental Health benefit and are subject to the maximum specified in the Medical Summary of Benefits.
- (6) **Blood,** blood plasma and blood derivatives, including charges for processing, transportation, handling and administration, and for donation, storage and administration of participant's own blood.
- (7) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered
 - (a) under the supervision of a Physician;
 - (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; and
 - (c) in a Medical Care Facility as defined by this Plan.
- (8) **Chemotherapy** and radiation including treatment with radioactive substances. The materials and services of technicians are included.
- (9) **Clinical Trials.** The Plan covers routine patient care costs related to an approved clinical trial for a qualified individual who meets the following requirements:
 - (a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and
 - (b) either the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

For the purposes of clinical trials, life-threatening disease or condition is defined as any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. This plan does not cover clinical trials related to other diseases or conditions.

An **approved clinical trial** is defined as a clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The study or investigation must:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- involve a drug trial that is exempt from having such an investigational new drug application.

When a service is part of an approved clinical trial, it is covered even though it may otherwise be an investigational service as defined by the Plan.

Routine patient care costs generally include items and services that typically are covered under the Plan for an individual not enrolled in a clinical trial and are subject to the same terms for coverage under the Plan. For example, a service that requires precertification will require precertification whether or not the service is provided during a clinical trial.

Routine patient care costs associated with clinical trials exclude:

- the investigational drug, item, device or service itself.
- services and supplies provided by the trial sponsor without charge to the Plan Participant.
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(10) Cochlear Implants are covered if

- (a)** services are in accordance with accepted medical practice; and
- (b)** services are not otherwise excluded by the Plan. Non-covered services include but are not limited to services that require Pre-certification for which Pre-certification is not obtained, treatment considered Experimental, Investigational, and/or not Medically Necessary, services not ordered by a Physician, and services performed by a non-covered Provider.

Replacement batteries for cochlear implants are covered.

Speech Therapy/Auditory Rehabilitation services provided in conjunction with the placement of a cochlear implant are subject to the Speech Therapy/Auditory Rehabilitation maximum specified in the Summary of Medical Benefits.

Cochlear implants are not covered for hearing loss due to aging.

- (11) **Contraception**, including Physician charges and supplies related to injections solely for the purpose of contraception, Intrauterine Devices (IUDs) and other contraceptive devices which require placement by a Physician.
- (12) **Dental Services** are covered under the Medical Plan when performed for the treatment of conditions related to the teeth or structures supporting the teeth as specified below. For coverage of routine dental care, refer to the Dental Plan section, beginning on page 52.

Eligible Expenses under the Medical Plan include:

- (a) Treatment of a tumor.
- (b) Expenses for dental surgery, dental treatment or dental appliances required as a result of an accidental Injury to natural teeth.
 - (i) This benefit applies only to damage to Sound Natural Teeth.
 - (ii) All of the following requirements must be met:
 - 1. Other bodily Injury was sustained as a result of the accident; and
 - 2. The first service is received within ninety (90) days of the date of the accident.
- (c) General anesthesia, when rendered in a Hospital or outpatient surgical facility, and associated Hospital or facility charges for dental care provided to a covered dependent child, when all of the following conditions and requirements are met:
 - (i) The child has a physical defect or physical or mental disability which prevents performing necessary dental treatment in the Dentist's office.
 - (ii) The attending Dentist certifies the services are necessary to maintain the integrity of current or future permanent dentition.
 - (iii) The child's attending Physician certifies the physical or mental condition, as well as approves general anesthesia for the child.
 - (iv) Services are approved by the Pre-Certification and Utilization Review Administrator, based on the above criteria.

Non-eligible expenses: Except for Eligible Expenses listed above, services involving teeth, structure or tissue around the teeth, the alveolar process or the gums are not covered.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, preparing the mouth for the fitting of or continued use of dentures, damage to caps, crowns, implants, bridges, dentures and partials, mouth, tooth, or jaw restoration due to an Injury sustained from biting or chewing, any service or supply which is not necessary to restore the condition and function that existed immediately prior to the accident, any service incurred more than one year after a covered dental accident, and inpatient or outpatient hospitalization for services not covered by the Medical Plan.

- (13) **Durable Medical or Surgical Equipment.** Rental is covered if deemed Medically Necessary. These items may be bought rather than rented if long term care is planned, the equipment cannot be rented, or it is likely to cost less to purchase than to rent. The decision to rent or purchase is at the discretion of the Plan.

Breast Pump. When prescribed by attending physician and obtained from designated In-network Provider:

- (a) purchase of 1 (one) selected model breast pump per birth and/or
- (b) rental of hospital-grade breast pump when pre-certified as Medically necessary.

Covered supplies for covered Durable Medical Equipment, for example insulin pump supplies, do not require pre-certification but are limited to a 90-day supply.

Covered services do not include durable equipment such as whirlpool baths, air conditioners, purifiers, dehumidifiers, exercise equipment and other self-help devices which are not Medically Necessary, supplies which are not Medically Necessary but are used for comfort, convenience or personal hygiene, for example, heating pads, hot water bottles, supplies for non-hospital grade breast pump, wigs and hair pieces, and items considered deluxe equipment.

The Plan reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided.

Repair and maintenance charges for Durable Medical Equipment are not Eligible Expenses if damage is due to negligence or misuse.

- (14) Eyeglasses.** Charges for initial purchase of eyeglasses or contact lenses immediately following cataract surgery or to replace the human lens absent at birth or lost through intraocular surgery, Injury or when caused by a medically ascertainable Illness.

Covered services do not include services or supplies related to prescription glasses or contacts except as specified above; eye surgery, such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring); or orthoptics or vision training/therapy.

- (15) Hearing Aids.** The following services related to hearing aids for Dependent children up to the child's eighteenth (18th) birthday are covered:

- (a) Initial audiology evaluation.
- (b) Initial hearing aid(s), including cord and charger.
- (c) Replacement hearing aid(s) if existing hearing aid(s) cannot be altered to meet the needs of the Plan Participant.
- (d) Fittings, adjustments, counseling and repairs not covered by the hearing aid warranty.
- (e) Speech therapy/auditory rehabilitation, subject to the Plan Maximum stated in the Summary of Medical Benefits.

Covered expenses do not include batteries, or any expense otherwise excluded by the Plan. Non-covered services include but are not limited to services that require Pre-certification for which Pre-certification is not obtained, treatment considered Experimental, Investigational, and/or not Medically Necessary, services not ordered by a Physician, and services performed by a non-covered Provider.

- (16) Hemodialysis.** When provided as an inpatient, or as an outpatient in a Hospital or other eligible facility.
- (17) Home Health Care Services and Supplies.** Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Illness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be by written order of the attending

Physician and be contained in a Home Health Care Plan. Order must be renewed every 30 days or as required by the Pre-certification and Utilization Review Administrator.

A home health care visit will be considered a periodic visit by either a home health aide under the supervision of a Registered Nurse, physical therapist, or speech therapist, an RN or LPN, therapist, psychiatric social worker, nutritionist, or registered dietician, as the case may be.

Total parenteral nutrition and prescription drugs are a covered expense under the Home Health benefit if not covered by the Prescription Drug Plan.

Ineligible expenses include Custodial Care that could be safely performed by a properly trained person, such as a family member or household resident; maintenance care, such as feeding and bathing, when provided solely to maintain the patient's condition, where no significant practical improvement can be expected; and dietary supplements.

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

Covered Charges for Hospice Care Services and Supplies are payable as described in the Summary of Medical Benefits.

Charges incurred during a period of remission are not covered under the hospice benefit. This applies if, during such remission, the terminally ill person is discharged from the hospice care program.

- (19) Hospital Services.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center within a licensed Hospital facility. Covered Charges for room and board will be payable as shown in the Summary of Medical Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Covered expenses include incremental nursing services, private room charges when ordered by the Physician for purposes of isolation, and charges for an Intensive Care Unit stay as described in the Summary of Medical Benefits.

Room charges made by a Hospital having only private rooms will be paid at 90% of the average private room rate.

Non-covered expenses include personal services and supplies, and convenience items billed by the Hospital, including guest meals and cots.

- (20) Infertility.** Diagnostic services for infertility evaluation. Services are subject to the maximum specified in the Summary of Medical Benefits. Services associated with the treatment of Infertility are not covered.

- (21) Laboratory studies** for the diagnosis and treatment of Illness and/or Injury. The Plan will not pay laboratory services that are inconsistent with the Physician's diagnosis or for ineligible conditions (for example, weight loss programs).

- (22) Mastectomy and Reconstructive Mammoplasties.** Mastectomy for treatment of disease, prophylactic mastectomy for prevention of breast cancer and reconstructive mammoplasties will be considered Covered Charges.

The mammoplasty coverage will include reimbursement for the following services:

- (a)** reconstruction of the breast on which a mastectomy has been performed; and

- (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- (c) prostheses and treatment of physical complications during all stages of mastectomy, including lymphedemas.

(23) Medical supplies. Coverage for orthopedic appliances and dressings includes:

- (a) Colostomy bags and supplies required for their use.
- (b) Catheters.
- (c) Dressings when Medically Necessary for conditions such as cancer, diabetic ulcers and burns.
- (d) Splints, trusses and casts.
- (e) Leg braces when required for all normal activities (i.e., occupation or household duties).
- (f) Arm braces, back braces.
- (g) Maxillofacial prosthesis.
- (h) Cervical collars.
- (i) Surgical implants.
- (j) Fitting, adjusting, and repairing of such orthopedic appliances.
- (k) Compression stockings that require a prescription, up to a maximum of eight (8) stockings per Plan Year.

(24) Mental Health and Substance Abuse (Behavioral Health Services).

Psychoanalysis or psychotherapy that can be credited towards earning a degree or furtherance of training of a participant is not covered, regardless of diagnosis or symptoms that may be present.

Covered Charges for care, supplies and treatment of Mental Health and Substance Abuse will be limited as follows:

Eligible Expenses include services by a Physician, Clinical Psychologist (Ph.D., Ed.D, Psy.d), Licensed Clinical Social Worker (LCSW), Clinical Nurse Specialist in psychiatric nursing or any duly licensed Provider as described in Defined Terms.

Room charges made by a Hospital having only private rooms will be paid at 90% of the average private room rate.

Hospitalization for mental health/Substance Abuse treatment may be an Eligible Expense when approved through the Mental Health and Substance Abuse Pre-certification Administrator before treatment begins.

Partial Hospitalization Treatment provides care or services for at least four (4) hours a day, but less than seven and one half (7½) hours per day;

Intensive Outpatient Care provides care or services for at least seven and one half (7½) hours per day, up to twelve (12) hours per day.

No benefits will be provided for the treatment of Substance Abuse unless the treating facility certifies to the Claims Administrator that the participant has completed the full continuum of care necessary and available at that facility.

Court ordered psychiatric evaluations are not covered by the Plan.

Premarital and marital counseling; family counseling; sex therapy; and counseling with participant's friends, employer, school counselor, or school teacher are not covered.

(25) Midwifery Services. The Medically Necessary services performed by an in-network midwife and rendered at an in-network facility.

(26) Newborn Nursery/Physician Care.

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

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

Charges for covered routine nursery care will be applied toward the coverage of the newborn child.

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

Circumcision of an infant within the first eighteen months of life, whether performed during the initial newborn confinement or in an outpatient setting, is a covered expense.

Charges for covered routine Physician care will be applied toward the coverage of the newborn child.

(27) Nutritional Guidance. One consultation at the time a participant is initially diagnosed with heart disease and/or diabetes for nutritional guidance, when determined by the attending Physician to be Medically Necessary, and when services are rendered on an outpatient basis.

(28) Obesity. Medically Necessary services associated with Obesity or Morbid Obesity, as defined in this Plan, which can be reasonably expected to improve the physical complications of the obesity and/or as required by law. Case Management may be required if requested by the Plan Administrator.

Non-eligible expenses include charges for instruction or activities for weight reduction, weight control or physical fitness even if the services are performed or prescribed by a Physician. Surgical treatment for Obesity, including Morbid Obesity, and services related to this surgery or any complications from this surgery are not covered.

(29) Occupational therapy by a licensed occupational therapist. Occupational therapy benefits are provided when:

(a) There is a documented medical Illness or Injury requiring treatment.

(b) There is a treatment plan submitted with estimated length of time for therapy, along with a statement certifying the above condition is met.

Therapy must be ordered by a Physician, result from an Injury or Illness and improve a body function. Benefits are subject to the maximum specified in the Summary of Medical Benefits.

Occupational therapy benefits are not provided for behavior disorders, communication delays, learning disabilities and/or developmental delays, intellectual disabilities and related conditions, motor dysfunctions, recreational programs, maintenance therapy or supplies used in occupational therapy. See page 31 for specific Pervasive Developmental Disorder coverage.

(30) Out of State Services. Any of the services described in this document are Eligible Expenses when rendered outside the State of Colorado if the services are Medically Necessary or a Medical Emergency. The participant is responsible for obtaining sufficient information to complete and submit the claim form for reimbursement. This may require a copy of the receipt and/or medical records.

(31) Oxygen. Oxygen and its administration.

(32) Pervasive Developmental Disorder (PDD) is covered only as follows:

(a) Coverage is provided only for pre-kindergarten children who are eligible and enrolled dependent children on this Plan.

(b) This benefit is provided for disorders defined in the current DSM version as types of PDD, including Autistic Disorder and Asperger's Disorder.

(c) Covered services include:

(i) Initial evaluation may include services such as medical evaluation, parent and/or child interview, evaluation by a speech-language pathologist, and other evaluations and tests ordered by the Physician.

(ii) Based on the results of the initial evaluation, treatment ordered by the Physician.

(iii) PDD evaluation and treatment benefits are not available for services otherwise excluded by the Plan. Non-covered services include but are not limited to services that require Pre-certification for which Pre-certification is not obtained, treatment considered Experimental, Investigational, and/or not Medically Necessary, services not ordered by a Physician, and services performed by a non-covered Provider.

(d) Payment for all services related to PDD, including but not limited to evaluation, tests and treatment, is limited to the Plan Year maximum specified in the Summary of Benefits.

Benefits for Speech, Occupational and Physical Therapy for PDD are limited to the maximum visits listed in the Summary of Benefits.

(33) Physical therapy by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions that are subject to significant improvement through short-term therapy.

There are no benefits for physical therapy services given solely to maintain function at the level to which it has been restored, when no further significant practical improvement can be expected, or for motor or developmental delay. See page 31 for specific Pervasive Developmental Disorder coverage.

Benefits are subject to the maximum specified in the Summary of Medical Benefits.

Nutritional supplements, cervical pillows, ice packs and any other supplies are not Eligible Expenses.

Physical therapy services do not include the services of a masseur, physical culturist or physical education instructor.

Massage Therapy services are not an Eligible Expense.

- (34) Physician Care.** The professional services of a Physician for covered surgical or medical services.

The following rules apply to surgical services:

- (a)** Charges for multiple surgical procedures will be a covered expense subject to current fee survey data.
- (b)** Charges of an assistant surgeon, if the surgical procedure requires an assistant. The eligible amount is 20% of the surgery's Usual, Customary and Reasonable fee. Eligible non-physician Providers are:
 - (i)** Physician Assistant, and
 - (ii)** Certified Surgical Technologist (CST), and
 - (iii)** Certified Surgical Assistant (CSA)

- (35) Podiatric Services.** Medically Necessary services,

- (a)** not subject to the "Foot Care" exclusion on page 37, and
- (b)** provided by a licensed podiatrist

are covered services, including but not limited to office visits, surgery, diagnostic services, and Foot Orthotics. Coverage for Foot Orthotics is limited to the maximum listed in the Summary of Medical Benefits.

- (36) Pregnancy.** The Usual, Customary and Reasonable (UCR) Charges for the care and treatment of Pregnancy are covered the same as any other Illness for a covered Member, covered Spouse, covered Civil Union Partner, or covered Domestic Partner.

There is no coverage of Pregnancy for a Dependent child.

- (37) Prescription Drugs** (see Prescription Drug Program on page 47).

- (38) Preventive Care.**

- (a)** Network Provider: Routine Preventive Care listed in the Summary of Medical Benefits is covered. In addition, coverage for Preventive Care required by law is provided. A current listing of Preventive Care services, including woman's preventive medicine required by law can be accessed at www.HealthCare.gov/center/regulations/prevention.html. There is no annual maximum for Preventive Care Services by Network Providers.
- (b)** Non-network Provider: Routine Preventive Care listed in the Summary of Medical Benefits is covered. In addition, coverage for Preventive Care required by law is provided. A current listing of Preventive Care services required by law can be accessed at www.HealthCare.gov/center/regulations/prevention.html. The maximum benefit for Preventive Care Services provided by Non-network Providers is specified in the Summary of Medical Benefits.

If a claim is submitted that includes both routine Wellness Services and additional services which are related to the diagnosis and/or treatment of an Illness or Injury, the Wellness Services Benefit will be paid first for eligible Wellness Services, and the balance of the charges which are related to an Illness or Injury will be considered under the Major Medical Benefit.

Benefits exclude physical, psychiatric or psychological exams for employment, licensing, school, insurance, sports, adoption, and marriage or related to judicial or administrative proceedings or conducted for purposes of medical research except for services covered in conjunction with Clinical Trials as required by law, and immunizations or services for the purpose of foreign travel.

- (39) Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

Inpatient nursing charges are covered only when care is Medically Necessary and not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

Outpatient private duty nursing care is not covered.

- (40) Prosthesis/Prosthetic Devices.** The initial purchase, fitting, repair or replacement of a fitted prosthesis/prosthetic device that replaces all or part of a missing body part. Repair or replacement due to negligence or misuse is not covered.

- (41) Radiology services** for the diagnosis and treatment of Illness and/or Injury, including mammograms indicated by personal or family history (close direct line relations). The Plan will not pay radiology services that are inconsistent with the Physician's diagnosis or for ineligible conditions (for example, Cosmetic Surgery).

- (42) Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

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

Benefits are subject to the maximum specified in the Summary of Medical Benefits.

Custodial Care and domiciliary care are not covered. Facilities provided only for rest, the aged, or Custodial Care are not covered as Skilled Nursing Facilities.

- (43) Speech Therapy/Auditory Rehabilitation** by a covered provider operating within the scope of their license. Benefits for speech therapy will be provided 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 amount of time.
- (b)** Improvement would not normally be expected to occur without intervention.
- (c)** Treatment is rendered for a condition that is the direct result of a diagnosed neurological, muscular, or structural abnormality affecting the organs of speech.
- (d)** 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 of the above conditions are met.

Covered expenses include treatment of speech delay in three (3) to five (5) year old patients, only when secondary to persistent otitis media or serious otitis media. This

must be documented by the treating Physician as persisting longer than six (6) months with documented bilateral 25-decibel hearing loss. The goal of the therapy is a significant improvement of the patient's condition within two (2) months.

Benefits are subject to the maximum specified in the Summary of Medical Benefits.

Covered services do not include treatment for stuttering or treatment for a learning disorder. See page 31 for specific Pervasive Developmental Disorder coverage, page 25 for services following cochlear implants and page 27 for services related to hearing aids for children.

- (44) **Sterilization procedures** are a covered expense. Reversals of sterilization procedures are not covered.
- (45) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
- (46) **Temporomandibular Joint Syndrome/Jaw Joint.** Medically Necessary services for care and treatment of jaw joint conditions, including Temporomandibular Joint syndrome (TMJ) up to the maximum specified in the Summary of Medical Benefits.
- (47) **Transplant, Organ or Tissue.** Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:
 - (a) The transplant must be performed to replace an organ or tissue.
 - (b) Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Plan Participant. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:
 - i. evaluating the organ or tissue;
 - ii. removing the organ or tissue from the donor; and
 - iii. transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

Benefit payments for donor charges are subject to the separate Donor maximum Benefit limit as shown in the Summary of Medical Benefits.

The reasonable cost of transportation for the recipient. This benefit is payable when the participant has been authorized to obtain the procedure in a city other than his/her usual residence. The mode and cost of transportation must be approved by the Pre-certification and Utilization Review Administrator.

The Plan will pay the cost of transportation for the recipient and one other individual to and from the Hospital or other facility where the transplant procedure is performed, and all reasonable and necessary lodging and meal expenses incurred up to a daily aggregate maximum as specified in the Summary of Medical Benefits for the individual accompanying the recipient.

Coverage for all transportation, lodging and meal expenses for the accompanying individual shall not exceed the amount specified in the Summary of Medical Benefits.

The Plan will not cover an animal organ or artificial organ transplant, expenses of a participant to donate an organ for transplant unless the recipient is also a Plan Member (family member covered under this Plan), the cost of a donor search or compatibility testing, or Experimental and/or Investigational procedures.

- (48) Urgent Care Facility/ER Alternative Visits.** Medically Necessary Urgent Care charges including facility and related Physician charges incurred at time of presentation to an Urgent Care Facility/ER Alternative (in-network); or Urgent Care Facility if Plan Participant is traveling greater than 100 miles from residence (for purposes other than to seek non-preapproved medical care) and/or Resident participating in “away” rotation.

EXCLUSIONS

Note: Exclusions related to Prescription Drugs are shown in the Prescription Drug Benefits Section beginning on page 47.

Note: Exclusions related to Dental services are shown in the Dental Benefits Section beginning on page 52.

For all Medical Benefits shown in the Summary of Medical Benefits, a charge for the following is not covered. This list is not exhaustive.

- (1) **Acupuncture/acupressure.** Charges for and in connection with acupuncture or acupressure.
- (2) **Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD).** Services related to ADD and ADHD except those specifically listed under "Detail of Medical Benefits". This includes speech, physical or other associated therapies.
- (3) **Batteries,** unless specifically listed as covered under Detail of Medical Benefits.
- (4) **Biofeedback.** Expenses associated with biofeedback.
- (5) **Breast Implant Removal.** Expenses for removal of breast implants unless the participant has been diagnosed with a current medical condition that would establish the medical necessity to remove the implant. Replacement implants are covered only if the original implant was initially inserted as a result of reconstruction following surgical removal of all or part of the breast tissue due to an illness. Replacement must be a non-silicone solution implant.
- (6) **Chiropractic Care.** Services rendered by a chiropractor.
- (7) **Clinical Trials.** Services and supplies specifically excluded in the requirements set forth in the Affordable Care Act (ACA) mandate or listed within this plan document. Refer to the Clinical Trials section for additional information.
- (8) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.
- (9) **Cosmetic.** Services, procedures, surgeries or supplies related to cosmetic or reconstructive surgery that is done for aesthetic purposes and not to restore an impaired function of the body unless the service meets one of the following conditions:
 - (a) Repair or alleviation of damage resulting from an injury; or,
 - (b) Surgical removal of breast tissue resulting from an illness or as otherwise certified as an eligible surgery under this Plan. (Also see Women's Health and Cancer Right Act, page 91); or
 - (c) A congenital disease or anomaly resulting in a functional defect.Cosmetic procedures performed for psychiatric or psychological reasons or to change family characteristics or conditions due to aging are not covered under this Plan.
Complications or subsequent surgery related in any way to any previous cosmetic procedure shall not be covered, regardless of medical necessity.

- (10) **Counseling.** Benefits for counseling, including, but not limited to, premarital or marital counseling; family counseling; sex therapy; or counseling with participant's friends, employer, school counselor, or school teacher.
- (11) **Custodial Care Expenses.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
- (12) **Dental expenses.** Expenses for services, including x-ray exams, involving one or more teeth, the tissue or structure around the teeth, the alveolar process, or the gums, except as specified under "Detail of Medical Benefits".
- (13) **Equipment and Services, Non-Medical.** Expenses for rental or purchase of equipment which may be used for non-medical purposes, or for comfort, convenience or personal hygiene, including but not limited to comfort and convenience items billed by the Hospital (such as guest trays and cots, admission kits, etc.), spa and health club memberships, air conditioners, dehumidifiers, purifiers, whirlpools, exercise equipment, heating pads, hot water bottles, ice packs and cervical pillows, whether or not prescribed by a Physician.
- (14) **Excess charges.** The part of an expense for care and treatment of an Injury or Illness that is in excess of the Usual, Customary and Reasonable (UCR) Charge.
- (15) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (16) **Experimental/Investigational or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary. This includes services not necessary for the diagnosis and treatment of a covered Illness or Injury, except as specified under Preventive Care, and Clinical Trials, as required by law, and services not ordered by a Physician.
- (17) **Eye care.** Services for:
 - (a) Routine eye examinations, including refraction, services related to eyeglasses or contacts, and exams for their fitting; and
 - (b) Eye surgery, such as radial keratotomy or other eye surgery when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring) or other to correct refractive disorders; and
 - (c) Orthoptics or vision training/therapy.

This exclusion does not apply to charges for initial purchase of eyeglasses or contact lenses immediately following cataract surgery or to replace the human lens absent at birth or lost through intraocular surgery, Injury or when caused by a medically ascertainable Illness, unless the attending Physician certifies that due to a change in the patient's condition, a change in prescription to the originally covered device is Medically Necessary.
- (18) **Foot care.** Treatment of corns, calluses, or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).
- (19) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the primary or sole purpose of obtaining medical services.

- (20) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- (21) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
- (22) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting for Plan Participants age 18 and over.
- (23) **Hospice Care Services and Supplies.** Charges incurred during a period of remission are not covered under the hospice benefit if, during such remission, the terminally ill person is discharged from the hospice care program.
- (24) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (25) **Illegal acts.** Charges for services received as a result of Injury or Illness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (26) **Infertility.** Charges for Infertility treatment, to include but not be limited to all services related to, and complications of, artificial insemination, sterilization reversals, in-vitro fertilization, embryo transfers, surrogate parenting which involves a Plan Participant either as a donor, recipient or surrogate, Prescription Drugs (benefits provided by separate Prescription Drug Program), hormone therapy, any surgical procedures and diagnostic tests, except as stated in the "Detail of Medical Benefits" section.
- (27) **Instruction.** Charges for instruction or programs for stress management, birthing preparation or breaking habits.
- (28) **Itemized Bills.** Charges for providing itemized bills, operative reports, office notes, completed Provider claim forms, or other basic information necessary to process a claim.
- (29) **Maintenance Treatment.** Services given solely to maintain function at the level to which it has been restored, or when no further significant practical improvement can be expected.
- (30) **Massage Therapy.** Massage Therapy and related expenses.
- (31) **Mastectomy Bras and Camisoles.**
- (32) **Midwife/midwifery services, non-network or out-of-network.** Services performed by non-network midwife Provider and/or rendered at non-network facility.
- (33) **Missed or cancelled appointments.** Charges for broken, cancelled or missed appointments.
- (34) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (35) **No obligation to pay.** Charges incurred for which the patient has no legal obligation to pay.

- (36) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Plan Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Illness.
- (37) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.
- (38) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
- (39) **Obesity.** Charges for instruction or activities for weight reduction, weight control, or physical fitness even if the services are performed or prescribed by a Physician.
Surgical treatment for obesity, including Morbid Obesity, and services related to this surgery or any complications resulting from this surgery are not covered.
- (40) **Occupational.** Expenses for any condition for which all or part of the services could be made available to the participant under any of the following, regardless of whether the participant waives or fails to assert rights under a-c below:
 - (a) Workers' Compensation;
 - (b) Employer's liability (regardless of the employer's ability to pay);
 - (c) Occupational disease or public health law.
- (41) **Occupational Therapy.** Expenses for behavior disorders, communication delays, learning disabilities and/or developmental delays, intellectual disabilities and related conditions, motor dysfunctions, recreational programs, maintenance therapy or supplies used in occupational therapy. See Pervasive Developmental Disorder for specific coverage and exclusions related to PDD.
- (42) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-prescription drugs and medicines, first-aid supplies, and non-hospital adjustable beds.
- (43) **Pervasive Developmental Disorder (PDD).** Expenses for any services related to PDD for any covered Dependent who is Kindergarten Age or older.
- (44) **Physical Therapy.** Services given solely to maintain functioning at the level to which it has been restored, or when no further significant practical improvement can be expected; nutritional supplements, cervical pillows, ice packs and other supplies; services of a masseur, physical culturist or physical education instructor; Massage Therapy services.
- (45) **Plan design exclusions.** Charges excluded by the Plan design as mentioned in this document.
- (46) **Pregnancy.**
 - (a) Expenses related to the Pregnancy of a Dependent child or grandchild;
 - (b) Charges for birthing preparation classes such as Lamaze;
 - (c) Breast pumps other than as specified under "Durable Medical Equipment"; or

- (d) Elective termination of Pregnancy: except when in cases therapeutic abortion, which is an abortion recommended by attending Physician performed to save the life or health of the mother, or as a result of rape or incest.
- (47) **Private Duty Nursing.** Expenses for private duty nursing services
- (a) when requested by or for the convenience of the patient or the patient's family; or
 - (b) when the services consist primarily of bathing, feeding, exercising, home-making, moving the patient, or acting as a companion or sitter; or
 - (c) when otherwise deemed not Medically Necessary; or
 - (d) which ordinarily would be provided by the Hospital staff; or
 - (e) when provided as an outpatient arrangement.
- (48) **Prosthesis/Prosthetic Device Replacement.** Charges for replacement of Prosthesis/prosthetic device that meet any of the following conditions:
- (a) Condition not covered by the Plan, and
 - (b) Charges for the replacement of prosthesis/prosthetic device unless determined to be Medically Necessary by the attending Physician due to a change in the participant's condition or wear. Replacement due to negligence or misuse is not covered.
- (49) **Psychoanalysis/psychotherapy.** Psychoanalysis or psychotherapy that can be credited towards earning a degree or furtherance of the education or training of a Participant, regardless of diagnosis or symptoms that may be present.
- (50) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Illness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Summary of Medical Benefits or required by applicable law.
- (51) **Sales Tax.** Sales tax except where required by state statute for medical expenses.
- (52) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- (53) **Services provided by relative.** Professional services performed by a person who ordinarily resides in the Plan Participant's home or is related to the Plan Participant as a Spouse, Civil Union Partner, Domestic Partner, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (54) **Services provided or prescribed by Residents.** Any treatment or service prescribed or furnished by a Provider or Physician who is a Member of this Plan. This includes treatment or services prescribed by the Member for him/herself, a family member, or any participant covered under this Plan.
- (55) **Special Education.** Expenses for special education, including but not limited to related counseling, therapy, or care for learning deficiencies, developmental delays, intellectual disabilities or behavioral problems, whether or not associated

with Mental Health Condition or other disturbances, including cognitive orthotic devices (such as artificial speech synthesizers) and methods that retrain or alleviate problems caused by deficits in attention (Attention Deficit Disorder), visual, processing, memory reasoning, problem solving, and executive functions, except for those services related to ADD, ADHD, and PDD specifically listed under "Detail of Medical Benefits".

- (56) **Speech therapy/Auditory Rehabilitation.** Treatment for stuttering or treatment for a learning disorder.
- (57) **Sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (58) **Transplant, Organ and Tissue**
 - (a) The Plan will not cover an animal organ or artificial organ transplant.
 - (b) The Plan does not cover the expenses of a participant to donate an organ for transplant unless the recipient is also a Plan Member (family member covered under this Plan).
 - (c) The Plan does not cover the cost of a donor search or compatibility testing.
 - (d) Experimental and/or Investigational procedures are not Eligible Expenses.
- (59) **Travel.** Expenses, including services and immunizations, for the purpose of foreign travel.
- (60) **Travel expenses of:**
 - (a) A Physician attending a Plan Participant; or
 - (b) A Participant, whether or not the travel was recommended by a Physician, except for covered ambulance services and travel expenses specified under the "Transplant, Organ and Tissue" benefit.
- (61) **Usual, customary and reasonable.** Any portion of the cost in excess of usual and customary amount for Eligible Expenses.
- (62) **Vocational services.** Services for vocational testing, training or rehabilitation.
- (63) **War or Act of Terrorism.** Any loss that is due to declared or undeclared war or act of terrorism.
- (64) **Wigs.** Wigs and hairpieces.

PRE-CERTIFICATION & UTILIZATION REVIEW REQUIREMENTS

The patient or family member must call the Pre-certification & Utilization Review Administrator (see page 2), to receive certification of certain Medical Services. This call must be made at least 7-10 days in advance of non-emergency services. Following Emergency Admission, Pre-certification & Utilization Review Administrator must be notified within 48 hours after confinement begins (within 72 hours if confinement begins on a Friday or Saturday) or as soon as reasonably possible.

CAUTION: It is the responsibility of the Plan Participant to assure Pre-certification is obtained when required. If a service requires Pre-certification and it is not obtained, all related charges will be denied and will become the responsibility of the Plan Participant.

Pre-certification of services is not a guarantee of benefits payable and will not result in payment of benefits that would not otherwise be payable under Plan provisions.

UTILIZATION REVIEW PROGRAM

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

The program consists of:

- (1) Pre-certification of Medical Necessity is required for the following services:

Durable Medical Equipment:

Costing more than \$500 and/or

Rented more than 60 days and

Hospital Grade Breast Pumps

(Exceptions: Pre-certification of oxygen for newborns up to one year of age is not required. Covered supplies for covered Durable Medical Equipment, for example insulin pump supplies, do not require pre-certification, but are limited to a 90 day supply.)

Genetic Testing

Hearing Aids

Home Health Care

Hospitalizations*

Emergency:

Pre-certification management must be notified within forty-eight (48) hours after confinement begins (within 72 hours if confinement begins on a Friday or Saturday) or as soon as reasonably possible following the Emergency Admission. This includes Hospitalization for Mental Health and/or Substance Abuse.

Non-Emergency: Pre-certification should be requested at least 7-10 days in advance of confinement. This includes Hospitalization for Mental Health and/or Substance Abuse.

Hospice Care

Network Non-availability

Occupational therapy (outpatient)

Outpatient surgical procedures performed at a free-standing surgical facility or in the outpatient department of a Hospital

- that require an incision, laser, use of an Operating Room or are invasive (Surgery in a Physician's office does not require Pre-certification, even if a treatment room is used)

Pediatric Dental Services: General anesthesia and Hospital or facility charges only as specified on page 26

Prosthesis/Prosthetic device
Scans, MRI, CT, PET scans (outpatient)
Skilled Nursing Facility stays
Sleep studies
Speech therapy (outpatient)

Transplants, Organ and Tissue

★The Plan does NOT require certification for a childbirth length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

However, it is recommended that you notify the Pre-certification and Utilization Review Administrator of the approximate date of delivery. If the admission exceeds the 48 or 96 hour allowance, this information will assist in certification of additional days.

Refer to the Newborns' and Mothers' Health Protection Act of 1996 on page 91 for additional information.

Retrospective review of Medical Necessity of the listed services provided on an emergency basis within 48 hours of admission or within 72 hours if confinement begins on a Friday or Saturday;

- (2) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- (3) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care Provider.

If a particular course of treatment or medical service is not certified, it means that the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

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

Here's how the program works.

Pre-certification Request/Pre-service Claim. Before a Plan Participant enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the Pre-certification and Utilization Review Administrator will, in conjunction with the attending Physician, certify the care as appropriate. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The program is set in motion by a telephone call from the Plan Participant. Contact the Pre-certification & Utilization Review Administrator at the telephone number on your ID card **at least 7-10 days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Member
- The name, Health Plan ID number and address of the covered Member
- The name of the Plan (CU GME Health Benefits Plan)
- The name and telephone number of the attending Physician

- The name of the Medical Care Facility, proposed date of admission and length of stay or proposed out-patient service
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

If there is an Emergency Admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the Pre-certification & Utilization Review Administrator within 48 hours of the first business day after the admission or within 72 hours if an admission is on a Friday or Saturday.

The Pre-certification/Utilization Review Administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. Failure to follow this procedure may reduce reimbursement received from the Plan.

If the Plan Participant does not receive authorization as explained in this section, there will be no coverage.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The Pre-certification & Utilization Review Administrator will monitor the Plan Participant's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Plan Participant either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

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

Timing of Pre-certification Request Determinations. The Pre-certification & Utilization Review Administrator will notify Claimant of Benefit Determinations as follows:

Pre-Certification Request (Pre-Service Claim) must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the request. This period may be extended by the Pre-certification & Utilization Review Administrator for up to an additional 15 days if, for reasons beyond its control, the decision cannot be made within the first 15 days. The Pre-certification & Utilization Review Administrator must notify the Claimant prior to the expiration of the first 15 day period, explaining the reason for the delay, requesting any additional information, and advising when a decision can be expected. If more information is requested to decide the claim, the notice of extension will specifically describe the required information and Claimant will be given at least 45 days from receipt of notice to provide the specified information. The Pre-certification & Utilization Review Administrator then must decide the claim no later than 15 days after the Claimant supplies the additional information or after the period of time allowed to supply the information ends, whichever comes first. If the Pre-certification & Utilization Review Administrator wants more time, Claimant's consent is required. The Pre-certification & Utilization Review Administrator will provide Claimant with written notice that request has been granted or denied before the end of the time allotted for the decision.

Notice of an Adverse Benefit Determination regarding a Concurrent Care Decision will be provided sufficiently in advance of any termination or reduction of benefits to allow Claimant to appeal and obtain a determination before the benefit is reduced or terminates.

Urgent Care Claim must be decided as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receipt of the request. Claimant will be notified within 24 hours if more information is needed or request is incomplete. The claimant will have a period of not less than 48 hours to respond with the requested specified information. The Pre-

certification & Utilization Administrator will then provide notice of Benefit Determination within 48 hours after the earlier of receipt of the specified information, or the end of the period of time given Claimant to provide the information. If the Benefit Determination is provided orally, it will be followed in writing no later than 3 days after the oral notice.

If the Urgent Care Claim involves a Concurrent Care Decision, notice of the Benefit Determination (whether adverse or not) will be provided as soon as possible, but not later than 24 hours after receipt of request for extension of treatment or care, as long as the request is made at least 24 hours before the prescribed period of time expires or the prescribed number of treatments ends.

For information about the right to appeal services denied in full or in part due to Pre-certification denial, refer to the section titled Appeals for Pre-certification Request/Pre-service Claims, page 72.

CASE MANAGEMENT

Case Management is a program whereby a case manager monitors patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

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

Alternative Care: With the concurrence of the primary Physician within the specialty of the service, the Participant and the Plan Administrator, Case Management may recommend alternative care or treatment that may either reduce the costs incurred by the Plan or improve the benefits realized by the Participant. The Plan Administrator reserves the right to approve payment of benefits under the Plan on a case by case basis, for alternative treatment or services received by a Participant that would otherwise not be covered under the Plan or for treatments or services provided by an alternative care facility.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

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

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

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

PRESCRIPTION DRUG BENEFITS

This Plan includes a prescription drug formulary. Contact the Pharmacy Benefits Manager (PBM) listed on page 3 for further information regarding this benefit and to see if a specific drug is covered under this plan. Not all prescription drugs are covered. The formulary is subject to change.

	NETWORK (IN-NETWORK) PROVIDERS	NON-NETWORK (OUT-OF-NETWORK) PROVIDERS
Out-of-pocket Annual (Plan Year) Maximum		
Per Plan Participant Per Family Unit	\$ 800 \$1,200 The Out-of-pocket Annual Maximum for the medical and prescription drug plans are separate. See Summary of Medical Benefits for Medical Plan Out-of-pocket Annual Maximum.	N/A

Summary of Prescription Benefits		
Tier	Retail	Mail Order
1-Covered generics and some lower cost brand products	\$10/30-day supply	\$20/90-day supply
2-Preferred brand products	\$25/30-day supply	\$50/90-day supply
3-Non-preferred brand products	\$50/30-day supply	\$100/90-day supply
4-Specialty drugs Obtain through Specialty Pharmacy	\$75/30-day supply 30-day supply maximum	
Affordable Care Act (ACA) coverage	As required by the ACA, specified prescription and OTC products, including certain contraception, smoking cessation and breast cancer prevention medications, are covered at no charge from a network pharmacy.	
Over the counter (OTC) medication coverage	Covered OTC products must be obtained from a network pharmacy with presentation of a written prescription at time of purchase.	
Brand Name Drugs where Generic is available	Participant pays higher copayment plus the difference in cost between the higher and lower cost drug. The difference in cost does not count towards the Annual Out-of-pocket Maximum.	

COPAYMENTS

The prescription Copayment amount is applied to each covered retail, mail order or specialty pharmacy drug charge. Prescription drug Copayments accumulate towards the prescription

drug out-of-pocket maximum. It is not a Covered Charge under the medical plan and is not applicable to the medical plan Copayment maximum.

Retail

A single retail pharmacy purchase of a covered drug is limited to a 90-day supply. A separate Copayment, as listed in the Summary of Prescription Benefits, will be applied to each 30-day supply, resulting in a maximum of three 30-day Copays per retail purchase.

Mail Order

A single mail order pharmacy purchase of a covered drug is limited to a 90-day supply. A separate Copayment, as listed in the Summary of Prescription Benefits, will be applied to each 90-day supply, resulting in a maximum of one 90-day Copay per mail order purchase.

COVERED PRESCRIPTION DRUGS

- (1) All drugs which may be dispensed upon written prescription by a Physician as regulated either by federal or state law, but excludes any drugs stated as not covered under this Plan.
- (2) Compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- (3) Insulin and other diabetic supplies when prescribed by a Physician.
- (4) Injectables (may be subject to prior authorization).
- (5) Infertility drugs limited to \$250 maximum per Plan year.

COVERED OVER THE COUNTER (OTC) DRUGS

The Plan covers certain products, such as tobacco use cessation medications and contraceptives which may be purchased OTC.

While these medications may legally be dispensed without a written prescription, in order to receive the appropriate Copayment, the covered Participant must present a written prescription for the specific OTC medication to the participating retail pharmacy or mail order pharmacy at the time of purchase.

Covered OTC medications are not covered if purchased at a non-participating Pharmacy or if written prescription is not presented at time of purchase.

For additional information contact the Pharmacy Benefits Manager listed on page 3.

COVERED AFFORDABLE CARE ACT (ACA) DRUGS

In compliance with the ACA, the Plan covers certain preventive medications at no Copayment to the Plan Participant when a prescription is presented at time of purchase at an in-network pharmacy. Categories of coverage include breast cancer prevention, heart attack prevention, smoking cessation and select vitamins and minerals, specific to age and gender requirements, and per the Affordable Care Act (ACA) guidelines. This list is subject to change as ACA guidelines are updated or modified.

For additional information contact the Pharmacy Benefits Manager listed on page 3.

MAIL ORDER DRUG BENEFIT OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for contraception, heart disease, high blood pressure, asthma, etc.).

How to Order a Prescription by Mail

- (1) Obtain a mail order form from the Mail Order Pharmacy. (See contact information on page 3.)
- (2) Complete and submit form and new prescription order to Mail Order Pharmacy.
- (3) Include Copayment as indicated on form.

SPECIALTY DRUGS

Selected oral, injectable, infused or inhaled specialty drugs, excluding insulin, must be purchased through a designated Specialty Pharmacy. Upon first fill of one of these drugs through a retail pharmacy, the retail pharmacy will receive a message "Next fill required at (Specialty Pharmacy)" which should be passed along to the participant.

After the initial fill, the Plan does not cover purchase of the drug from any retail pharmacy or the mail order pharmacy.

Specialty drugs have a 30-day supply maximum per fill. All applicable Copayments and Plan provisions will apply.

For additional information about this benefit, contact the Specialty Pharmacy listed on page 3.

LIMITS TO THE PRESCRIPTION DRUG BENEFIT

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

- (1) Refills only up to the number of times specified by a Physician.
- (2) Refills up to one year from the date of order by a Physician.
- (3) Each prescription or refill may be obtained in the quantity prescribed by the Physician but may not exceed a 90-day supply.
- (4) Specialty Drugs are limited to a 30-day supply maximum.

REQUIREMENTS and PROCESSES

Requirements and processes, including but not limited to prior authorization, quantity limits, and step therapy may be included in this program.

Plan Participant, Provider or Pharmacy may contact the PBM for information regarding requirements and processes.

HOW TO FILE A CLAIM (NON-PARTICIPATING PHARMACY)

If a drug is purchased from a non-participating Pharmacy or a participating Pharmacy when the Plan Participant's ID card is not used, the amount reimbursable to the participant from the Prescription Drug Plan will be the amount allowable by the Prescription Drug Plan less the Copayment. The Plan Participant's total out-of-pocket cost may likely be greater than the Copayment at a Network Pharmacy and does not count towards the Plan Annual Out-of-pocket prescription drug plan maximum.

In order to receive payment for such a claim,

- (1) The participant must pay the full price of the drug to the Pharmacy or Physician.
- (2) The participant then submits a completed claim form to the Pharmacy Benefits Manager identified in your Plan Contact Information page 3 for reimbursement.
- (3) Claims must be filed within 365 days of the date of purchase.

Claim forms for prescriptions purchased at non-participating pharmacies or a Physician's office may be obtained directly from the Pharmacy Benefits Manager identified on the Plan Contact Information, page 3.

EXPENSES NOT COVERED

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

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Blood or blood plasma.**
- (3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (4) **Contraceptive devices.** Including, but not limited to, IUDs and diaphragms.
- (5) **Devices.** Devices of any type, even though such devices may require a prescription. These include, but are not limited to, therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- (6) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.
- (7) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Plan Participant.
- (8) **FDA.** Any drug not approved by the Food and Drug Administration.
- (9) **Growth hormones.**
- (10) **Immunization.** Immunization agents or biological sera.
- (11) **Inpatient medication.** A drug or medicine that is to be taken by the Plan Participant, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
- (12) **Investigational.** A drug or medicine that is limited by federal law to investigational use even though a charge is made to the Plan Participant.
- (13) **Medical exclusions.** A charge for medication for a condition not covered by the Medical Plan.
- (14) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- (15) **Non-legend or off-label use of drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses unless prior authorization is obtained. Prior authorization guidelines will include but are not limited to failure, contraindication or intolerance of drug(s) that are FDA-approved for diagnosis.
- (16) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or Over the Counter (OTC) medications described on page 48.
- (17) **Plan Member prescribed drugs.** Any drug prescribed for a Plan Participant by a Physician who is an active Member of this Plan at the time the prescription is written and/or filled.

- (18) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.
- (19) **Sexual dysfunction agents.**
- (20) **Surgical Supplies.**
- (21) **Travel.** A charge for Prescription Drugs for the purpose of foreign travel.
- (22) **Vitamins,** dietary supplements, or vitamin supplements except for prenatal vitamins and as required by law.
- (23) **Weight Loss Medications.** A charge for Weight Loss Medications.

DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a Plan Participant while covered under this Plan.

Deductible, per Plan Year	
Individual	\$50
Per Family Unit	\$100
The Deductible applies to these Classes of Service: Class B Services – Basic Class C Services – Major Class D Services – Orthodontia	
Percentages Payable	Benefits are Subject to Usual, Customary and Reasonable Allowance
Class A Services – Preventive	100%
Class B Services – Basic	80%
Class C Services – Major	50%
Class D Services – Orthodontia	50%
Maximum Benefit Amount	
Maximum Dental Benefit	\$2,000 per person per Plan Year
Occlusal guards for bruxism	\$ 500 per person per Lifetime
Class D-Orthodontia	\$2,000 per person per Lifetime

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Plan Year, a Plan Participant must meet the Deductible shown in the Summary of Dental Benefits.

Family Unit Limit. When the dollar amount shown in the Summary of Dental Benefits has been incurred by members of a Family Unit toward their Plan Year Deductibles, the Deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Plan Year benefits will be paid for the dental charges in excess of the Deductible amount. Payment will be made at the rate shown under Dental Percentage Payable in the Summary of Dental Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The maximum dental benefit amounts are shown in the Summary of Dental Benefits.

CHOICE OF DENTIST

A participant may obtain care from a provider participating in the Aetna Dental Access ®/Aetna Dental Administrators network or any licensed Dentist When care is provided by Dentist who participates in Aetna’s dental network, participants can save money on out-of-pocket expenses and the Dentist will file the claim.

DENTAL CHARGES

Dental charges are based on the network status of the provider on the date of service for necessary care, appliances or other dental material listed as a covered dental service.

Network Provider

-Negotiated rate for covered service.

Non-Network Provider

-Usual, Customary and Reasonable (UCR) charges for covered service.

DETERMINATION OF INCURRED DATE

- For an appliance, or modification of an appliance - on the date the impression is taken.
- For a crown, bridge or gold restoration - on the date the tooth is prepared.
- For root canal therapy - on the date the pulp chamber is opened.
- For all other services - on the date the service is received.

PREDETERMINATION OF BENEFITS

If anticipated charges for any one course of treatment are expected to exceed \$300, the attending Dentist may submit a plan of treatment (prepared on a predetermination of benefits form) to be approved by the Claims Administrator prior to such expense being incurred. A predetermination of benefits form is not necessary if emergency care is required.

Predetermination of benefits permits the review of the proposed treatment in advance and allows for resolution of any questions before, rather than after, the work has been done. Additionally, the participant and the Dentist will know in advance what is covered and what the estimated benefits are, assuming the individual remains covered.

The Dentist should send the treatment plan to the CU GME Health/Dental Plan c/o the Claims Administrator at the address or fax number listed on page 2.

The Claims Administrator will notify the Dentist and the Member of the estimated benefits payable under the Plan.

COVERED DENTAL SERVICES

Class A Services:

Preventive and Diagnostic Dental Procedures

- (1) Routine oral exams. Limit of two per Plan Participant each Plan Year.
- (2) Routine prophylaxis. Limit of two per Plan Participant each Plan Year.
- (3) Two bitewing x-ray series every Plan Year.
- (4) One full mouth x-ray or complete x-ray series every three years.
- (5) One fluoride treatment for covered Dependent children under age 18 each Plan Year.
- (6) Sealants on the occlusal surface of a permanent posterior tooth for Dependent children under age 15, once per tooth in any four years.

**Class B Services:
Basic Dental Procedures**

- (1) Dental x-rays not included in Class A.
- (2) Consultations and examinations by a Dentist, other than for routine or orthodontic purposes.
- (3) Denture repair.
- (4) Emergency palliative treatment for pain.
- (5) Endodontics (root canals).
- (6) Extractions. This service includes local anesthesia and routine post-operative care.
- (7) Fillings, other than gold.
- (8) General anesthetics, upon demonstration of Medical Necessity.
- (9) Interproximal discing.
- (10) Nightguards for bruxism subject to the maximum payment in the Summary of Dental Benefits.
- (11) Oral surgery.
- (12) Pathology.
- (13) Periodontics (gum treatments).
- (14) Preventive resin restoration – permanent tooth.
- (15) Space maintainers.

**Class C Services:
Major Dental Procedures**

- (1) Bridgework (fixed/initial placement) to replace one or more natural teeth.
- (2) Clasp or rest addition to existing partial removable dentures.
- (3) Crowns (initial placement).
- (4) Denture, initial missing teeth.
- (5) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold upon demonstration of Medical Necessity.
- (6) Implants, when Medically Necessary.
- (7) Precision attachments for removable dentures.
- (8) Rebasings or relining of removable dentures.
- (9) Recementing bridges, crowns or inlays.
- (10) Repair of crowns, bridgework and removable dentures.
- (11) Replacing a crown or an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if the existing crown, denture or bridgework was installed at least five years prior to replacement and cannot currently be made serviceable.

Class D Services:

Orthodontic Treatment and Appliances

This coverage applies to orthodontic treatment (a program to straighten teeth) for Members and Dependents who are covered under the Dental Plan on the date treatment commences.

Eligible charges are those made to the participant for an Orthodontic procedure that is in an orthodontic treatment plan which has been determined to be necessary for proper function and is not cosmetic. Predetermination is recommended prior to commencement of treatment.

The claim will be paid beginning when the orthodontic appliances are first inserted, and as billed thereafter for the duration of the treatment plan, as long as the patient remains covered under this Plan or until the Maximum Benefit Amount is reached.

Charges for a procedure for which an active appliance was installed before the patient was covered by this Plan are not covered.

DENTAL EXCLUSIONS

A charge for the following is not covered:

- (1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.
- (2) **Cosmetic Dentistry.** Services or supplies which are primarily cosmetic, including but not limited to, hypoplasia, fluorosis, discoloration of teeth or deformed teeth. Veneers, pontics and facings or veneers placed on crowns or bridge units for teeth after the first molar will always be considered cosmetic.
- (3) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
- (4) **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.
- (5) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.
- (6) **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.
- (7) **Missed or cancelled appointments.** Charges for broken, cancelled or missed dental appointments.
- (8) **Missing Teeth.** A denture or fixed bridge involving replacement of teeth missing before the individual was covered, unless it also replaces a tooth that is extracted while covered, and such tooth was not an abutment for a denture or fixed bridge installed during the preceding (5) years.
- (9) **No listing.** Services which are not included in the list of covered dental services.
- (10) **Orthodontia.** Charges for a procedure for which an active appliance was installed before the patient was covered by this Plan are not covered.
- (11) **Orthognathic surgery.** Surgery to correct malpositions in the bones of the jaw.
- (12) **Personalization.** Personalization of dentures.
- (13) **Pre-Coverage.** An appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or gold restoration for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered.

- (14) **Replacement.** Replacement of lost or stolen appliances.
- (15) **Splinting.** Crowns, fillings, restorations or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.
- (16) **Temporomandibular Joint Dysfunction (TMJ) Jaw Joint.** Services and supplies for pain or treatment related to the misalignment or discomfort of the Temporomandibular Joint (jaw hinge) including splinting services, supplies, and appliances.

DEFINED TERMS

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

Adverse Benefit Determination means any of the following: a denial, reduction, rescission, or termination of a claim for benefits, or a failure to provide or make payment for such a claim (in whole or in part) including determinations of a Claimant's eligibility, the application of any review under the Pre-certification & Utilization Review Program, and determinations that an item or service is Experimental/investigational or not Medically Necessary or appropriate.

Affiliated Hospital is any Hospital which is affiliated with the University of Colorado School of Medicine for funding, training, medical instruction, determination of stipend or any other affiliated or integrated medical instruction program.

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

Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD). As defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM).

Authorized Representative, if the Claimant chooses, may be designated by the Claimant in a written authorization provided to the Pre-Certification & Utilization Review Administrator for Pre-certification Requests, or the Claims Administrator for Post-Service Claims. The authorization must clearly indicate the nature and extent of the authorization. The Provider of services may act as an Authorized Representative with written authorization. When an Urgent Care Claim is involved, a health care professional with knowledge of the medical condition will be permitted to act as a Claimant's authorized representative without a prior written authorization.

Behavioral Health services, as used in this document, are the diagnosis, treatment and rehabilitation of mental and substance abuse conditions.

Benefit Determination is the Claims Administrator's (for post-service claims) or the Pre-certification & Utilization Review Administrator's (for Pre-certification Requests and Medical Necessity review) decision regarding the acceptance or denial of a claim for benefits under the Plan.

Bereavement Period is the six month period following the death of a member of the Plan Participant's family to include only Spouse, Civil Union Partner, Domestic Partner, son, daughter, sibling or parent of the Participant or Participant's Spouse, Civil Union Partner or Domestic Partner.

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

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

Brand Name means a trade name medication.

Claimant is any Plan Participant making a claim for benefits. Claimants may file claims themselves or may act through an Authorized Representative.

Claims Administrator is the persons or organization designated by the CU GME Health Benefits Plan responsible for the administration and processing of claims in accordance with the Plan Document.

Close Relative means a person in participant's immediate family to include only the Spouse, Civil Union Partner, Domestic Partner, son, daughter, parent or sibling of the Plan Participant or of his or her Spouse, Civil Union Partner or Domestic Partner.

Coinsurance means an arrangement where the participant pays a percentage of the Eligible Expense.

Concurrent Care Decision is a decision by the Pre-Certification & Utilization Review Administrator regarding coverage of an ongoing course of treatment that has been approved in advance by the Pre-Certification & Utilization Review Administrator.

Continuous Confinement means an uninterrupted confinement at an inpatient facility. Confinements at two or more different facilities will be considered continuous if the patient is transferred directly from one facility to another. A Continuous Confinement begins on the initial admission date and ends on the date the patient is discharged to home or another outpatient setting. Leave days for confinements related to treatment of Mental Health and Substance Abuse do not constitute an interruption of the confinement.

Copayment/Copay means the amount of money paid each time a particular service is used. Typically, some services have Copayments and others do not.

Cosmetic Dentistry means dentally unnecessary procedures.

Cosmetic Procedure/Surgery means a procedure performed solely for the improvement of a Plan Participant'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 this Plan.

Covered Charge. See Eligible Expense.

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

Deductible means the amount of money that is paid once a Plan Year per Plan Participant. Typically, there is one Deductible amount per Plan Year and it must be paid before any money is paid by the Plan for any covered services. Each July 1st, a new Deductible amount is required.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Durable Medical Equipment (DME) Equipment prescribed by the attending Physician for a covered condition which meets all of the following requirements:

- (1) It is Medically Necessary;
- (2) It can withstand repeated use;
- (3) It is not considered deluxe equipment, such as motor-driven chairs or beds, when standard equipment is adequate;
- (4) It is primarily and customarily used to serve a medical purpose (modifications to the home such as air cleaners and humidifiers do not qualify as DME);
- (5) It is not disposable;

- (6) It is not useful in the absence of an Illness or Injury;
- (7) It would have been covered if provided in a Hospital;
- (8) It is appropriate for use in the home; and
- (9) It is not used for comfort, convenience or personal hygiene.

Effective Date is the date a Member or dependent becomes eligible to receive Plan benefits.

Eligible Expense means the usual, customary and reasonable charges for Medically Necessary services and supplies incurred by a participant covered under the Plan. Furthermore, "Eligible Expense" means only those services or supplies which are ordered by a Provider (other than a Close Relative or Resident) operating within the scope of his/her license as recognized by the state in which treatment is received, which are provided for in the context of the Plan, and which are not considered Experimental or Investigational.

Emergency Admission/Medical Emergency occurs if emergency services are necessary to screen and stabilize participants in cases where a prudent layperson, acting reasonably, believes that an emergency medical condition exists.

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered except for services or items covered in conjunction with Clinical Trials as required by law.

The Plan Administrator must make an independent evaluation of the Experimental/ non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The Plan Administrator will be guided by the following principles:

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

Reliable Evidence shall mean only published reports and articles in the medical and scientific literature generally considered to be authorized by the appropriate national professional community; the written protocol or protocols used by the

treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

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

Family Unit is the covered Member and the family members who are covered as Dependents under the Plan.

Foot Orthosis/Orthotic is an in-shoe medical device that is used to brace, support, or protect the foot or a part of the foot.

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

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

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

Home Health Care Plan must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days, states the diagnosis, certifies that the Home Health Care is in place of Hospital confinement, and specifies the type and extent of Home Health Care required for the treatment of the patient.

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

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

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

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

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

Hospital is an institution which is engaged primarily in providing medical care and treatment of ill and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of ill and injured persons by or under the supervision of a staff

of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

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

A facility for treatment of mental health or Substance Abuse which is state licensed as a Hospital or a facility approved to furnish services for the care and treatment of alcoholism, chemical dependency or mental, psychoneurotic and personality disorders by the appropriate state agency.

For purposes of this Plan, the definition of Hospital excludes a facility for convalescence, nursing, rest, or the aged; or furnishes domiciliary or Custodial Care, including training in daily living routines; or provides educational or rehabilitative care.

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

Individual Contract Date is the start date listed on the training agreement between the Intern, Resident or Fellow and the University of Colorado School of Medicine and Affiliated Hospitals.

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury to the body caused by unexpected external means. Any loss which contributed to or is caused by a physical weakness, such as a hernia, will be considered a loss under the definition of Illness, and not a loss resulting from an Injury.

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

Kindergarten Age means a child who is age-eligible to access the kindergarten program provided by the local school district.

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

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

Massage Therapy is services provided by a massage therapist, including rubbing and kneading areas of the body, usually using the hands, to relieve muscle spasm and other symptoms.

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

Medically Necessary care and treatment is recommended or approved by a Physician or Dentist. Treatments must meet certain guidelines to be deemed Medically Necessary. Among other things, the Plan Administrator may determine if such treatments are:

- (1) Based on documented and peer-reviewed literature, or contained in reports and guidelines published by nationally recognized health care organizations;
- (2) Based on significant data from controlled clinical trials which shows the treatment is safe and effective;
- (3) Approved by specialists in the relevant field;

- (4) The most appropriate level of services which can be safely provided given the patient's health status;
- (5) Likely to produce a significant, positive outcome; and
- (6) No more costly than any covered alternative service or supply which meets the above tests.

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

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

Member is an Intern (individuals in first year of training in a graduate medical education program), Resident (individuals in training in a graduate medical education program), or Fellow (residents in training in a designated subspecialty GME program) of the University of Colorado School of Medicine and Affiliated Hospitals, or designated residents in a dentistry or pharmacy residency.

Mental Health Condition means any disease or condition, regardless of whether the cause is organic, that is classified as a mental disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which:

- (1) The pressure of excess weight causes physical trauma; or
- (2) Where pulmonary and circulatory insufficiencies are present; or
- (3) Where complications related to the treatment of conditions such as arteriosclerosis, diabetes or coronary disease, exist; and
- (4) The body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Plan Participant.

Network Provider (In-network Provider, Preferred Provider Organization [PPO] Provider or, Dental Administrator network) means a legally licensed health care Provider which provides services and supplies within the scope of his/her license, and which has entered into a contract with the Preferred Provider Organization.

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

Non-network Provider (Out-of-network Provider) means a legally licensed health care Provider which provides services and supplies within the scope of its license, but which has NOT entered into a contract with the Preferred Provider Organization or Dental Administrator network.

Over the Counter (OTC) drugs means medications which may be purchased without a written prescription.

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

Partial Hospitalization/Intensive Outpatient Care is an outpatient program specifically designed for the diagnosis or active treatment of Mental Health or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's

functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission and shall be licensed to provide Partial Hospitalization services/Intensive Outpatient Care, if required, by the state in which the facility is providing these services. Partial Hospitalization Treatment provides care or services for at least four (4) hours a day, but less than seven and one half (7 ½) hours per day; Intensive Outpatient Care provides care or services for at least seven and one half (7-½) hours per day, up to twelve (12) hours per day.

Pervasive Developmental Disorder (PDD) is characterized by impaired development in social function, communication and behavior. Impairment in social interaction, problems with verbal and nonverbal communication, and unusually or severely limited activities and interests are frequently included. For purposes of this Plan, PDD will be defined as in the current DSM version. Examples of PDD include Asperger's Disorder, Autism, childhood disintegrative disorder, Rett's disorder and unspecified pervasive developmental disorder.

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

Physician/Provider is any duly licensed individual, other than a Hospital Intern or Resident, employed by any health care facility, who is legally entitled to practice medicine in all its branches under the laws of Colorado, or under the laws of the state or jurisdiction where the services are rendered, and who customarily bills patients for his or her services. In-network, licensed midwives rendering services at an in-network facility are Providers for this Plan.

Mental Health Provider shall include:

- a duly licensed Physician, Clinical Psychologist (Ph.D., Ed.D, Psy.d),
- Licensed Clinical Social worker (LCSW),
- Clinical Nurse Specialist in psychiatric nursing, or
- Other duly licensed individual as described above.

Also, Physician shall mean a person other than a Close Relative of the person receiving medical treatment and specifically excludes CU GME Plan Members from treatment of other Plan Participants.

Placement for Adoption means assumption and retention by the Member of a legal obligation for primary support of a child in anticipation of adoption of that child.

Plan means the plan provided by the University of Colorado School of Medicine and Affiliated Hospitals for the eligible Interns, Residents, and Fellows and residents in a dentistry or pharmacy residency training program designated as eligible by the training program and Plan Administrator. This Plan is the entire document between the parties, and is the governing document by which all disputes will be settled regarding the Plan.

Plan Administrator is the Office of Graduate Medical Education.

Plan Participant is any Member or Dependent who is covered under this Plan.

Plan Sponsor is Regents of The University of Colorado.

Plan Year is the 12-month period beginning on July 1 of any year through June 30th of the following year.

Post-Service Claim is any claim for a benefit under the Plan related to care or treatment that the Plan Participant has already received.

Pre-Certification Request (Pre-Service Claim) is a request for approval that the Plan requires the Participant to obtain before certain medical care or treatment is received in order to receive benefits for that care or treatment under the Plan. Pre-certification requests are submitted to the

Pre-Certification & Utilization Review Administrator.

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

Prescription Drug means drugs or medications which require a Physician's written prescription for purchase. All Prescription Drugs and medicines must be listed in the United States Pharmacopoeia, the National Formulary, or the Homeopathic Pharmacopoeia, and must be evaluated as "probably effective" in the current edition of the American Medical Association's Drug Evaluations. All Prescription Drugs and medicines must be approved by the Food and Drug Administration.

Protected Health Information (PHI) Protected Health Information means any health information, whether oral or recorded in any form or medium, that reasonably can be used to identify the individual, and:

- (1) Is created or received by a health care Provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
- (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual, or the past, present, or future payment for the provisions of health care to an individual.

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

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

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

Sound Natural Teeth are teeth that:

- (1) are free of active or chronic clinical decay; and,
- (2) have at least 50% bone support; and,
- (3) are functional in the arch; and,
- (4) have not been excessively weakened by multiple dental procedures; or,
- (5) have been treated for one or more of the conditions referenced in 1-4 above, and as a result of such treatment have been restored to normal function.

Specialty Pharmacy means a licensed pharmacy where certain oral, injectable, infused or inhaled specialty prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

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

Temporomandibular Joint (TMJ) syndrome is a disorder of the temporomandibular joint(s), including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular Joint.

Total Disability for a Member is the inability to perform each of the main duties of his or her training program with the University of Colorado School of Medicine. For a dependent, Total Disability is the inability to perform the normal activities of a healthy person of the same age and sex.

Urgent Care Claim is a subset of Pre-Certification Request (pre-service claim) and is a claim for medical care or treatment which, if subject to the time periods for making non-urgent care determinations either (a) could seriously jeopardize the Claimant's life, health or ability to regain maximum function or (b) would, in the opinion of a physician with knowledge of the Claimant's medical condition, subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Any claim that a physician with knowledge of the Claimant's medical condition determines is an Urgent Care Claim as described herein shall be treated as an Urgent Care Claim under the Plan.

Urgent Care Facility is a facility which provides Urgent Care Services and meets all state requirements, which may include licensing or functional requirements, such as extended hours and services, beyond the scope of routine physician office care.

Urgent Care Services are medical, surgical, hospital and related health care services and testing performed at an Urgent Care Facility which are not emergency services, but which are determined in accordance with generally accepted medical standards to have been necessary to treat a condition requiring prompt medical attention.

Usual, Customary and Reasonable expenses are charges made by a Hospital, Physician or other Provider as are normally made in the community and surrounding communities in which the services are rendered for similar services provided under similar conditions to persons of like circumstances. The basis for determination of reasonable and customary charges for this plan will be reviewed periodically by the Plan Administrator.

For purposes of this Plan, the basis for determination of Usual, Customary and Reasonable (UCR) charges is:

- (1) For Hospital Expenses - for room and board, the Hospital's semi-private room rate and for ancillary services/supplies, the Hospital's normal charge.
- (2) For Medical and Outpatient Diagnostic X-ray and Lab Expenses - Medical and Diagnostic X-ray and Lab Expenses will be allowed up to the 90th percentile as determined by fee survey data.
- (3) For Surgical Benefits - Surgical benefits provided under the Major Medical Expense Plan will be allowed up to the 90th percentile as determined by fee survey data.
- (4) For Anesthesia - Anesthesia benefits will be allowed up to the 90th percentile as determined by the fee survey data guidelines.
- (5) Multiple Surgeries – Current Medicare guidelines.

- (6)** For All Dental Expenses - benefits will be allowed up to the 90th percentile as determined by fee survey data.

The Plan will reimburse the actual charge billed if it is less than the Usual, Customary and Reasonable (UCR) Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual, Customary and Reasonable (UCR).

HOW TO FILE A POST-SERVICE CLAIM

The following section contains procedures and requirements for submission of post-service claims. For information related to Pre-certification Request/Pre-service Claim procedures and requirements, see page 42.

WHEN CLAIMS SHOULD BE SUBMITTED

Submit claims for medical and dental services to the Claims Administrator at the address listed on page 2. Claims should be submitted as soon as possible but must be received by the Claims Administrator within one year from the date of the expense.

Oral or written communications with the Claims Administrator regarding a Plan Participant's eligibility or coverage under the Plan are not claims for benefits, and the information provided by the Claims Administrator or other Plan representative in such communications does not constitute a certification of benefits or a guarantee that any particular claim will be paid. Benefits are determined at the time a formal claim for benefits is submitted according to the procedures outlined herein.

The Claims Administrator will follow administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated participants.

PPO Provider Claims

If the Participant obtains services from a PPO Provider, the Provider will file a claim on the Participant's behalf for those services.

Non-PPO Provider and Dental Provider Claims

A non-PPO Provider and Dentist may submit bills directly to the Claims Administrator on a standard Provider claim form, or the patient may submit the claim. The following information must be included on each claim:

Member name, Health Plan ID number and address

Patient name

Diagnosis - ICD code - (medical claims)

Fully itemized statement, including dates of service, place of service, appropriate procedure codes and charges for each service

Name, address and tax identification number of the Provider

Details of any accidental Injury, if applicable

Written instructions to pay Provider or Member (if this is missing, payment will be made to Member)

Missing information will be requested from the Provider and/or Member, and the claim will be delayed until that information is received.

How to File a Claim for Auto-Related Expenses

In addition to the above information required for claim submission:

- (1) Notify the Claims Administrator you have been involved in an auto accident.
- (2) Provide all of the following information to the Claims Administrator:
 - (a) Date and circumstances of the accident.
 - (b) A copy of the police report.

- (c) Name and address of your auto insurance agent.
- (d) A copy of the face sheet from your auto insurance policy, showing the coverages in effect at the time of the accident.
- (e) Auto insurance information of the party responsible for the accident (if you were not responsible) including responsible party's name, auto insurance address, policy number and contact information.
- (f) Details of the legal action (if any).

You may be provided a "Subrogation Agreement" that you must sign prior to the payment of any benefits by the CU GME Health Benefits Plan. (See Third Party Recovery Provision on page 81.) As stated in the Third Party Recovery Provision and in the Subrogation Agreement, the CU GME Plan requires that the Plan be reimbursed for payments made by the Plan for medical expenses related to the auto accident when any recovery is received from the auto insurance carrier or as a result of legal action.

Timing of Post-Service Claim Benefit Determinations

The Claims Administrator will notify the Claimant in writing of its benefit determination. This notice will be provided on the Explanation of Benefits (EOB) form which is sent from the Claims Administrator each time a claim is processed. Claimant should review the EOB form to determine how the claim was processed.

If a claim for benefits is denied in whole or in part, the EOB serves as the notice of Adverse Benefit Determination and will be provided within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Claims Administrator for up to an additional 15 days if the Claims Administrator both determines that such an extension is necessary due to matters beyond its control and provides written notice, prior to the end of the original 30 day period, of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If an extension is necessary due to failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and Claimant will be given at least 45 days from receipt of the notice to provide the specified information.

The applicable time period for the Benefit Determination begins when a claim is submitted in accordance with the reasonable procedures of the Plan, even if all the information necessary to make a Benefit Determination has not been submitted. However, if the time period for the Benefit Determination is extended due to failure to submit information necessary to decide a claim, the time period for making the Benefit Determination will be suspended from the date the notice of extension is sent until the earlier of: (a) the date on which response to the request for additional information is received, or (b) the date established by the Claims Administrator for the furnishing of the requested information (at least 45 days).

If the Adverse Benefit Determination was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are Experimental/Investigational, or not Medically Necessary or appropriate, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was neither consulted in connection with the Adverse Benefits Determination nor is a subordinate of any such individual.

If the claim is denied based on failure to submit information necessary to decide the claim, the Claims Administrator may, in its sole discretion, renew its consideration of the denied claim if

the additional information is received within 180 days after original receipt of the claim. In such circumstances, Claimant will be notified of the Claim Administrator's reconsideration and subsequent Benefit Determination.

Notification of Adverse Benefit Determination for Post-service Claims

If all or part of a claim is denied, the EOB will include the following information:

- (1)** Identification of the claim, including date of service, name of provider and claim amount (if applicable);
- (2)** The specific reason(s) for the Adverse Benefit Determination, including the denial codes and corresponding meaning, and the Plan's standard, if any, used in denying the claim;
- (3)** Reference to the specific Plan provisions on which the determination was based;
- (4)** A description of any additional information or material needed from Claimant to complete the claim and an explanation of why such material or information is necessary;
- (5)** If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request;
- (6)** If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge, upon request.
- (7)** The right to request the diagnosis and treatment codes (and their corresponding meaning);
- (8)** A description of the Plan's review or appeal procedures, including applicable time limits.

HOW TO FILE AN APPEAL

If a claim has been partially or fully denied, the participant is entitled to a further review of the claim. The participant or Authorized Representative may request a review and submit written comments, documents, records or other information to support the participant's position. A full and fair review will be conducted of all benefit appeals, impartially and independently from the individual(s) who made the initial Adverse Benefit Determination and without deference to the Adverse Claim Determination. The participant will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits.

Appeals for Post-service Claims

Appeals related to Post-service Claims are to be submitted to the Claims Administrator (see Plan Contact Information, page 2).

Initial Appeal

- (1) If a participant disagrees with the action taken or amount paid on any claim by, or on behalf of, the participant for benefits, the participant should first call the Claims Administrator for an explanation.
- (2) If the participant is not satisfied with the explanation given by the Claims Administrator, then the participant or Authorized Representative may send a written request to the Claims Administrator for reconsideration of the participant's claim.
 - (a) The request for reconsideration should be accompanied by written comments, documents, records and other information which support the participant's reason for appealing the Adverse Benefit Determination.
 - (b) To be eligible for review, all appeals must be submitted to the Claims Administrator in writing **no later than 180 calendar days** after the date of the first Adverse Benefit Determination (Explanation of Benefits) for the services for which review is requested.
- (3) The Claims Administrator will provide written notice of its decision no later than 30 calendar days after receipt of the appeal.

Second Level Appeal

- (1) If the participant has submitted a timely initial appeal and is not satisfied with the response, the initial appeal decision may be submitted for a second level appeal.
- (2) Written second level appeal should be submitted c/o the Claims Administrator and clearly be identified as a second level appeal. The appeal must be submitted **within 60 calendar days after the initial appeal denial from the Claims Administrator**. Contact the Claims Administrator or Office of Graduate Medical Education for further information regarding the procedure for a second level appeal.
- (3) When a second level appeal is to be reviewed by the Trust Committee, the review will occur at the next scheduled Trust Committee meeting following receipt of the written appeal. However, if the appeal is received in the 30 day period immediately preceding the date of the meeting, the appeal may not be reviewed until the date of the second meeting following the plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the Committee following the plan's receipt of the request for review. If such an extension of time for review is required because of special

circumstances, the Plan Administrator shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefits determination will be made prior to the commencement of the extension.

The Plan Administrator will provide written notice of the decision of the Trust Committee no later than 5 days following the date the benefit determination made.

If the participant did not submit a timely initial appeal, there is no right to file a second level appeal.

Notification of Post-service Appeal Decisions

The Claimant will receive notice of the appeal decision within the timeframes stated above. If it is determined that benefits are payable, action will be taken to reprocess the claim as soon as possible.

If the claim remains denied after appeal review, written notification of the denial shall include:

- (a) Identification of the claim, including date of service, name of provider, claim amount (if applicable);
- (b) The specific reason(s) for the denial, including reference to the Plan provisions upon which the denial was based, and the Plan's standard, if any, used in denying the claim;
- (c) A statement regarding the right, upon request and free of charge, to access and receive copies of documents, records and other information (other than medically or legally privileged documents) that are relevant to the claim including diagnosis and treatment codes (and their corresponding meaning);
- (d) If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request;
- (e) If the denied appeal was based on a Medical Necessity, Experimental/investigational or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to the participant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request; and
- (f) A statement describing any additional appeal procedure that may be available by the Plan, how to obtain information about such procedures and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA [3272]).

Appeals for Pre-certification Request, Pre-service Claims and Medical Necessity Review

To be eligible for review, all post service appeals must be submitted in accordance with the timeframes and processes listed above.

Urgent Care Claim Appeals

An Adverse Benefit Determination of an Urgent Care Claim may be appealed on an expedited basis, either orally or in writing by calling the Pre-certification & Utilization Review Administrator. All necessary information, including the response to the urgent care claim appeal may be transmitted between the Pre-certification & Utilization Review Administrator and Claimant by telephone, facsimile, or other available similarly expeditious method.

An Urgent Care Claim Appeal will be decided by the Pre-certification and Utilization Review Administrator as soon as possible, taking into account the medical emergencies, but not later than 72 hours after the appeal is received. A decision communicated orally will be followed-up in writing no later than 3 days after the oral notice.

Other Pre-certification Request/Pre-service Claim Appeals

(1) Services denied because the Medical Necessity Guidelines used by the Pre-Certification and Utilization Review Administrator are not met (non-urgent care claim related to care that has not yet been provided)

The appeal request should include as much information as possible in support of the appeal and *must* include contact information for the referring provider and provider of service. If additional information is required, the Claimant will be contacted.

(2) Services denied because Pre-certification was required but not obtained (post-service review)

The appeal request should include as much information as possible in support of the appeal and *must* include contact information for the referring provider and provider of service. If additional information is required, the Claimant or provider will be contacted.

(a) If Medical Necessity is confirmed and the services are otherwise covered by Plan provisions, the Pre-Certification & Utilization Review Administrator will notify the Claimant and Claims Administrator and the claim will be reprocessed. To determine the amount payable for the claim, the following will be deducted from the payment of Covered Expenses and will be the Participant's responsibility:

- (i)** A \$1,000 penalty for non-compliance with the Plan Pre-certification requirements; **AND**
- (ii)** All other patient responsibility amounts, including but not limited to Deductibles, Copayments, and Coinsurance.
- (iii)** The above payment determination is final for claims where pre-certification was required, not obtained, and Medical Necessity is confirmed upon appeal. No further appeal process is available in this situation.
- (iv)** This section is not applicable to the requirement for pre-certification of network non-availability. Pre-certification of network non-availability must occur before the service is rendered.

Appeals will be decided by the Pre-certification & Utilization Review Administrator within a reasonable period of time appropriate to the medical circumstances, but no later than 30 calendar days after the appeal is received. If the appeal is denied, the written Notification of appeal denial will include:

- (a)** Information suitable to identify the claim;

- (b) The specific reason(s) for the Adverse Benefit Determination, including the applicable Plan's standard, if any, used in denying the claim;
- (c) Or reference to the specific Plan provisions on which the Adverse Benefit Determination was based;
- (d) A statement regarding the right, upon request and free of charge, to access and receive copies of documents, records and other information that are relevant to the claim including diagnosis and treatment codes (and their corresponding meaning);
- (e) If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request;
- (f) If the denied appeal was based on a Medical Necessity, Experimental/investigational or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to the participant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request; and
- (g) A statement describing any additional appeal procedure offered by the Plan and the right to obtain information about such procedures.

External Review of Claims

In some instances, the Claimant or Authorized Representative may request further review by an independent review organization (IRO). This request for external review must be made, in writing, **within 4 months of the date** of notification of an Adverse Benefit Determination or final Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. This external review is mandatory, i.e., Claimant is required to undertake this external review before judicial review may be pursued.

Within five (5) business days following the date of receipt of the external review request, the Claims Administrator will complete a preliminary review of the request to determine whether:

- a. The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- b. The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the group health plan;
- c. The Claimant has exhausted the Plan's internal appeal process;
- d. The Claimant has provided all the information required to process an external review.

The Plan will notify the Claimant within one (1) business day of completion of its preliminary review if:

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

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

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

- a. The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.
- b. The assigned IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.
- c. Within five business days after the date of assignment of the IRO, the Claims Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination. Failure by the Claims Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claims Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to the Adverse Benefit Determination or final internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify the Claimant and the Plan.
- d. Upon receipt of any information submitted by the Claimant, the assigned IRO must within one business day forward the information to the Claims Administrator. Upon receipt of any such information, the Plan may reconsider its Adverse Benefit Determination or final internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Plan must not delay the external review. The external review terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or final internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to the Claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Plan.
- e. The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- i. The Claimant's medical records;
 - ii. The attending health care professional's recommendation;
 - iii. Reports from appropriate health care professionals and other documents submitted by the Plan, Claimant, or the Claimant's treating provider;
 - iv. The terms of the Claimant's plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
 - v. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - vi. Any applicable clinical review criteria developed and used by the plan, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
 - vii. The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available
- f. The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claimant and the Plan.
- g. The assigned IRO's decision notice will contain:
- i. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial);
 - ii. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - iii. The references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 - iv. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - v. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the Claimant;
 - vi. A statement that judicial review may be available to the Claimant; and
 - vii. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

If Claimant remains dissatisfied with the outcome of the external review, Claimant may choose to pursue legal review. This should not be started until the available internal and external appeal levels have been exhausted, or until 90 days have elapsed since request for appeal was filed if Claimant has not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. Any lawsuit must be filed in the State of Colorado and started within the applicable statute of limitations for the State of Colorado.

Expedited External Review of Claims

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

- a. a Claimant receives an Adverse Benefit Determination that involves a medical condition of the Claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the Claimant's ability to regain maximum function and the claimant has filed a request for an expedited appeal; or
- b. a Claimant receives a final internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

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

- a. The Claimant is or was covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
- b. The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the group health plan;
- c. The Claimant has exhausted the Plan's internal appeal process;
The Claimant has provided all the information and forms required to process an external review.

The Plan will notify the claimant within one (1) business day of completion of its preliminary review if:

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

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

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

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

COORDINATION OF BENEFITS

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

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

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

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

Note: Coordination of benefits does not apply to automobile insurance in Tort Auto Insurance States, including Colorado. Please refer to "Third Party Recovery Provision" on page 81 for applicable Plan provisions.

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

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

Penalties, including nonpayment of services, applied by the primary plan due to lack of compliance with Pre-certification or other requirements of the primary plan are not covered by this Plan.

In order for payment to be considered under this Plan as secondary payor, Plan Participant must follow all provisions of this Plan, for example, Pre-certification.

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

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

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

- (a)** The benefits of the plan which covers the person directly (that is, as a Member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
- (b)** The benefits of a benefit plan which covers a person as a Member who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Member. The benefits of a benefit plan which covers a person as a Dependent of a Member who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Member. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
- (c)** The benefits of a benefit plan which covers a person as a Member who is neither laid off nor retired or a Dependent of a Member who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
- (d)** When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
 - (i)** The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - (ii)** If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
 - (iii)** If the other plan does not have the rule described in (i) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- (e)** When a child's parents are divorced or legally separated, these rules will apply:
 - (i)** This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - (ii)** This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - (iii)** This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
 - (iv)** If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination

rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

- (v) For parents who were never married to each other, the rules apply as described above if paternity has been established.
- (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.
- (3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare would be the primary payer if the person had enrolled in Medicare, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under any of these parts.
- (4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
- (5) The Plan will pay primary to TRICARE and a State Child health plan to the extent required by federal law.

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

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

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

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

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

Exception to Medicaid. This Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Plan Participant under the Plan.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

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

The Plan Participant:

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

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

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to recover payment for medical or dental expenses from the Plan Participant. Also, the Plan's right to Subrogation still applies if the Recovery received by the Plan Participant is less than the claimed damage, and, as a result, the claimant is not made whole.

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

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

Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms:

"Plan Participant" means anyone covered under the Plan, including minor dependents.

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

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

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

"Third Party" means any Third Party including but not limited to another person or a business entity.

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

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Members and their families covered under The CU GME Health Benefits Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Members and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator and COBRA Continuation Administrator are listed in the Plan Contacts (page 2). Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Continuation Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA Continuation Coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Members and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active Plan Participants who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who Can Become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

- (1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Member, the Spouse, Civil Union Partner, or Domestic Partner of a covered Member, or a dependent child of a covered Member, Spouse, Civil Union Partner, or Domestic Partner. If, however, who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (2) Any child who is born to or placed for adoption with a Member during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (3) A Member's enrollment in any part of the Medicare program.
- (4) A dependent child's ceasing to satisfy the Plan's requirements for a dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the Member, covered spouse or other Qualified Beneficiary, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Plan, any substantial elimination of coverage under the Plan occurring within twelve (12) months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a Member, or the spouse, or a dependent child of the Member, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the CU GME Leave Policy does not constitute a Qualifying Event. A Qualifying Event will occur, however, if a Member does not return to training as specified in the Policy and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of the time specified in the leave policy and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the Member and family members will be entitled to COBRA continuation coverage even if they failed to pay the Member portion of premiums for coverage under the Plan during the leave.

What Factors Should be Considered when Determining to Elect COBRA Continuation Coverage?

You should take into account that a failure to continue your group health coverage will affect your rights under federal law. Also, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within thirty (30) days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the Procedure for Obtaining COBRA Continuation Coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the Election Period and How Long Must it Last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends sixty (60) days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the sixty (60) day period, all rights to elect COBRA continuation coverage are forfeited.

Is a Covered Member or Qualified Beneficiary Responsible for Informing the Plan Administrator of the Occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Plan Administrator will notify the COBRA Continuation Administrator of the Qualifying Event within thirty (30) days following the date coverage ends when the Qualifying Event is:

- (1) the end of training or reduction of hours in training,
- (2) death of the Member,
- (3) commencement of a proceeding in bankruptcy with respect to the Plan, or

- (4) enrollment of the Member in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Member and Spouse, loss of eligibility of a Civil Union Partner or Domestic Partner or a dependent child's loss of eligibility for coverage as a dependent child), you or someone on your behalf must notify the COBRA Continuation Administrator in writing within sixty (60) days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the COBRA Claims Administrator during the sixty (60) day notice period, any Spouse, Civil Union Partner, or Domestic Partner or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the COBRA Continuation Administrator.

NOTICE PROCEDURES: Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the COBRA Continuation Administrator listed in the Plan Contacts Section of this document.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- (1) the **name of the plan or plans** under which you lost or are losing coverage,
- (2) the **name and address of the Member** covered under the plan,
- (3) the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- (4) the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a divorce, legal separation, or loss of eligibility of a Civil Union Partner or Domestic Partner, your notice must include a copy of the divorce decree, the legal separation agreement, documentation of dissolution of Civil Union or Notice of Termination of Domestic Partnership.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the COBRA Continuation Administrator receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Members may elect COBRA continuation coverage for his or her Spouse, Civil Union Partner, or Domestic Partner and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children or other Qualified Beneficiary do not elect continuation coverage within the sixty (60) day election period described above, the right to elect continuation coverage will be lost.

Is a Waiver Before the End of the Election Period Effective to End a Qualified Beneficiary's Election Rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the COBRA Continuation Administrator.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When May a Qualified Beneficiary's COBRA Continuation Coverage be Terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (3) The date upon which the Plan ceases to provide any group health plan (including a successor plan) to any Member.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (a) (i) twenty-nine (29) months after the date of the Qualifying Event, or (ii) the first day of the month that is more than thirty (30) days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate the coverage of a Qualified Beneficiary on the same basis that the Plan terminates the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage or obtaining benefits under the Plan.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the Maximum Coverage Periods for COBRA Continuation Coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- (1) In the case of a Qualifying Event that is a termination of training or reduction of hours of training, the maximum coverage period ends eighteen (18) months after the Qualifying Event if there is not a disability extension and twenty-nine (29) months after the Qualifying Event if there is a disability extension.
- (2) In the case of a covered Member's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of training or reduction of hours of training, the maximum coverage period for Qualified Beneficiaries other than the covered Member ends on the later of:
 - (3) thirty-six (36) months after the date the covered Member becomes enrolled in the Medicare program; or
 - (4) eighteen (18) months (or twenty-nine (29) months, if there is a disability extension) after the date of the covered Member's termination of training or reduction of hours of training.
- (5) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Member during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (6) In the case of any other Qualifying Event than that described above, the maximum coverage period ends thirty-six (36) months after the Qualifying Event.

Under What Circumstances Can the Maximum Coverage Period be Expanded?

If a Qualifying Event that gives rise to an eighteen (18) month or twenty-nine (29) month maximum coverage period is followed, within that eighteen (18) or twenty-nine (29) month period, by a second Qualifying Event that gives rise to a thirty-six (36) months maximum coverage period, the original period is expanded to thirty-six (36) months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than thirty-six (36) months after the date of the first Qualifying Event. The COBRA Continuation Administrator must be notified of the second qualifying event within sixty (60) days of the second Qualifying Event. This notice must be sent to the COBRA Continuation Administrator in accordance with the procedures above.

How Does a Qualified Beneficiary Become Entitled to a Disability Extension?

A disability extension will be granted if an individual (whether or not the covered Member who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Member's training, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first sixty (60) days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the COBRA Continuation Administrator with notice of the disability determination on a date that is both within sixty (60) days after the date of the determination and before the end of the original eighteen (18) month maximum coverage. This notice should be sent to the COBRA Continuation Administrator in accordance with the procedures above.

Does the Plan Require Payment for COBRA Continuation Coverage?

For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan Allow Payment for COBRA Continuation Coverage to be Made in Monthly Installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for Payment for COBRA Continuation Coverage?

Timely Payment means a payment made no later than thirty (30) days after the first day of the coverage period. Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than forty-five (45) days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the COBRA Continuation Administrator.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is thirty (30) days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

Must a Qualified Beneficiary Be Given the Right to Enroll in a Conversion Health Plan at the End of the Maximum Coverage Period for COBRA Continuation Coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the one hundred eighty (180) day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan.

Is COBRA Continuation Coverage Available to Civil Union Partners, Domestic Partners and Children of Civil Union Partners and Domestic Partners?

A Civil Union Partner Domestic Partner, and children of a Civil Union Partner or Domestic Partner are treated as a Qualified Beneficiary. This gives the Civil Union Partner, Domestic Partner and their children the contractual rights outlined in this document but does not extend statutory provisions to the Civil Union Partner, Domestic Partner or their children.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or COBRA Continuation Administrator. For more information about your rights COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting this group health plan, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and

phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your COBRA Continuation Administrator Informed of Address Changes

In order to protect your family's rights, you should keep the COBRA Continuation Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Continuation Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Member and Dependent Coverage: The Member's funding source, via the Regents of The University of Colorado and contributions by the Members, except in approved instances, including but not limited to self-payment during an approved leave of absence, pays the entire premium of Member and Dependent coverage under this Plan.

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

Claims Administrator is Not a Fiduciary. A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

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

Overpayment. If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of overpayment to a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

On October 21, 1998, the federal government passed the Women's Health and Cancer Rights Act of 1998. One of the provisions of this act requires group health plans to notify health plan Members of their rights under this law.

Benefits Guaranteed by this Law

The provisions of this law require that group health plans that provide medical and surgical benefits in connection with a mastectomy **must** provide benefits for certain reconstructive surgery. This includes:

- Reconstruction of the breast on which a mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Protheses and physical complications of all stages of mastectomy, including lymphedemas.

The law also states that "the services will be considered in a manner determined in consultation with the attending Physician and the patient". In other words, you and your Physician will determine the most appropriate treatment for your individual situation.

Coverage of these services is subject to the terms and conditions of your health plan, including your Plan's normal Copayment, annual Deductibles and Coinsurance provisions.

If you have any questions regarding your benefits or rights under this act, call the Claims Administrator listed in the Plan Contact Information of this document.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PRIVACY AND SECURITY STANDARDS

This Plan provision is intended to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), and the implementing regulations thereunder, 45 C.F.R. Parts 160 and 164, (“Privacy Standards” AND “Security Standards”).

CU GME Health Benefits Plan incorporates the following policies with respect to the use and disclosure of Protected Health Information (“PHI”), as defined in the Privacy Standards. The CU GME Health Benefits Plan (“Plan”) will use PHI to the extent and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment payment for health care and health care operations, as follows:

Uses and Disclosures of PHI by the Plan.

- (1)** Payment for health care includes, but is not limited to, activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:
 - (a)** Determination of eligibility, coverage, and cost sharing amounts (for example, cost of a benefit, Plan maximums, and Copayments as determined for an individual’s claim);
 - (b)** Coordination of benefits;
 - (c)** Adjudication of health benefit claims (including appeals and other payment disputes);
 - (d)** Subrogation of health benefit claims;
 - (e)** Establishing participant contributions;
 - (f)** Risk adjusting amounts due based on enrollee health status and demographic characteristics;
 - (g)** Billing, collection activities and related health care data processing;
 - (h)** Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
 - (i)** Obtaining payment under a contract for reinsurance (including stop loss and excess of loss insurance);
 - (j)** Medical necessity review, or reviews of appropriateness of care or justification of charges;
 - (k)** Utilization review, including Pre-certification, preauthorization, concurrent review and retrospective review;
 - (l)** Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, SSN, payment history, account number, and name and address of the provider and/or health Plan), and
 - (m)** Reimbursement to the Plan.
- (2)** Health care operations include, but are not limited to, the following activities:
 - (a)** Quality assessment;

- (b) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;
 - (c) Rating Provider and Plan performance, including accreditation, certification, licensing or credentialing activities;
 - (d) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop loss insurance and excess of loss insurance);
 - (e) Conducting or arranging for medical review, legal services and auditing functions including fraud and abuse detection and compliance programs;
 - (f) Business planning and development, such as conducting cost management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of methods of payment or coverage policies,
 - (g) Business management and general administrative activities of the entity, including, but not limited to:
 - (i) Management activities relating to implementation of and compliance with the requirements of HIPAA's administrative simplification requirements;
 - (ii) Customer service, including the provision of data analysis for policyholders, Plan Sponsor, or other covered entity;
 - (iii) Resolution of internal grievances; and
 - (iv) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.
 - (h) Compliance with and preparation of all documents and reports as required by law.
- (3) The Plan, through its duly authorized representatives, agents and contractors, will use and disclose PHI consistent with the Plan Document and as permitted or required by applicable state and federal law, including but not limited to HIPAA and the Privacy Standards, and as permitted by authorization of the Plan Participant or beneficiary.
- (4) For purposes of this section, the Regents of the University of Colorado, a body corporate, is the Plan Sponsor. Upon receipt of PHI from the Plan or any duly authorized agent or representative thereof, the Plan Sponsor agrees to:
- (a) Not use or further disclose the information other than as permitted or required by the Plan Document or as required by law;
 - (b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
 - (c) Not use or disclose PHI for employment related actions and decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;

- (d) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- (e) Make PHI available to the individual in accordance with the access requirements of HIPAA;
- (f) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- (g) Make available the information required to provide an accounting of disclosures in accordance with HIPAA;
- (h) Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and
- (i) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purposes for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

Adequate Separation Between the Plan and Plan Sponsor

- (5) Adequate separation between the Plan Sponsor and the Plan exists. The Plan Sponsor does not participate in any manner with the function or administration of the Plan and has no access to or use of PHI associated with the Members of the Plan. Additionally, the Plan Sponsor has no involvement in or access to information related to the human resource functions performed by the Office of Graduate Medical Education for personnel who may also be Members of the Plan.

Safeguard of electronic Protected Health Information (ePHI)

- (6) The Plan has implemented reasonable and appropriate policies and procedures to ensure that its creation, receipt, maintenance, or transmission of electronic Protected Health Information ("ePHI") complies with the applicable administrative, physical and technical safeguards required for ePHI under the Security Standards 45 C.F.R. Part 164.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the CU stipend funding source and contributions by the Members. The Plan is not insured.

PLAN NAME

CU GME Health Benefits Plan

PLAN EFFECTIVE DATE: February 1, 1978

PLAN YEAR: July 1 - June 30th

PLAN SPONSOR

Regents of The University of Colorado
c/o Graduate Medical Education
C293
13001 E. 17th Place Room N4223
Aurora CO 80045

PLAN ADMINISTRATOR

Graduate Medical Education
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CLAIMS ADMINISTRATOR

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