Plan Document and Plan Summary
Health Plan PPO-2

Revised and Updated Effective August 1, 2021

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Introduction

This document is a description of the Poudre School District PPO-2 Health Plan (the Plan). Oral statements from employees of the Plan Sponsor or others are not binding, and the written terms of this Plan document will control in all matters. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an Eligible Employee and Dependents when the Eligible Employee and such Dependents satisfy the waiting period and all the eligibility requirements of the Plan.

The Employer fully intends to continue this Plan, but reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason. The authority to end the Plan lies with the Employer and shall be affected by a written resolution adopted by the Board of Education.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, maximums, Deductibles, Coinsurance, Copayments, Exclusions, Limitations, definitions, eligibility and the like.

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

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, 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.

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

The Employer is a governmental employer and is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Nothing in this document will be interpreted to imply that this Employer or this Plan is subject to the requirements of ERISA.

This document summarizes the Plan rights and benefits for Plan Participants and is divided into the following parts:

Eligibility, Funding, Effective Date, and Termination

Explains eligibility for coverage under the Plan, how the benefit is funded, and when the coverage takes effect and terminates.

Enrollment

Explains appropriate enrollment requirements including Open Enrollment, timely or late enrollment, and special enrollment.

Schedule of Benefits

Provides an outline of the Plan reimbursement formulas as well as payment Limits on certain services.

Benefit Descriptions

Explains when the benefit applies and the types of Covered Charges.

Medical Cost Management Services

Explains the methods used to curb unnecessary and excessive charges and outlines the pre-certification requirements for services.

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

Claim Provisions

Explains the rules for filing Claims and the Claim appeal process.

Plan Exclusions

Identifies services that are **not** covered.

Mental/Behavioral Health and Substance Abuse Schedule of Benefits

Explains when the benefit applies, the types of Covered Charges, and provides an outline of the Plan reimbursement formulas as well as payment Limits on certain services.

Coordination of Benefits

Shows the Plan payment order when a Plan Participant is covered under more than one plan.

Prescription Drug Benefits

Explains when the Pharmacy benefit applies and the types of Covered Charges.

Third Party Recovery Provision

Explains the Plan's right to recover payment of charges when a Plan Participant has a Claim against any responsible Third Party or Third Party insurance company because of Injuries or Illness.

COBRA Continuation Options

Explains when a Plan Participant's coverage under the Plan ceases and the continuation options which are available.

HIPAA Privacy Compliance

Explains the Plan's and Plan Participants' rights and responsibilities under the HIPAA Privacy rules.

Other Legal Notices

Explains the Plan's and Plan Participants' rights and responsibilities under certain acts as determined by the federal government.

Defined Terms

Defines those Plan terms that have a specific meaning.

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Eligibility, Funding, Effective Date and Termination Provisions

Eligibility and Funding

Eligible Classes of Employees

All Active Employees of the Employer.

Active Employee Requirement

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

Eligibility Requirements and Funding for Employee Coverage

An Employee is eligible for coverage under the PPO-2 Plan if the Employee is in an eligible class of Employees and meets the eligibility requirements outlined below. Assignments designated as temporary, substitute, or contract, assignments on the "S" salary schedule, or with variable working hours as defined by the District, do not count towards benefits eligibility. In addition, employees meeting the guidelines of a full-time employee as defined by the Affordable Care Act are eligible.

- An administrative Employee with a contract between 70% and 100% (5.60 to 8 hours per day);

  OR

  A licensed Employee with a contract between 70% and 100%;

  OR

  A classified Employee that is in an assignment that is normally scheduled for at least 1,041.55 hours in an Academic Year;

  OR

  An Employee with a combination of eligible assignments equal to one of the above.

Funding is derived from both the Employer and contributions made by the Covered Employee.

Eligible Classes of Dependents

The Plan Administrator may require proof of relationship documentation proving that the individual or individuals meet the specific definition of a Dependent under the Plan. A Dependent is any one of the following persons:

- A Covered Employee's spouse
  The term "Spouse" shall mean the person to whom the Covered Employee is legally married to under the laws of a state or nation. This includes common law marriages.

- A Covered Employee's domestic partner
  The term "Domestic Partner" shall mean a same gender or opposite gender individual who is at least eighteen years of age and who:
  - Is not married to any other person (nor can the Covered Employee be married to any other person);
  - Is not in a domestic partnership with another person;
  - Is not in a civil union with another person;
  - Is not related to the Covered Employee by blood to a degree of closeness that would prohibit legal marriage;
  - Is engaged in an exclusive committed relationship with the Covered Employee;
  - Currently shares a residence with the Covered Employee;
  - Is jointly responsible with the Covered Employee for living expenses

- A Covered Employee's partner in a civil union
  The term "Partner in a Civil Union" shall mean a person who has established a civil union relationship. A "Civil Union" means a relationship established between two eligible persons pursuant to state statutes that entitles them to receive benefits and protections and be subject to the responsibilities of spouses.

- A Covered Employee's children including children of a Spouse, Domestic Partner and a Partner in a Civil Union from birth to the limiting age of twenty-six (26) years.

  The term "children" shall include biological children, adopted children or children placed with a Covered Employee in anticipation of adoption or Foster Children. Stepchildren may also be included as long as a biological parent remains married to the Covered Employee and also resides in the Covered Employee's household.

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

If a Covered Employee is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents. The Plan Sponsor may require legal documentation proving legal guardianship.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan. To the extent required under Colorado Revised Statute Section 14-14-112 and to the extent the order meets the requirements of the Statute, the Plan will recognize medical child support orders.

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

After such two (2) year period, the Plan Sponsor may require subsequent proof not more than once each year. The Plan Sponsor reserves the right to have such Dependent examined by a Provider of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the Covered Employee's home, but who are not eligible as defined; the legally separated or divorced former spouse of the Employee; any person who is on active duty in any military service of any country; parents of the Employee; spouses of children covered under the Plan; children of children covered under the Plan unless they meet one of the definitions of Eligible Classes of Dependents as defined above, or any person who is covered under the Plan as an Active Employee.

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

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

Eligibility Requirements and Funding for Dependent Coverage

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

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

Funding for Dependent coverage is derived solely from contributions made by the Covered Employee.

Eligible Dependents enrolled in the Plan must be enrolled in the same plan as the Active Employee and cannot be enrolled if the Active Employee does not participate in one of the Poudre School District health plans.

Effective Date

Effective Date of Employee Coverage

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

- The eligibility requirement.
- The Active Employee requirement.
- The enrollment requirements of the Plan.

Effective Date of Dependent Coverage

Dependent coverage will take effect under this Plan on the day that the eligibility requirements are met; the Active Employee is covered under the Plan; and all enrollment requirements are met.

Termination of Coverage

When Employee Coverage Terminates

Coverage will terminate on the earliest of these dates (except in certain circumstances, a Covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to enroll, see the Notice of Right to COBRA Continuation Coverage section):

- The date the Plan is terminated.
- The last day of the calendar month in which the Covered Employee ceases to be in one of the eligible classes. This includes death or termination of active employment of the Covered Employee.
- In the case where the Employee fails to pay the premium, the last day of the month in which premiums were paid.
- In the case where an Employee elects to drop coverage during Open Enrollment, the last day of the Plan Year.

Continuation During Periods of Employer-Approved Leave of Absence or Layoff

A person may remain eligible for a limited time if the Covered Employee ceases to work due to leave of absence or layoff. This continuance will end as follows:

Based on the last day of the month in which the Covered Employee no longer receives pay with the District unless covered under FMLA, as noted below.

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

Continuation During Family and Medical Leave

Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor.

During any leave taken under the FMLA, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the Covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Plan Participants if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started and will be reinstated to the same extent that it was in force when that coverage terminated. For example, waiting periods will not be imposed unless they were in effect for the Plan Participants when Plan coverage terminated.

Rehiring a Terminated Employee

A Terminated Employee who is rehired will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements. However, if the Terminated Employee returns to work for the Employer within the same Plan Year, the Employee is not allowed to make new benefit elections for the remainder of the Plan Year, unless due to a Qualified Status Change.

Rehiring a Staffed-Out or Non-Renewed Employee

An Employee that is Non-Renewed or Staffed-Out of their current assignment that is rehired by the District by September 30 of the following Academic Year will maintain their original date of hire for eligibility purposes, but will be considered a new hire for enrollment in one of Poudre School District's health plans.

Employees on Military Leave

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Plan Participants covered under the Plan before leaving for military service.

- The maximum period of coverage for a person under such an election shall be the lesser of:
  - The eighteen (18) month period beginning on the date on which the person's absence begins; or
  - The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.

- A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for thirty (30) days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- An Exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an Exclusion or waiting period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

When Dependent Coverage Terminates

A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to enroll, see the Notice of Right to COBRA Continuation Coverage section):

- The date the Plan or Dependent coverage under the Plan is terminated.
- The date that the Employee's coverage under the Plan terminates for any reason including death.
- The date a covered spouse loses coverage due to loss of dependency status.
- On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan.
- The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- In the case of Totally Disabled Dependents, the date proof of the disability is requested, in the event the Covered Employee fails to submit proof of the disability or the Covered Employee refuses to allow the Plan to examine the Dependent.
- In the case where an Employee elects to drop Dependents during Open Enrollment, the last day of the Plan Year.

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Enrollment

Enrollment Requirements

An Eligible Employee must enroll for coverage and any voluntary Dependent coverage by completing the online enrollment process available through the Medical Benefits Claims Administrator's website within thirty-one (31) days of the effective date of coverage.

Enrollment in the Plan will be on a pre-tax basis unless the Employee requests a post-tax option within thirty-one (31) days of the effective date of coverage or during the annual Open Enrollment period. Pre-tax means applicable premiums paid by the Employee are deducted before required income and PERA retirement taxes are withheld.

An Eligible Employee has the **option** to enroll in one of the Poudre School District health plans. If an Employee does not elect coverage under one of these plans within the enrollment period, the Employee will not have coverage under any district health plans.

An Eligible Employee must provide proof of relationship documents to enroll a Dependent in one of the Poudre School District health plans. The documentation must confirm the Dependent meets the eligible Dependent definition under the Plan for enrollment.

Once an Eligible Employee enrolls for coverage in a Poudre School District health plan, the Employee and Eligible Dependents are not allowed to change plans during a Plan Year unless they move outside the Network Coverage area. Such change must be made within thirty-one (31) days of the date the Employee moves to the new residence.

Enrollment Requirements for Newborn Children

A newborn child of a Covered Employee is not automatically enrolled in this Plan. Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section

"Timely or Late Enrollment" following this section, there will be no payment from the Plan and the Covered Employee will be responsible for all costs.

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

If the newborn child is not enrolled within thirty-one (31) days of birth, the enrollment will be considered a Late Enrollment.

Open Enrollment

The Plan's Open Enrollment period is held annually, prior to the beginning of the Plan Year. During Open Enrollment, Employees may:

- enroll themselves and their Dependents who are Late Enrollees in the Plan,
- drop coverage for themselves if not required to enroll as noted in the Enrollment section of this document,
- drop coverage for their Dependents,
- change health plans

Benefit choices for Late Enrollees made during the Open Enrollment period will become effective the first day of the next Plan Year.

Plan Participants will receive detailed information regarding Open Enrollment from the Plan Sponsor.

Timely or Late Enrollment

- **Timely Enrollment** - The enrollment will be "timely" if the online enrollment process is completed and received by the Plan Sponsor no later than thirty-one (31) days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

  If two Employees (Spouse, Domestic Partner, or Partner in a Civil Union) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other Covered Employee with no waiting period as long as coverage has been continuous.

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

  If a Plan Participant loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan

coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the day a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period. Coverage begins on the first day of the next Plan Year.

Special Enrollment Periods

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date an Employee or their Dependents first become eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period.

An Eligible Employee has thirty-one (31) days from the date of a Qualifying Event to enroll in the Plan.

- **Individuals losing other coverage.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

  – The Employee or Dependent was covered under a group health plan or had insurance coverage at the time coverage under this Plan was previously offered to the individual.
  – If required by the Plan Sponsor, the Employee stated in writing at the time that coverage was offered that the other group health plan or health insurance coverage was the reason for declining enrollment.
  – The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (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.
  – The Employee or Dependent requests enrollment in this Plan not later than thirty-one (31) days after the date of exhaustion of COBRA coverage or termination of non-COBRA coverage described above. Coverage will begin the day following the date of loss of coverage provided the online enrollment process is completed and received in a timely manner.

  If the Employee or Dependent lost the other coverage for cause (such as making a fraudulent Claim), that individual does not have a special enrollment right.

- Dependent beneficiaries. If:

  – The Employee is a Plan Participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

– A person becomes a Dependent of the Employee through marriage, domestic partnership, civil union relationship, or birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the Covered Employee (and the Employee as a Covered Employee). In the case of the birth or adoption of a child, the spouse of the Covered Employee may be enrolled as a Dependent of the Covered Employee if the spouse is otherwise eligible for coverage.

A child will be considered placed for adoption when a Covered Employee becomes legally obligated to support that child, totally or partially, prior to that child's adoption. The enrollment requirements for newborn children will also apply to an adopted child or a child placed with a Covered Employee for adoption. If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The Special Enrollment Period for a Dependent is a period of thirty-one (31) days and begins on the date of the marriage, domestic partnership, civil union relationship, birth, adoption or placement for adoption.

The coverage of the Dependent and any others including other Eligible Dependents, or an Employee enrolled in the Special Enrollment Period will be effective as stated below provided the online enrollment process is completed and received in a timely manner:

– In the case of marriage, the date of marriage;
– In the case of a civil union, the date of the civil union;
– In the case of a domestic partnership; the date of declaration of the partnership;
– In the case of a Dependent's birth, as of 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.

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Schedule of Benefits - PPO-2 Health Plan

**Note: See Mental/Behavioral Health and Substance Abuse section for Mental/Behavioral Health and Substance Abuse benefit information.

Verification of Eligibility

Call (970) 224-4600 or (866) 644-7873 toll free to verify eligibility and benefits **before** the service is provided.

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

Note: The following services must be pre-certified or reimbursement from the Plan may be reduced or denied. Please see the Medical Cost Management section in this booklet for further details.

- Acupuncture Services
- Bariatric Surgery (including gastric bypass and lap band)
- Breast Pumps and Supplies
- Chiropractic Services
- Devices and Durable Medical Equipment
- Genetic Testing
- Hearing Aids
- Home Health Care
- Hospice
- Hospitalizations
- Neuro-feedback Therapy (Only available under Mental/Behavioral Health and Substance Abuse benefits. Reference that section for further details.)
- Outpatient Surgical Procedures
- Outpatient Therapies

- Rehabilitation and Skilled Nursing Facility Admissions
- Substance Abuse/Mental/Behavioral Disorder Treatments (Only available under Mental/Behavioral Health and Substance Abuse benefits. Reference that section for further details.)
- Transplant Benefits
- Voluntary Early Discharge Maternity Program

The attending Provider is not required to obtain pre-certification from the Plan for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.

This Plan contains a Network Provider Organization. There are no Non-Network Providers or services available under this Plan except as noted below.

This Plan has entered into an agreement with certain Hospitals, Providers and other health care Providers, which are called Network Providers. These Network Providers have agreed to accept reduced fees for services provided to Plan Participants.

It is the Plan Participant's choice as to which Provider to use. However, if a Non-Network Provider is used, there will be no benefit coverage.

Under the following circumstances, the Network benefit may be made for certain Non-Network services:

- If a Plan Participant has no choice of Network Providers in the specialty that the Plan Participant is seeking within the Network Coverage Area.
- If a Plan Participant is out of the Network Coverage Area and has a medical Emergency or Urgent Care service requiring immediate care.
- If a Plan Participant receives the following services at a Network facility by a Non-Network Provider:
  - Provider services
  - anesthesia services
  - or other services provided by a Hospital based Provider

A list of Network Providers is available to Plan Participants, at no cost, and updated as needed. The list may be obtained through the Medical Benefits Claims Administrator or the district's benefits office.

Coinsurance payable by Plan Participants

Coinsurance is a percentage of allowed charges that the Plan Participant must pay before the Plan pays.

The following chart shows the amount of Deductibles and Coinsurance required.

The Deductibles listed in the chart are separate from the inpatient Mental/Behavioral and Substance Abuse Deductible.

Only Network expenses will apply toward the Out-of-Pocket Maximum. Some Network expenses **do not** apply toward the Out-of-Pocket Maximum, as noted.

When Spouses, Domestic Partners, or Partners in a Civil Union are both Covered Employees, it is the Covered Employee's responsibility to notify the Medical Benefits Claims Administrator for Claim cross-referencing. It is important that cross-referencing occur in such cases, as it will affect the family Deductible and family Out-of-Pocket Maximums. The Covered Employee should make the request by sending a letter to the Medical Benefits Claims Administrator including names and social security numbers so the correct records can be cross-referenced.

Benefit Description	Network Providers
Plan Year Deductible	Individual: $1,000 Family: $3,000
Plan Year Out-of-Pocket Maximum	Individual: $7,050 Family: $14,100
Lifetime Maximum	None
Primary Care Office Visit	Plan pays 70%; Plan Participant pays 30% after Deductible
Specialist Office Visit	Plan pays 70%; Plan Participant pays 30% after Deductible
Preventive Services **Annual Physical/Wellness Exam (age 2 and up)**	Plan pays 100%
Preventive Services **Well Child Care (to age 2)**	Plan pays 100%
Preventive Services **Mammograms/Routine Prostate Exams**	Plan pays 100%
Acupuncture Services	Plan pays 50% based on Usual and Customary Charges; Plan Participant pays 50% (does not apply toward the Annual Deductible or medical Out-of-Pocket Maximum); 20-visit maximum per Plan Year combined with Chiropractic Services; no designated Network Providers. See Acupuncture Services under Medical Benefits section for additional information
Ambulance Services	Plan pays 70%; Plan Participant pays 30% after Deductible
Bariatric Surgery (Gastric Bypass/Lap Band)	$2,500 Copayment; two (2) year enrollment in Plan required; must meet pre-surgical requirements; surgery only allowed one (1) time; See Schedule of Bariatric Surgery Benefits in the Medical Benefits section for additional information

Breast Pumps and Supplies	Plan pays 100%; limit one (1) pump per birth
Chiropractic Services	Plan pays 50%; Plan Participant pays 50% after Deductible; 20-visit maximum per Plan Year combined with Acupuncture Service. See Chiropractic Services under Medical Benefits section for additional information
Durable Medical Equipment	Plan pays 70%; Plan Participant pays 30% after Deductible
Emergency Services	Plan pays 70%; Plan Participant pays 30% after Deductible
Hearing Aids (to age 19)	Plan pays 70%; Plan Participant pays 30% after Deductible
Hearing Aids (Age 19 and up)	Plan pays 70% to $1,500 maximum per hearing aid during a five (5) year period; Plan Participant pays 30% after Deductible; initial hearing aid and replacements limited to one (1) per ear every five (5) years; Amounts payable by the Plan Participant **do not** count toward the medical Out-of-Pocket Maximum
Home Health Care	Plan pays 100%
Hospice Care	Plan pays 100% to a maximum of 180 days
Inpatient Hospital	Plan pays 70%; Plan Participant pays 30% after Deductible (semi-private room rate)
Laboratory and X-Ray – Diagnostic	Plan pays 70%; Plan Participant pays 30% after Deductible
MRIs, CAT and PET Scans	Plan pays 70%; Plan Participant pays 30% after Deductible
Non-surgical treatment of chronic foot conditions, including orthotics	Plan pays 70%; Plan Participant pays 30% after Deductible
Outpatient/Ambulatory Surgery	Plan pays 70%; Plan Participant pays 30% after Deductible
Skilled Nursing Facility Care	Plan pays 70%; Plan Participant pays 30% after Deductible (semi-private room rate); 60-day Plan Year limit on length of stay
Therapies - Physical, Occupational, Speech	Plan pays 70%; Plan Participant pays 30% after Deductible; 30 sessions maximum per acute condition

Transplants	Plan pays 70%; Plan Participant pays 30% after Deductible; See Schedule of Transplant Benefits in the Medical Benefits section for additional information
Urgent Care	Plan pays 70%; Plan Participant pays 30% after Deductible
Wig after Chemotherapy and Prosthetics	Plan pays 70%; Plan Participant pays 30% after Deductible

This is a summary of PPO-2 Health Plan benefits. Plan Participants should always refer to the detailed description of Medical Benefits in this document before making a determination of benefits.

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Medical Benefits

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

Benefit Payment

Each Plan Year, benefits will be paid for the Covered Charges of a Plan Participant that are in excess of any Coinsurance. Payment will be made at the applicable rate in the schedule of benefits. No benefits will be paid in excess of the maximum benefit amount or any listed Limit of the Plan.

Out-Of-Area Services

For expenses incurred outside of the Network Coverage Area for Emergency Services or Urgent Care, as defined in this document, the Plan will pay for Covered Charges at the Network level of benefits, subject to the Usual and Customary Limits allowed in the Plan, and subject to any Deductibles and Coinsurance maximums.

For expenses incurred outside of the Network Coverage Area for services other than Emergency Services or Urgent Care, there will be no benefit coverage and the charges will be the responsibility of the Plan Participant.

Out-Of-Country Services

Expenses incurred for covered Emergency Services or Urgent Care while out of the United States will be reimbursed as any other Emergency or Urgent Care treatment. For Covered non-Emergency services received while out of the country there will be no benefit coverage and the charges will be the responsibility of the Plan Participant.

Out-Of-Pocket Maximum

Covered Charges are payable at the percentages shown each Plan Year until the Out-of-Pocket Maximum shown in the schedule of benefits is reached. Then, Covered Charges incurred by a Plan Participant will be payable at 100% (except for the charges excluded or any items noted below) for the remainder of the Plan Year.

When a family unit reaches the Out-of-Pocket Maximum, Covered Charges for that family unit will be payable at 100% (except for the charges excluded or any items noted below) for the remainder of the Plan Year.

Charges for acupuncture services **do not** count toward the Annual Deductible or medical Out-of-Pocket Maximum.

Charges incurred by a Plan Participant age 19 and up for hearing aids **do not** count toward the medical Out-of-Pocket Maximum or the Mental/Behavioral Health and Substance Abuse Out-of-Pocket Maximum.

Charges in excess of Usual and Customary **do not** count toward Out-of-Pocket Maximums.

Only Network expenses will apply toward the Out-of-Pocket Maximum.

In addition, the following charges **do not** count toward the medical Out-of-Pocket Maximums:

- Outpatient mental/behavioral treatment
- Inpatient mental/behavioral treatment
- Outpatient Substance Abuse treatment
- Inpatient Substance Abuse treatment
- Cost containment penalties

These benefits have a separate Out-of-Pocket Maximum. See the Mental/Behavioral Health and Substance Abuse section in this book for additional information.

Maximum Benefit Amount

The maximum benefit amount is described in the schedule of benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Plan Participant.

Schedule of Bariatric Surgery/Procedure Benefits

- Plan Participant must be enrolled in the Plan for a minimum of two (2) years before being eligible for bariatric surgery/procedure benefits
- Surgery/procedure by Network Provider
  - $2,500 Copayment
- Surgery/procedure by Non-Network Provider
  - No Benefit (No Out-of-Pocket Maximum applies)
- Surgery/procedure only allowed one time
- Plan Participant must meet the following pre-surgery requirements:

- BMI > 35 with life threatening complication (includes additional major risk factor or co-morbidity)
- Provider statement documenting proof of tried and failed weight loss of at least a 12-month period of time
- Provider statement of a minimum of five (5) counseling sessions to include one (1) pre-surgical psychological evaluation and four (4) counseling sessions
  - Plan Participant must contact the Mental/Behavioral Health and Substance Abuse Administrator to schedule the pre-surgical evaluation.
  - The Mental/Behavioral Health and Substance Abuse Administrator will ensure that the Plan Participant is aware of their obligation to participate in an additional four (4) counseling sessions. If the surgery/procedure date is too soon for those sessions to occur, The Mental/Behavioral Health and Substance Abuse Administrator will let them know to contact their Provider to reschedule the surgery/procedure.
  - The Mental/Behavioral Health and Substance Abuse Administrator will either provide the counseling sessions or will provide a referral to a Network Provider specialist.
  - If the Plan Participant is referred to a Network Provider specialist, the specialist will provide certification to the Mental/Behavioral Health and Substance Abuse Administrator that the four (4) counseling sessions have been completed.
  - The Mental/Behavioral Health and Substance Abuse Administrator will provide the Provider with the psychological evaluation and the certification that the four (4) counseling sessions have been completed.
  - The Provider will follow the Medical Cost Management Services procedures to confirm the pre-surgical requirements have been met to move forward with pre-certification of the surgery/procedure.

The Plan will pay Covered Charges incurred by a Plan Participant for an Illness or Injury, subject to any Deductibles, Co-pays, Co-insurance amounts, maximum or limits shown in the Plan's Schedule of Benefits.

It will be the Plan Participant's responsibility to obtain prior certification for all bariatric surgery/procedure related services through Medical Cost Management Services. If prior certification is not obtained, benefits may not be payable for such services or benefits may be subject to reduced levels as outlined in the individual Plan provisions.

Schedule of Transplant Benefits

- Transplant Network Provider (Center of Excellence)
  - 70% Plan, 30% Plan Participant
- Non-Transplant Network Provider (No out-of-pocket maximum applies.)
  - No Benefit
- Transplant Lifetime Maximum for Non-Transplant Network Provider
  - $100,000

- Aggregate maximum for donor search, procurement, transportation and storage
    - $35,000
- Transplant Related Transportation & Lodging Expenses Maximum Benefit, Transplant Network Providers
    - $10,000
- Transplant Related Transportation & Lodging Expenses Maximum Benefit, Non-Transplant Network Provider
    - No Benefit

The Plan will pay Covered Charges incurred by a Plan Participant for an Illness or Injury, subject to any Deductibles, Co-pays, Co-insurance amounts, maximum or limits shown in the Plan's Schedule of Benefits. Transplant benefits are based on the Usual and Customary Charge or the Transplant Network's negotiated rate.

It will be the Plan Participant's responsibility to obtain prior certification for all transplant related services through Transplant Case Management. If prior certification is not obtained, benefits may not be payable for such services or benefits may be subject to reduced levels as outlined in the individual Plan provisions. The transplant and medical criteria for such transplant must be considered Medically Necessary and not Experimental and/or Investigational for the Plan Participant's medical condition for which the transplant is recommended. The Plan Participant's medical condition must not be included within the individual Plan exclusions.

Transplant Network

In accordance with the terms of the Plan, benefits for covered transplants will be provided by a "Transplant Network," who are a group of select providers, chosen for their high volume of transplants performed and success in the treatment of these complicated procedures as Transplant Network Providers. A Plan Participant must have such health benefits approved in advance by Transplant Case Management to receive in-network benefits. Providers who are not part of the Transplant Network for transplant benefits are considered to be non-Transplant Network Providers even if they are considered as Network Providers as part of the Plan's general health services network.

Examples of transplant benefits that are currently payable under the Plan provided they are not excluded for any reason are**:**

- Heart
- Lung
- Heart/Lung combined
- Liver
- Autologous Bone Marrow or Stem Cell Transplant (for certain conditions)
- Allogeneic Bone Marrow or Stem Cell Transplant (for certain conditions)
- Kidney
- Kidney/Pancreas (simultaneous)

- Additional procedures that are identified by Transplant Network Provider as necessary to meet transplant criteria are subject to Medical Necessity review.

- Use of life support equipment or temporary mechanical equipment pending acquisition of a matched human organ.

- Ventricular assist device as a bridge or alternative to heart transplant, subject to Medical Necessity review and prior approval by the Plan.

- Inpatient room, board, supplies, drugs, other medical services and professional fees related to transplant procedure.

- Disease management of the condition (as required by the Transplant Network Provider) for which the transplant is performed, during the period after evaluation and prior to transplant.

- Post transplant care through Transplant Network Provider immediately after discharge from the transplant up to one (1) year after the transplant, including monitoring for recurrence of underlying disease condition for which the transplant was performed.

- Transportation to and from the Transplant Network Provider and lodging near the Transplant Network Provider during evaluation, transplant admission and up to thirty (30) to ninety (90) days immediately after hospital discharge from the transplant (subject to Medical Necessity review) for the Plan Participant and one designated adult companion up to the amount in the Schedule of Transplant Benefits.

- *Driving Costs:* Travel distance from Plan Participant's legal residence to the Transplant Network Provider must be 50 miles or more one-way to qualify for transplant-related travel benefits. Mileage reimbursement is based on current Internal Revenue Service approved deductions. Covered mileage is based on vehicle odometer reading at the start of travel to the Transplant Network Provider and upon return home and must be submitted for reimbursement. Air or ground ambulance to the Transplant Network provider for transplant must be arranged through Transplant Case Management and is subject to Medical Necessity review and approval by the Plan.

- Lodging near the Transplant Network facility must be arranged through the Transplant Network discounted lodging program.

- Limit of $50 each per day for food for Plan Participant (outpatient only) and one adult companion. Adult companion is defined as a consistent primary caregiver to the Plan Participant from evaluation up to ninety (90) days post-transplant. Alcoholic beverages, personal convenience items, food for other Plan Participants, family or friends, and others not covered by the Plan will not be

reimbursed. Original receipts must be submitted to receive transplant related travel and lodging benefits reimbursement.

- Retransplantation (subject to Medical Necessity review).

- Evolving transplant treatments for multiple myeloma (Tandem Transplant or Planned Multiple Bone Marrow or Stem Cell Transplants) that have demonstrated statistically improved survival rates as compared to current medical practice standard (single Autologous Bone Marrow or Stem Cell Transplant) (subject to Medical Necessity review).

This list is not an exclusive list and contains illustrations designed to assist you in determining coverage under the Plan.

Covered Charges

Covered Charges are the Usual and Customary 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.

- **Annual physical/wellness exams.** Covered Charges under medical benefits are payable for annual physicals/wellness exams including lab work when the diagnosis is associated with the well exam and not a different issue and routine immunizations as described in the schedule of benefits.

- **Clinical Trial Services.** The Plan provides coverage of routine patient costs for qualified individuals in an approved clinical trial.

  A qualified individual is defined as someone who is eligible to participate in an approved clinical trial and either the individual's doctor has concluded that participation is appropriate, or the participant provides medical and scientific information establishing that their participation is appropriate.

  An approved clinical trial is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening diseases or conditions including federally funded trials, trials conducted under an Investigational new drug application reviewed by the FDA or drug trials exempt from having an Investigational new drug application.

  A life-threatening condition is defined as any disease from which the likelihood of death is probable unless the course of the disease is interrupted.

  Routine patient costs include all items and services consistent with the coverage provided in the Plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) 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; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of

the Plan's Network area unless Non-Network benefits are otherwise provided under the Plan. If a participating Provider is participating in an approved clinical trial, the Plan may require the individual to participate in the trial through that participating Provider if the Provider will accept the individual as a participant in the trial.

- **Emergency Services.** Covered Charges incurred as defined in the Defined Terms section of this Plan.

- **Home Health Care Services and Supplies.** Charges for Home Health Care Services and Supplies are covered only for the 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 certified by the attending Provider and be contained in a Home Health Care Plan.

  Charges for total parenteral nutrition (TPN) or oral nutritional therapy will be covered only if it is pre-certified by the Medical Benefits Claims Administrator.

  Mothers with newborns voluntarily released from the Hospital one (1) day early based on Federal guidelines are entitled to one (1) visit by a registered nurse as well as the services of a homemaker for four (4) hours on two (2) days within thirty (30) days following delivery. The homemaker may perform duties such as grocery shopping, preparing meals, laundry, and light housekeeping. Charges will be covered only if pre-certified by the Medical Benefits Claims Administrator as part of the voluntary early discharge maternity program.

  A Home Health Care visit will be considered a periodic visit by either a nurse or therapist.

- **Hospice Care Services and Supplies.** Charges for Hospice Care Services and Supplies are covered only when the attending Provider has certified the Plan Participant's condition as being terminal and determined that life expectancy is less than six (6) months.

  Covered Charges for Hospice Care Services and Supplies are payable as described in the schedule of benefits.

- **Hospital Care.** The medical services and supplies furnished by a Hospital or Location of Care or a licensed Birthing Center. Covered Charges for room and board will be payable as described in the schedule of benefits. After twenty-three (23) observation hours, a confinement will be considered an inpatient confinement.

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

    This coverage is only provided if a parent is a Plan Participant who was covered under the Plan at the time of the birth, the newborn child is an eligible Dependent and is neither Injured nor Ill, and the newborn is properly enrolled in the Plan.

    A newborn child is ***not*** automatically enrolled or covered for the first thirty-one (31) days after birth. A newborn child must be enrolled in the Plan on a timely

basis, as defined in the section "Timely or Late Enrollment" to have coverage under the Plan.

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

Charges for covered Routine Well Newborn Nursery Care will be applied toward the Plan of the newborn child.

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (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 forty-eight (48) hours (or ninety-six [96] hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six [96] hours).

See Home Health Care Services and Supplies under Covered Charges for additional information on the voluntary early discharge maternity program.

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

Charges for covered routine Provider care will be applied toward the Plan of the newborn child.

Charges for an intensive care unit stay are payable as described in the schedule of benefits.

- **Immunizations.** Covered Charges for routine immunizations are payable under the annual physical/wellness exam benefit unless otherwise noted under the Plan Exclusions. In addition, the following adult immunizations are Covered Charges if the Plan Participant meets the recommended criteria as set by the Centers for Disease Control and Prevention immunization schedule: Hepatitis A, Hepatitis B, Herpes Zoster (Shingles), Human Papillomavirus (HPV), Influenza (flu shot); Measles, Mumps, Rubella (MMR); Meningococcal, Pneumococcal (Pneumonia); Tetanus, Diphtheria, Pertussis (Td/Tdap), and Varicella (Chickenpox).

  Reimbursement for the Herpes Zoster (Shingles) vaccination will not be held to the network requirement based on supply issues.

- **Inpatient Rehabilitation.** There is a 60-day Plan Year limit on the length of stay for inpatient rehabilitation.

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

- **Acupuncture Services** when deemed Medically Necessary (subject to a 20-visit maximum per Plan Year combined with chiropractic services). In addition, the following criteria applies:
  - Acupuncture requires pre-certification through the Medical Benefits Claims Administrator as outlined in the Medical Cost Management Services section of this document.
  - Services do not need to be obtained by a Network Provider
  - The Plan will pay 50% based on Usual and Customary Charges. Charges do not apply toward Annual Deductible or medical Out-of-Pocket Maximum.
  - Needle acupuncture (manual or electroacupuncture) is a covered benefit for any of the following indications:
    - Nausea of pregnancy; or
    - Pain from osteoarthritis of the knee or hip (adjunctive therapy); or
    - Post-operative and chemotherapy-induced nausea and vomiting; or
    - Chronic (minimum 12-week duration) low back pain or neck pain; or
    - Chronic (minimum 12-week duration) headache
  - The Plan considers acupuncture Experimental and Investigational for all other indications because there is inadequate scientific research assessing the efficacy of acupuncture compared with placebo, sham acupuncture or other modalities of treatment in these conditions.
  - Maintenance treatment, where the Plan Participant's symptoms are neither regressing or improving, is considered **not** Medically Necessary. If no clinical benefit is appreciated after four weeks of acupuncture, then the treatment plan should be reevaluated. Further acupuncture treatment is not considered Medically Necessary if the Plan Participant does not demonstrate meaningful improvement in symptoms.
  - The Plan considers acupuncture point injection (also known as acupoint injection therapy, biopuncture) Experimental and Investigational for the following conditions (not an all-inclusive list) because the effectiveness of this approach has not been established:
    - Amyotrophic lateral sclerosis
    - Cancer-related pain
    - Cervical spondylosis
    - Chronic daily headache
    - Dysmenorrhea (menstrual pain)
    - Lateral elbow pain (tennis elbow)
  - The Plan considers dry needling Experimental and Investigational because of inadequate evidence of its effectiveness.

- Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Medical Benefits Claims Administrator finds a longer trip was Medically Necessary.

- **Anesthetic;** oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

- Rental or purchase of **Breast Pumps** (and supplies). A breast pump may be bought rather than rented but will be considered bought once the cost for rental reaches the purchase price through the Network Provider. There is a limit of one (1) pump per birth. Coverage for breast pumps and supplies requires pre-certification as outlined in the Medical Cost Management Services section of this document. Supplies include those items necessary for the use of the breast pump (or to make the pump operate) including the standard power adapter, tubing and tubing adapters, and shield/splash protectors. It does not include coverage for other breastfeeding supplies such as maternity bras, nursing pads, bottles, and storage bags.

- **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Provider; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within twelve (12) weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

- Radiation therapy or **chemotherapy**. The materials and services of technicians are included.

- **Chiropractic Services** when deemed Medically Necessary (subject to a 20-visit maximum per Plan Year combined with acupuncture services). In addition, the following criteria applies:
  - Chiropractic requires pre-certification through the Medical Benefits Claims Administrator as outlined in the Medical Cost Management Services section of this document.
  - Services must be obtained by a Network Provider. There is no coverage for Non-Network Providers.
  - The Plan will pay 50% based on the Network contracted rate for Network Providers.
  - Chiropractic services are a covered benefit when all of the following criteria are met:
    - The Plan Participant has a neuromusculoskeletal disorder; and
    - The Medical Necessity for treatment is clearly documented; and
    - Improvement is documented within the initial two (2) weeks of chiropractic care.
  - Office visits are a Covered Charge as follows:
    - A new patient exam or an established patient exam is performed for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of chiropractic services. A new patient is one who has not received any professional services from the Provider, or another Provider of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the Provider, or another Provider of the same specialty who belongs to the same group practice, within the past three years.
    - Established patient exams are performed to assess the need to initiate, continue, extend, or change a course of treatment. The established patient

exam is only covered when used to determine the appropriateness of chiropractic services. The established patient exam must be Medically Necessary.
    - Subsequent office visits, may involve an adjustment, a re-examination and other services, in various combinations
    - Adjunctive modalities and procedures such as rehabilitative exercise, traction, electrical muscle stimulation, and other therapies are covered only when provided during the same course of treatment and in conjunction with chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.
  - X-ray and laboratory tests are a Covered Charge as follows:
    - When prescribed as Medically Necessary chiropractic services and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or Hospital.
  - The Plan considers the following Experimental and Investigational. This list is not all-inclusive.
    - Manipulation when it is rendered for non-neuromusculoskeletal conditions (e.g., attention-deficit hyperactivity disorder, dysmenorrhea, epilepsy; and gastro-intestinal disorders, not an all-inclusive list)
    - Manipulation of infants for non-neuromusculoskeletal indications (e.g., infants with constipation).
    - Chiropractic manipulation has no proven value for treatment of idiopathic scoliosis or for treatment of scoliosis beyond early adolescence, unless the Plan Participant is exhibiting pain or spasm, or some other Medically Necessary indications for chiropractic manipulation are present.
  - The Plan does **not** consider the following Medically Necessary. This list is not all-inclusive.
    - Continuing chiropractic care if no improvement is documented within the initial two (2) weeks, unless the chiropractic treatment is modified.
    - Continuing chiropractic care if no improvement is documented within thirty (30) days despite modification of chiropractic treatment
    - Continuing chiropractic care once the maximum therapeutic benefit has been achieved
    - Chiropractic manipulation in asymptomatic persons or in persons without an identifiable clinical condition
    - Chiropractic care in persons whose condition is neither regressing nor improving

– Initial **contact lenses** or glasses required following cataract surgery or the eye condition keratoconus.

– The injectable **contraceptive**, Depreprovera.

– Medically prescribed **contraceptive devices** including intrauterine devices (IUD).

– Rental of **Durable Medical or surgical Equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to

exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Medical Benefits Claims Administrator.

- **Genetic counseling.** Covered Charges incurred with respect to genetic counseling when medically indicated.

- **Hearing aids and other hearing related services** as deemed Medically Necessary by a licensed physician and licensed audiologist. Coverage for hearing aids requires pre-certification as outlined in the Medical Cost Management Services section of this document. Coverage includes initial assessment, fitting, adjustments, and the required auditory training. For Plan Participants age 19 and up, initial hearing aids and replacements are limited to one (1) per ear every five (5) years. A new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the medical needs of the Plan Participant.

- Testing and Treatment of **Infertility** is limited to:

  Covered Charges include the following items, provided they are for the initial diagnosis of Infertility:

  - Documentation of ovulation (BBTs and endometrial biopsies);
  - Semen analysis;
  - Hysterosalpingogram (dye test);
  - Postcoital test;
  - Ultrasound (not to exceed two [2]);
  - Initial blood work for the determination of initial hormonal levels and thyroid levels and other blood work to determine medical causes of Infertility performed.

  Covered Charges include only those expenses incurred after a documented period of one (1) year of Infertility.

  Exclusions and Limitations (Also refer to the Exclusions section):

  - Laparoscopy for the treatment of Infertility or as a diagnostic procedure in connection with an Infertility determination.
  - Additional procedures may be eligible following per review to determine medical appropriateness to rule out any health risks not relating to the treatment of Infertility.
  - Experimental procedures, test-tube fertilizations, and reversals of sterilization procedures are not covered.
  - Blood work performed to monitor hormone levels or for the treatment of Infertility or inducement of Pregnancy.

- **Mammograms.** Covered Charges for mammograms will be payable as described in the schedule of benefits.

- Treatment of **Mental/Behavioral Disorders and Substance Abuse.** Covered Charges for care, supplies and treatment of mental/behavioral disorders and Substance Abuse will be limited as follows:

All treatment is subject to the benefit payment maximums shown in the Mental/Behavioral Health and Substance Abuse schedule of benefits.

– Injury to or care of **mouth, teeth and gums.** Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under medical benefits only if that care is for the following oral surgical procedures:

  - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
  - Emergency repair due to Injury to sound natural teeth.
  - Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
  - Excision of benign bony growths of the jaw and hard palate.
  - External incision and drainage of cellulite.
  - Incision of sensory sinuses, salivary glands or ducts.
  - Removal of impacted teeth while the Plan Participant is confined in a Hospital for at least eighteen (18) hours; such confinement must be required due to a hazardous medical condition of the Plan Participant.

  In cases of accidental Injury, the services must be rendered within one (1) year after the accident and while the person is covered under this Plan. No charge will be covered under medical benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

– **Neuro-Feedback Therapy.** Covered Charges are explained under the Mental/Behavioral Health and Substance Abuse section of this document.

– **Organ Transplant Donor**
  Benefits are provided for reasonable and necessary expenses incurred with respect to the donation of an organ or tissue by a donor who is not covered by this Plan, which includes surgery, acquisition, storage, and transportation subject to the following:

  - Testing and tissue are provided for typing to identify a suitable donor. For bone marrow or stem cell transplants, limit of three (3) maximum potential donor typing.

    Transplant donor benefits are included in the Plan Participant's lifetime maximum Plan benefits.

  Benefits for organ transplants are not provided for charges:

  - living donor health services which are not included in the Transplant Network rate.
  - which exceed reasonable and customary charges, or are not Medically Necessary,
  - for animal to human transplants,
  - for artificial or mechanical devices designated to replace human organs,

- to keep a donor alive for the transplant operation,
- beyond the Plan's maximum benefits,
- which are otherwise excluded by the Plan,
- for organ transplants considered Experimental and/or Investigational, or unproven,
- for services required to meet the patient selection criteria for the approved transplant procedure industry; unapproved rehabilitation services; treatment for nicotine or caffeine addiction; services and related expenses for weight loss programs; nutritional supplements; appetite suppressants; and supplies of a similar nature otherwise not covered under the general Plan provisions unless otherwise stated herein.

– The initial purchase, fitting and repair of **orthopedic appliances** such as braces, splints or other appliances, which are required for, support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Illness.

– Non-surgical treatment of chronic foot problems, including **orthotics** as described in the schedule of benefits.

– **Prescription Drugs.** (As defined in the Prescription Drug schedule of benefits).

– **Preventive Services.** Covered Charges under medical benefits are payable for Routine Preventive Services as described in the schedule of benefits. Additional Preventive Services covered under the Plan include evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF). These Preventive Services may require coordination of services between medical Covered Charges and Mental/Behavior Health and Substance Abuse Covered Charges. When the USPSTF recommendations and guidelines are updated, they will apply to this Plan. The updates will be effective on the first day of the Plan Year, one year after the updated recommendations or guideline is issued.

– **Prostate Exams.** Covered Charges under medical benefits are payable as described in the schedule of benefits.

– **Prosthetic Devices.** The initial purchase or replacement due to the pathological changes or normal growth, fitting, or repair of fitted prosthetic devices**,** which replace body parts. Repair or replacement of a broken appliance is limited to once in every five (5) Plan Year period. Replacement of an external breast prosthesis will be allowed only when the breast prosthesis is three (3) years or older.

– **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

- reconstruction of the breast on which a mastectomy has been performed,

- surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Provider and the Plan Participant.

– **Sterilization** procedures.

– **Surgical dressings,** splints, casts and other devices used in the reduction of fractures and dislocations.

– **Therapies**. Prescribed Occupational Therapy, Physical Therapy or Speech Therapy services (each subject to a 30-visit maximum per acute condition) are payable when in the judgment of the Provider significant improvement can be obtained. When prescribed and/or provided by a Provider, the following types of therapy are covered:

Occupational Therapy for acute care (but not chronic care) performed by a properly accredited licensed occupational therapist or certified occupational therapy assistant (COTA), subject to a thirty (30) visit limit per acute condition, and all must be determined to be Medically Necessary.

For the PPO-1 and PPO-2 Health Plans, a written Provider's script is the only authorization needed.

Plan Participant's status may be re-evaluated on an ongoing basis and, if it is determined the condition is no longer medically indicated, coverage will end. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

Physical Therapy for acute care (but not chronic care) performed by a Provider or a registered/licensed physical therapist when a proper referral is obtained subject to a thirty (30) visit limit per acute condition and all must be determined to be Medically Necessary. Additional visits may be approved only after individual case review by the Medical Benefits Claims Administrator.

Short-term, outpatient physical therapy is for treatment of acute conditions that are subject to significant improvement within six (6) months of when treatment begins.

For the PPO-1 and PPO-2 Health Plans, a written Provider's script is the only authorization needed.

Plan Participant's status may be re-evaluated on an ongoing basis and, if it is determined the condition is no longer medically indicated, coverage will end.

Speech Therapy and audio therapy, including audio diagnostic testing (subject to a thirty (30) visit limit per acute condition) when performed by a licensed speech therapist and all must be determined to be Medically Necessary.

For the PPO-1 and PPO-2 Health Plans, a written Provider's script is the only authorization needed.

Plan Participant's status may be re-evaluated on an ongoing basis and, if it is determined the condition is no longer medically indicated, coverage will end.

Therapy must be justified as a result of a medical condition in order to be covered.

Speech Therapy needed due to a learning or Mental/Behavioral Disorder will be subject to the following provisions:

- Therapy for a Participant eligible for services under the federally mandated Head Start program or other similar government programs is not a covered benefit.
- Therapy for a Dependent child not eligible for services under Head Start or other similar government programs is a covered benefit subject to all other provisions of the Plan. In this case, the Dependent must be evaluated, and services must be recommended by the Dependent's local Child Find program.

– **Wig or artificial hairpieces.** Charges associated with the initial purchase of a wig after chemotherapy.

– Diagnostic **x-rays.**

- **Pregnancy.** The Usual and Customary Charges for the care and treatment of Pregnancy are covered the same as any other Illness. See Plan Exclusions for specific rules regarding Charges related to surrogacy.

  Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (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 forty-eight (48) hours (or ninety-six [96] hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six [96] hours).

  See Home Health Care Services and Supplies under Covered Charges for additional information on the voluntary early discharge maternity program.

  Therapeutic termination of a pregnancy by a Provider is a covered service, but only if such medical procedures are deemed necessary to prevent the death of a pregnant woman or her unborn child due to life-endangering circumstances as permitted under Colorado Revised Statutes.

- **Provider Care.** The professional services of a Provider for surgical or medical services.

  Charges for surgical procedures will be a Covered Charge subject to the following provisions:

- If a bilateral procedure is performed by one (1) surgeon, benefits for the procedure will be determined based on 150% of the contracted amount if the procedure is performed by a Network Provider. There will be no benefit payment if performed by a Non-Network Provider.

  If multiple procedures are performed by one (1) surgeon, benefits for the additional procedures will be based on 50% of the contracted amount if the procedure is performed by a Network Provider. There will be no benefit payment if performed by a Non-Network Provider. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures.

- If a procedure is performed by multiple (two [2] or more) surgeons, benefits will be based on 125% of the contracted amount if the procedure is performed by Network Providers and will be split equally between the surgeons. There will be no benefit payment if performed by Non-Network Providers. The surgeons must be different specialties to qualify as multiple surgeons.

  If multiple procedures are performed by multiple (two [2] or more) surgeons that could normally be performed by one surgeon, benefits will be based on the Usual and Customary Charge for that procedure.

  If multiple unrelated procedures are performed by multiple (two [2] or more) surgeons in separate operative fields, benefits will be based on the Usual and Customary Charge for each surgeon's primary procedure.

- If an assistant surgeon is required, if the assistant surgeon is a Medical Doctor or Doctor of Osteopathic Medicine, Covered Charge will not exceed 20% of the surgeon's Usual and Customary allowance. If the assistant surgeon is a non-Medical Doctor including a Physician Assistant or Certified Nurse Practitioner, the Covered Charge will not exceed 10% of the surgeon's Usual and Customary allowance.

- Professional services rendered by an anesthesiologist during performance of a surgical operation. Benefits are payable for the administration of anesthesia by the operating or assistant surgeon, based on a base rate plus a time component.

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

  - the Plan Participant is confined as a bed patient in the facility;

  - the attending Provider certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

  - the attending Provider completes a treatment plan, which includes a diagnosis, the proposed course of treatment, and the projected date of discharge from the Skilled Nursing Facility.

  Coinsurance payable will be based on the facility's semi-private room rate.

There is a 60-day Plan Year limit on the length of stay for Skilled Nursing Care Facility stays.

- **Urgent Care.** Covered Charges incurred as defined in the Defined Terms section of this Plan.

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Medical Cost Management Services

Note: Cost management services for mental/behavioral health disorders and substance abuse treatment is only available under the Mental/Behavioral Health and Substance Abuse benefits. Refer to Mental/Behavioral Health and Substance Abuse section for further details.

Medical Cost Management Services Phone Number

UCHealth Plan Administrators
(970) 224-4600 or (866) 644-7873 toll free

This information is also printed on the Plan Participant's medical ID card.

The Plan Participant, Plan Participant's representative, Medical Care Facility, or attending Provider must call this number to receive certification of certain Medical Cost Management Services. This call must be made at least forty-eight (48) hours in advance of services being rendered or within forty-eight (48) hours or when medically reasonable after an Emergency.

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

Utilization Review

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

The program consists of:

- Pre-certification of the Medical Necessity for the following non-Emergency services before medical and/or surgical care and/or services are provided:
  - Acupuncture Services

- Bariatric Surgery (including gastric bypass and lap band)
- Breast Pumps and Supplies
- Chiropractic Services
- Devices and Durable Medical Equipment
- Genetic Testing
- Hearing Aids
- Home Health Care
- Hospice
- Hospitalizations
- Neuro-Feedback Therapy (Only available under Mental/Behavioral Health and Substance Abuse benefits. Reference that section for further details.)
- Outpatient Surgical Procedures
- Outpatient Therapies
- Rehabilitation and Skilled Nursing Facility Admissions
- Substance Abuse/Mental/Behavioral Disorder Treatments (Only available under Mental/Behavioral Health and Substance Abuse benefits. Reference that section for further details.)
- Transplant Benefits
- Voluntary Early Discharge Maternity Program

- Retrospective review of the Medical Necessity of the listed services provided on an Emergency basis;

- Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Provider; and

- Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what is payable by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Provider 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.

The attending Provider does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.

The Plan offers a voluntary early discharge maternity program. For additional information, call the medical cost management services phone number in this section or refer to Home Health Care Services and Supplies under the Covered Charges section.

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

Here's How the Program Works

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

The utilization review program is set in motion by a submission in writing from the requesting Provider. Contact the utilization review administrator at the telephone number on your ID card **at least forty-eight (48) hours before** services are scheduled to be rendered with the following information:

- The name of the Plan Participant and relationship to the Covered Employee
- The name, social security number and address of the Covered Employee
- The name of the Employer
- The name and telephone number of the attending Provider
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

If there is an **Emergency** admission to a Medical Care Facility, the Plan Participant, Plan Participant's authorized representative, Medical Care Facility or attending Provider must contact the utilization review administrator **within forty-eight (48) hours** of the first business day after the admission or when medically reasonable.

If the Plan Participant does not receive authorization as explained in this section, the benefit payment will be reduced by five hundred dollars ($500). In addition, any amount paid by the Plan Participant due to a reduced reimbursement will not apply toward the Deductible or Out-of-Pocket Maximum.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Plan Participant's Medical Care Facility stay or use of other medical services and coordinate with the attending Provider, Medical Care Facility 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 Provider 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 Provider must request the additional services or days.

Second And/Or Third Opinion Program

A Second Medical Opinion is a re-evaluation of a condition or health care treatment by an appropriately qualified Provider. The Provider must be either a primary care physician or a specialist acting within his or her scope of practice and must possess the clinical background necessary for examining the Illness or condition associated with the request for a Second Medical Opinion. Upon completing the examination, the Provider's opinion is included in a consultation report.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an Emergency or of a life-threatening nature.

Failure to comply with a request for a second and/or third opinion will reduce reimbursement received from the Plan.

Nurse Case Management

Nurse Case Management is a program whereby a nurse case manager monitors Plan Participants and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The nurse case manager consults with the Plan Participant, the Plan Participant's representative and the attending Provider in order to develop a plan of care for approval by the Plan Participant's attending Provider and the Plan Participant. This plan of care may include but is not limited to the following:

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

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

The nurse case manager will coordinate and implement the Nurse Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Medical Benefits Claims Administrator, attending Provider, Plan Participant and Plan Participant's representative must all agree to the alternate treatment plan.

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

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How to Submit A Claim

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

Benefits will be paid by the Plan if notice of Claim is made within one hundred eighty (180) days from the date on which Covered Charges were first incurred.

When using a Network Provider, the Provider should submit the Claim for the Plan Participant.

When a Plan Participant has a Claim to submit for payment the Plan Participant or authorized representative must:

- Obtain a Claim form from the appropriate Claims Administrator or the District's Benefits Office.
- Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
- For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:
  - Plan Name
  - Employee's name
  - Name of Plan Participant
  - Name, address, telephone number of the Provider of care
  - Diagnosis
  - Type of services rendered, with diagnosis and/or procedure codes
  - Date of services
  - Charges
- Send the above to the appropriate Claims Administrator:

Medical Benefits Claims Administrator
UCHealth Plan Administrators
1107 South Lemay Avenue, Suite #400
Fort Collins, Colorado 80524
(970) 224-4600 or (866) 644-7873 toll free

Mental/Behavioral Health and Substance Abuse Administrator
PSD Employee Assistance Services
2850 McClelland Drive, Suite 2200
Fort Collins, Colorado 80525
(970) 488-4925

Claim Procedure

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a Plan Participant or by a representative of a Plan Participant that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. "Days" means calendar days.

There are different kinds of Claims and each one has a specific guideline for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Claims Administrator.

The types of Claims are described below:

- **Urgent Care Claim**
  A Claim involving Urgent Care is any Claim for medical care or treatment where using the following guidelines for determination (a) could seriously jeopardize the life or health of the Plan Participant or the ability of the Plan Participant to regain maximum function; or (b) in the opinion of the attending or consulting Provider, would subject the Plan Participant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

  Any Claim that a Provider with knowledge of the Plan Participant's medical condition determines is an Urgent Claim will be treated as an Urgent Claim. If there is no such Provider, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

  In the case of a Claim involving Urgent Care, a decision will be made and notification will be provided within forty-eight (48) hours, taking into account medical exigencies, but not later than seventy-two (72) hours after receipt of the Claim.

  In the case of a failure by a Plan Participant to follow the procedure for filing a Claim, the Plan Participant or authorized representative shall be notified for the failure and the proper procedures to be followed in filing a Claim for benefits. This notification will be provided to the Plan Participant or authorized representative, as appropriate, as soon as possible, but no later than twenty-four (24) hours following

the failure. Notification may be oral, unless written notification is requested by the Plan Participant or authorized representative.

In the case of any reduction or termination by the Plan of any ongoing course of treatment, the Claims Administrator must notify the Plan Participant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Plan Participant to appeal and obtain a determination or review of that adverse benefit determination before the benefit is reduced or terminated. Any request by a Plan Participant to extend the course of treatment beyond the period of time or number of treatments that is an Urgent Care Claim will be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator will notify the Plan Participant of the benefit determination within twenty-four (24) hours after receipt of the Claim by the Plan, as long as the Claim is made to the Plan at least twenty-four (24) hours before the prescribed period of time or number of treatments will expire.

- **Pre-Service Claim**
  A pre-service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification or mandatory second opinions. Please see the Medical Cost Management section of this booklet for further information about pre-service Claims.

  Decisions will be made and notification will be given to the Plan Participant within a reasonable period of time, but not later than fifteen (15) days from receipt of the Claim. If an extension to make the determination is necessary due to circumstances beyond the control of the Plan, notification may take up to an additional fifteen (15) days after the lapse of the first fifteen (15) days, as long as the Claims Administrator notifies the Plan Participant within the first review period of the circumstances for the extension and the date on which the Plan expects to issue a decision. However, if a period of time is extended due to the failure of the Plan Participant to submit information necessary to decide the Claim, the period for making the benefit determination will be tolled from the date in which the notification of extension is sent to the Plan Participant until the date on which the Plan Participant responds to the request for additional information. The Plan Participant will have forty-five (45) days from the date the notice was received to provide the requested information.

  In the case of a failure by a Plan Participant to follow the Plan's procedures for filing a pre-service Claim, the Plan Participant or authorized representative shall be notified for the failure and the proper procedures to be followed in filing a Claim for benefits. This notification will be provided to the Plan Participant or authorized representative, as appropriate, as soon as possible, but no later than five (5) days following the failure. Notification may be oral, unless written notification is requested by the Plan Participant or authorized representative.

  In the case of a determination involving non-urgent ongoing treatment, the Claims Administrator will notify the Plan Participant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Plan Participant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

- **Post-Service Claim**
  A post-service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a pre-service Claim; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the Plan Participant.

  Decisions will be made by the Claims Administrator within a reasonable period of time, but not later than thirty (30) days from the receipt of the Claim. If an extension to make the determination is necessary due to circumstances beyond the control of the Plan, notification may take up to an additional fifteen (15) days after the lapse of the first thirty (30) days, as long as the Claims Administrator notifies the Plan Participant within the first review period of the circumstances for the extension and the date on which the Plan expects to issue a decision. However, if a period of time is extended due to the failure of the Plan Participant to submit information necessary to decide the Claim, the period for making the benefit determination will be tolled from the date in which the notification of extension is sent to the Plan Participant until the date on which the Plan Participant responds to the request for additional information. The Plan Participant will have forty-five (45) days from the date the notice was received to provide the requested information.

- **Notice to Plan Participant of Adverse Benefit Determinations**
  Except with Urgent Care Claims, when the notification may be orally followed by written or electronic notification within three (3) days of the oral notification, the Claims Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the Plan Participant:

  – The specific reason or reasons for the adverse determination.
  – Reference to the specific Plan provisions on which the determination was based.
  – A description of any additional material or information necessary for the Plan Participant to perfect the Claim and an explanation of why such material or information is necessary.
  – A description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time Limits applicable to such procedures.
  – A statement that the Plan Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
  – If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the Plan Participant upon request.
  – 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 Plan Participant's medical circumstances, will be

provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Appeals

**Note: See the Prescription Drug section for pharmacy (prescription) appeals information.

If a Plan Participant disagrees with a Claim determination, they may request a review to formally request an appeal.

There are three types of appeals under the Plan:

- Administrative appeals - An Eligible Employee or a Dependent denied application to the Plan, or a Plan Participant denied benefits for failure to follow an administrative provision of the Plan may appeal the adverse decision.
- Medical Benefit Claims appeals – A Plan Participant may appeal Urgent Care Claims, pre-service Claims, and post-service Claims.
- Mental/Behavioral Health and Substance Abuse Benefit Claims appeals – A Plan Participant may appeal an adverse benefit determination for Mental/Behavioral and Substance Abuse Claims.

The decision for appeals on review shall be made by the Third Party administrator designated by Poudre School District. For Administrative appeals and Medical Benefit Claims appeals, the Third Party administrator shall be the Medical Benefits Claims Administrator. These appeals should be sent directly to:

UCHealth Plan Administrators
1107 South Lemay Avenue, Suite #400
Fort Collins, Colorado 80524
(970)224-4600 or (866)644-7873 Toll free

For Mental/Behavioral Health and Substance Abuse Claims appeals, the Third Party administrator shall be the Mental/Behavioral Health and Substance Abuse Administrator. These appeals should be sent directly to:

Employee Assistance Services
2850 McClelland Drive, Suite 2200
Fort Collins CO 80525
(970) 488-4925

The following levels of appeal are available under the Plan:

- First appeal level for Administrative appeals, Medical Benefit Claims appeals, and Mental/Behavioral Health and Substance Abuse Benefit Claims appeals,
- Second appeal level for Administrative appeals, Medical Benefit Claims appeals, and Mental/Behavioral Health and Substance Abuse Benefit Claims appeals,
- External voluntary appeal level for Administrative appeals, Medical Benefit Claims appeals, and Mental/Behavioral Health and Substance Abuse Benefit Claims appeals

The Plan Participant must submit the appeal to the appropriate Claims Administrator in writing, with the exception of Urgent Care claim review which may be requested orally.

The appeal must be submitted within 180 days after receipt of the Claim denial. If the appeal is not submitted within this time period, the Plan Participant will not be able to continue to pursue the appeal process and may jeopardize their ability to pursue the matter in any forum.

A Plan Participant may submit written comments, documents, records and other information relating to the Claim. If the Plan Participant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim.

If the appeal relates to a Claim for payment, the request should include the following:
• The patient's name and identification number as shown on the medical or dental ID card
• The date(s) of medical or dental service(s)
• The provider's name
• The reason the Plan Participant believes the Claim should be paid
• Any documentation or other written information to support the request for Claim payment.

First Level Appeal
The appeal will be reviewed and the decision made by a review committee not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional. For level one appeals, decisions will be made in accordance with the urgency of the Claim.

- In the case of Administrative appeals, decisions will be made and notification will be given as soon as possible, but no later than thirty (30) days after receipt by the Medical Benefits Claims Administrator of the Plan Participant's request for review.
- In the case of Urgent Care Claims, decisions will be made and notification will be given as soon as possible, taking into account medical exigencies, but no later than 72 hours after receipt of the request for review.
- In the case of a Pre-Service, non-Urgent Care Claim, a written notification of the determination will be made within a reasonable period of time appropriate to the medical circumstances but no later than 15 calendar days after receipt of an appeal for a required pre-service or concurrent care coverage determination. If an extension to make the determination is needed by the Claims Administrator for reasons beyond the control of the Plan, notification may take up to an additional 15 days after the lapse of the first 15 days. However, if a period of time is extended due to the Plan Participant's failure to submit information necessary to decide the Claim, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to the Plan Participant until the date on which the Plan Participant responds to the request for additional information. The Plan Participant will have 45 days to provide the requested information from the date the Plan Participant receives notice requesting further information.
- In the case of a Post-Service Claim, written notification of the determination must be made within a reasonable period of time, but not later than 30 calendar days

after receipt of an appeal for post-service coverage determination. If an extension to make the determination is needed by the Claims Administrator for reasons beyond the control of the Plan, notification may take up to an additional 30 days after the lapse of the first 30 days. However, if a period of time is extended due to the Plan Participant's failure to submit information necessary to decide the Claim, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to the Plan Participant until the date on which the Plan Participant responds to the request for additional information. The Plan Participant will have 45 days to provide the requested information from the date the claimant receives notice requesting further information.

Each Claim will receive a full and fair review. Deference will not be given to the initial denial and the Claims Administrator will look at the claim anew. The review will take into account all comments, documents, records, and other information the Plan Participant submits relating to the Claim without regard to whether such information was submitted or considered in the initial determination. The person who will review the Plan Participant's appeal will not be the same person as the person who made the initial decision, nor be a subordinate of the person who made the initial decision to deny the Claim. The Claims Administrator will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. If an extension of time to make a decision on review is required, the Claims Administrator will notify the Plan Participant prior to the expiration of the initial review period, state the reason(s) why the extension was needed, and state when it will make its determination.

A request to expedite the appeal process may be made if, (a) the time frames under this process would seriously jeopardize life, health or ability to regain maximum functionality or in the opinion of the Provider would cause the Plan Participant severe pain which cannot be managed without the requested services; or (b) the appeal involves non-authorization of an admission or continuing inpatient hospital stay. The medical reviewer, in consultation with the treating Provider, will decide if an expedited appeal is necessary. When an appeal is expedited, an oral response regarding the decision will be within 72 hours, followed up in writing.

Second Level Appeal

If the level one appeal decision is not satisfactory a second request for review may be made. To initiate a level two appeal, the Plan Participant must follow the same process required for a level one appeal. A medical director will conduct most requests for a second review. For level two appeals, acknowledgment in writing that the request has been received and scheduled for review. For required Pre-Service and concurrent care coverage determinations the review will be completed within 15 calendar days and for Post-Service Claims, the review will be completed within 30 calendar days. If more time or information is needed to make the determination, notification in writing will be sent to request the extension of up to 15 calendar days for Pre-Service Claims and up to 30 calendar days for Post Service Claims and to specify any additional information needed to complete the review.

A request to expedite the appeal process may be made if, (a) the time frames under this process would seriously jeopardize life, health or ability to regain maximum functionality or in the opinion of the Provider would cause the Plan Participant severe pain which cannot be managed without the requested services; or (b) the appeal involves non-authorization of an admission or continuing inpatient hospital stay. The medical reviewer, in consultation with the treating Provider, will decide if an expedited appeal is necessary. When an appeal is expedited, an oral response regarding the decision will be within 72 hours, followed up in writing.

Notice to Plan Participant of Adverse Benefit Determinations Upon Appeal
The notification of the benefit determination upon appeal shall be provided in writing or made electronically in accordance with reasonable standards for electronic notification; except with Urgent Care Claims, when the notification may be orally followed by written or electronic notification within three (3) days of the oral notification. The notice will state, in a manner calculated to be understood by the Plan Participant:

- The specific reason or reasons for the adverse determination
- Reference to the specific Plan provisions on which the determination was based;
- A statement that the Plan Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Plan Participant's Claim for benefits;
    1. If the adverse benefit determination was based on an internal rule, guideline, protocol or other similar criterion, the specific rule, guideline, protocol or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the Plan Participant upon request.
    2. If the adverse benefit determination is based on 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 Plan Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.
    3. Statements describing any voluntary appeal procedures and the Plan Participant's right to obtain information about such procedures.

Voluntary External Appeal to an Independent Review Organization (IRO)
A voluntary external appeal to an Independent Review Organization (IRO) is available to a Plan Participant only after the Plan Participant has exhausted all of the applicable levels of appeal.

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.

The Medical Benefits Claims Administrator coordinates the process, but the decision is made by an IRO at no cost to the Plan Participant.

The Plan Participant must submit the appeal to the Medical Benefits Claims Administrator in writing, with the exception of Urgent Care claim review which may be requested orally. The appeal must be submitted within four (4) months after receipt of the Claim denial. If the appeal is not submitted within this time period, the Plan Participant will not be able to continue to pursue the appeal process.

Upon receipt of the request, the Medical Benefits Claims Administrator will complete an initial review of the request within five (5) days and determine:

- Whether the participant was covered under the Plan at the time the service was requested or provided;
- Whether the denial relates to the participant's failure to meet the Plan's eligibility criteria;
- Whether the participant has exhausted all applicable levels of appeal; and
- Whether the participant has provided all of the information and forms necessary to process the external review.

Within one (1) business day after completion of the review, the Medical Benefits Claims Administrator will provide written notification to the participant of eligibility for external review. If the request was incomplete, the participant may submit any additional forms or information within the four (4) month filing period or the 48-hour period after the participant receives the notification (whichever is later).

The Medical Benefits Claims Administrator will submit the Claim and related information to the IRO for independent review. Note that information submitted to the IRO will include the Plan Participant's "Protected Health Information" (described in this Plan Document and Plan Summary). The IRO will access and rely on appropriate clinical expertise in making the review determination. The IRO does not have any direct financial interest in the Poudre School District Health Plans or the Plan Administrator (employer), nor will the IRO have any financial interest in the outcome of the review determination.

If the independent review involves an Urgent Care Claim, the IRO will issue the review determination within 72 hours after they receive the request. For all other Claims, the IRO will issue the review determination within 45 days after the IRO receives the request for an external review. The IRO review determination will be in writing and a copy will be sent to the Plan Participant by the Medical Benefits Claims Administrator.

A request to expedite the appeal process may be made if, (a) the time frames under this process would seriously jeopardize life, health or ability to regain maximum functionality or in the opinion of the Provider would cause the Plan Participant severe pain which cannot be managed without the requested services; or (b) the appeal involves non-authorization of an admission or continuing inpatient hospital stay. The medical reviewer, in consultation with the treating Provider, will decide if an expedited appeal is

necessary. When an appeal is expedited, an oral response regarding the decision will be within 72 hours, followed up in writing.

Final Decision

The decision as a result of the appeal process shall be final and binding upon all parties, including the applicant or petitioner and any person claiming under the applicant or petitioner. The provisions of the Claims appeal process shall apply to and include any and every claim to benefits from the Plan, and any claim or right asserted under this Plan document or against the Plan, regardless of the basis asserted for the claim and regardless of when the act or omission upon which the claim is based occurred.

Choosing the voluntary external appeal as the final level to determine an appeal will be binding in accordance with the IRO's decision.

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Plan Exclusions

Note:
- All Exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.
- All Exclusions related to Mental/Behavioral Health and Substance Abuse are shown in the Mental/Behavioral Health and Substance Abuse Plan.

If any services or supplies are not specifically addressed in this Plan, whether as an Exclusion or covered expense, it is not to be assumed that such services or supplies are covered under this Plan. In addition to any Exclusions described elsewhere in this Plan, the Plan shall not provide benefits for any expenses for services, treatments, supplies, or accommodations directly or indirectly related to the following Exclusions and, for Medical Benefits shown in the schedule of benefits, a charge for the following is not covered under the Plan:

- **Abortions.** Charges for induced abortions, except to the extent such medical procedures are deemed necessary to prevent the death of a pregnant woman or her unborn child due to life-endangering circumstances as permitted under Colorado Revised Statutes.

- **Behavioral modifications.** Charges for hypnotics.

- **Chelation therapy.**

- **Contraceptives.** Oral contraceptives, contraceptive devices, or other contraceptive drugs that are not specifically covered herein. See Prescription Drug section in this document for additional information.

- **Cosmetic surgery.** Services in connection with remedying a condition except in connection with treatment of a congenital abnormality in a newborn child who is covered under the Plan, repair or alleviation of damage resulting from a bodily Injury sustained while a Plan Participant is covered under the Plan for up to twenty-four (24) months after the date of the accident, or initial reconstruction due to a mastectomy.

- **Custodial Care.** Services or supplies provided mainly as a rest cure, for maintenance care or Custodial Care.

- **Dental Services.** Charges for dental care or treatment, dental surgery, or dental appliances, unless otherwise stated under Covered Charges.
  - Dental appliances, restorations, or procedures for (i) altering vertical dimension; (ii) restoring or maintaining occlusion; (iii) splinting; or (iv) replacement of tooth surface lost by abrasion or attrition;
  - Charges for dental care or treatment, dental surgery, or dental appliances, unless otherwise stated under Medical Benefits, except where eligible under medical as a surgical procedure (no dental coverage in effect).
- **Drugs.** For over-the-counter drugs, even if prescribed by a Provider and drugs that are not approved for sale in the United States unless otherwise specified as a covered benefit herein.
- **Educational or vocational testing.** Services for educational or vocational testing, training, or rehabilitation.
- **Excess charges.** The part of an expense for care and treatment of an Injury or Illness that is in excess of the Usual and Customary Charge.
- **Exercise programs.** Exercise programs for treatment of any condition, except for Provider-supervised cardiac rehabilitation, Occupational or physical therapy covered by this Plan.
- **Experimental or not Medically Necessary.** Care and treatment that is not Medically Necessary and expenses for any Experimental drug therapy or health procedures meeting the definition of Experimental/Investigational in this Plan.

  Except for approved clinical trials for cancer or other life-threatening diseases or conditions as outlined in the Medical Benefits section of this document.
- **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. For eyeglasses, including contact lenses, or examinations for the prescription or fitting thereof, except:
  - When necessitated by damage to the natural eye as a result of an Injury, which occurs while covered under this Plan, unless otherwise stated herein; and
  - For the first pair of glasses or contact lenses prescribed as a result of cataract surgery or the eye condition keratoconus or accidental Injury to the lens of the eye.

  In addition,
  - Examinations will only be covered for the purpose of evaluating the effects of an Illness or Injury;
  - Examinations for the purpose of evaluation or the prescription for an ocular related Illness or deficiency will not be covered; and

  - For eye examinations made for or in connection with diagnosis or treatment of astigmatism, myopia, or hyperopia to include orthoptic treatment and visual training and lazy eye, unless otherwise stated herein.

- **Foot care.** (a) Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), (b) treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease); and expenses for orthopedic shoes.

- **Foreign travel.** Care, treatment or supplies out of the United States if travel is for the sole purpose of obtaining medical services.

- **Government coverage.** (a) 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. If, with respect to a bodily Injury or Illness, a Plan Participant is entitled, or could have been entitled if proper application had been made, to any medical benefits paid by, reimbursed by, or provided by, or under the authority of any government or any governmental agency, such benefit shall discharge the obligation of this Plan as though and to the extent such benefit had been paid hereunder, but no Claim will be denied solely because treatment or services rendered in a Hospital owned or operated by a state or political subdivision thereof; and (b) care or treatment for which an Employee is not financially responsible that is provided or furnished by a Hospital operated by a government unit, or the government of any country, or any agency thereof, except as provided by federal law.

- **Hair loss.** Care and treatment for hair loss including wigs or artificial hairpieces, except as described in this Plan, hair transplants or any drug that promises hair growth, whether or not prescribed by a Provider.

- **Hearing aids.** Replacement or repair of a lost, missing, stolen or broken hearing aid is excluded under this Plan.

- **Home Health Care.** Charges for transportation services, any period during which the Plan Participant is not under the continuing care of a Provider, a masseur, physical culturist, physical education instructor, or any service rendered to the Plan Participant that could have been provided by any other properly trained person of the household without endangering the Plan Participant's life or seriously impairing his or her condition.

- **Hospital Expenses.** Charges for Hospital admission for diagnostic or evaluation procedures unless the tests could not be performed on an outpatient basis without adversely affecting the health of the Plan Participant. Charges for room and board for admission the night before surgery unless it is Medically Necessary.

- **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.

- **Immunizations**. Immunizations for foreign travel for both adults and children.
- **Impotence.** Care, treatment, services or supplies in connection with the treatment for sexual dysfunction.
- **Infertility.** Care, supplies, services and treatment for Infertility, except for diagnostic services rendered for Infertility evaluation. This Exclusion includes the following items:
  - Laparoscopy for the treatment of Infertility or as a diagnostic procedure in connection with an Infertility determination.
  - Experimental procedures, test-tube fertilizations, and reversals of sterilization procedures are not covered.
  - Blood work performed to monitor hormone levels or for the treatment of Infertility or inducement of Pregnancy.

  See Covered Charges section in this document for additional information.
- **Massage Therapy.** There are no benefits under this plan for Massage Therapy whether or not prescribed by a Provider.
- **Miscellaneous Exclusions.** (a) any charge under more than one (1) single coverage, unless specifically provided otherwise.
- **No charge.** Any charges the Plan Participant is not obligated to pay, is not billed, or would not have been billed except for the fact that the Plan Participant was covered under this Plan, unless care is rendered in a Veteran's Administration Hospital for a non-military service connected disability. Any charge under more than one (1) single coverage.
- **No-Fault Automobile Laws.** The benefits of this Plan will not be available to a Plan Participant to the extent of the minimum coverage required by any No-Fault law for injuries suffered while operating or riding in a motor vehicle owned by the Plan Participant if said vehicle is in operation on the public highways of the State of Colorado and such vehicle is not covered by No-Fault Automobile Insurance as required by law. However, this Exclusion will not apply to any Plan Participant injured in a motor vehicle accident if the Plan Participant is not the owner of the vehicle or if the Plan Participant is a passenger or a pedestrian, and such other person is not covered by No-Fault Automobile Insurance. No-Fault Automobile Insurance laws do not exist in Colorado.
- **No obligation to pay.** Charges incurred for which the Plan Participant or the Plan has no legal obligation to pay.
- **No Provider recommendation.** An Injury or Illness for which the person on whose behalf a Claim is presented is not under the care of a Provider.
- **Not specified as covered.** Incurred in connection with oriental pain control (acupressure), except when utilized in lieu of anesthesia.

- **Nursing Home.** Any services provided by a rest home, convalescent home, nursing home, or any institution providing primarily convalescent, rehabilitation, or Custodial Care.
- **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Illness. Medically Necessary charges for Morbid Obesity will be covered as provided in guidelines administered by the designated Third Party administrator and adopted by this Plan.
- **Occupational.** For any condition, Injury, disease, or disability for which there is coverage under Workers' Compensation or similar legislation, whether or not they are an active participant in the Workers' Compensation program. This Exclusion will not apply in situations where a Plan Participant is self-employed on a part-time basis, at a job that does not provide their primary source of income and they sustain an Injury or Illness while performing their duties.
- **Organ transplants.** Charges for non-human organ transplants or permanent artificial hearts.
- **Other Coverage.** Any service or supply which is covered in whole or in part under any other employee benefit plan provided or sponsored by the Employer or when covered by a spouse also covered under this Plan.
- **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, nonprescription drugs and medicines, non-Hospital adjustable beds, swimming apparatus, whirlpools, health spas or exercise equipment, whether or not prescribed by a Provider.
- **Private duty nursing.** Charges in connection with care, treatment or services of a private duty nurse.
- **Prosthetic devices.** Replacement or repair of a lost, missing, or stolen prosthetic device or other device or appliance is excluded under this Plan.
- **Relative providing services.** Professional services performed by a person who ordinarily resides in the Plan Participant's home or is related to the Plan Participant, whether the relationship is by blood or exists in law.
- **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 schedule of benefits.
- **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.

- **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This Exclusion includes medications, implants, hormone therapy, surgery, and medical treatment.
- **Smoking/tobacco cessation.** Care and treatment for smoking/tobacco cessation programs, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.
- **Speech Therapy.** For speech therapy unless incurred as a result of Illness or accident while covered under this Plan except that eligible services will be covered for learning and Mental/Behavioral Disorders for a Dependent child not eligible for the Head Start program or other similar government programs subject to all other provisions of the Plan.
- **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- **Surrogacy.** Care, treatment, services or supplies related to conception, pregnancy or delivery in connection with a Surrogacy Arrangement for pregnancy or birth, but only to the extent permitted by applicable law.
- **Temporomandibular Joint Syndrome.** All treatment, services, appliances or surgery related to the treatment of jaw joint problems including temporomandibular joint (TMJ, the joint between the jaw and the temple) pain or syndrome, or orthognathic treatment or surgery.
- **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Provider, except for ambulance charges as defined as a Covered Charge.
- **War.** Any condition, disability or expense resulting from or sustained as a result of war or an act of war, declared or undeclared.

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Mental/Behavioral Health and Substance Abuse Schedule of Benefits

All benefits described in this schedule are subject to the Exclusions and Limitations described more fully herein including, but not limited to, the Mental/Behavioral Health and Substance Abuse Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Customary; that services, supplies and care are not Experimental and/or Investigational.

All inpatient services MUST be pre-authorized through Employee Assistance Services (EAS) for any benefits to be covered. A five hundred dollar ($500) penalty will be assessed for failure to pre-authorize through Employee Assistance Services. This penalty will be in addition to applicable Deductibles and will not count toward the annual Out-of-Pocket Maximum. See Mental Health/Substance Abuse Cost Management Services in this section for additional information.

Employee Assistance Services contracts rates directly with the Providers. Plan Participants may be responsible for charges that exceed the Usual and Customary rate standard determined by EAS.

Eligibility

Plan Participants in the PPO-1 Plan and PPO-2 Plan.

Claims Submission

All Claims should be sent to:
Employee Assistance Services (EAS)
2850 McClelland Drive, Suite 2200
Fort Collins, CO 80525
970-488-4925

Mental Health/Substance Abuse Cost Management Services

Mental Health/Substance Abuse Cost Management Services Phone Number

Employee Assistance Services (EAS)
(970) 488-4925
Telephone assistance is available twenty-four (24) hours a day, seven (7) days a week.

This information is also printed on the Plan Participant's medical ID card.

The Plan Participant, Plan Participant's representative, Mental Health/Substance Abuse Care Facility, or attending Provider must call this number to receive certification of certain Mental Health/Substance Abuse Cost Management Services. This call must be made at least twenty-four (24) hours in advance of services being rendered or when medically reasonable after an Emergency.

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

Outpatient Care

Outpatient Care must be pre-assessed and a referral provided by EAS to a Network Provider for Network benefits to be approved by the Plan. Benefits will be reduced to 50% of the Usual and Customary rate as a result of failing to receive a referral from EAS or if care is administered by a Non-Network Provider.

If there has been a six (6) month break in Outpatient Services, Plan Participants must contact EAS for a renewal of the referral in order for benefits to be paid at the Network rate. Benefits will be reimbursed at the Non-Network rate until the renewal occurs.

Utilization Review

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

The program consists of:

- Pre-certification of the Medical Necessity for the following non-Emergency services before Mental/Behavioral Health and/or Substance Abuse care and/or services are provided:
  - Neuro-Feedback Therapy
  - Substance Abuse/Mental/Behavioral Disorder Treatments
- Retrospective review of the Medical Necessity of the services provided on an Emergency basis;

- Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Provider; and

- Certification of services and planning for discharge from a Mental Health/Substance Abuse Care Facility or cessation of Mental Health/Substance Abuse treatment.

The purpose of the program is to determine what is payable by the Plan.

If a particular course of treatment or Mental Health/Substance Abuse 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. Before a Plan Participant enters a Mental Health/Substance Abuse Care Facility on a non-Emergency basis or receives other listed Mental Health/Substance Abuse services, the utilization review administrator will, in conjunction with the attending Provider, certify the care as appropriate for Plan reimbursement. A non-Emergency stay in a Mental Health/Substance Abuse Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by the requesting Provider. Contact the utilization review administrator at the telephone number on your ID card **at least twenty-four (24) hours before** services are scheduled to be rendered with the following information:

- The name of the Plan Participant and relationship to the Covered Employee
- The name, social security number and address of the Covered Employee
- The name of the Employer
- The name and telephone number of the attending Provider
- The name of the Mental Health/Substance Abuse Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of services
- The proposed rendering of listed Mental Health/Substance Abuse services

Inpatient care must be pre-authorized by EAS and referred to a Network Provider for benefits to be approved by the Plan. If the Plan Participant does not receive authorization as explained in this section, the benefit payment will be reduced by five hundred dollars ($500), and failure to utilize approved Network Providers will result in a loss of benefits altogether. In addition, any amount paid by the Plan Participant due to a reduced reimbursement will not apply toward the Deductible or Out-of-Pocket Maximum.

Inpatient care is subject to criteria for Medical Necessity as adopted by Employee Assistance Services and as identified as best practices by the Joint Commission on

Accreditation of Healthcare Organizations. Employee Assistance Services provides pre-authorization, case management, and coordination of care through the inpatient stay.

If there is an **Emergency** admission to a Mental Health/Substance Abuse Care Facility, the Plan Participant, Plan Participant's authorized representative, Mental Health/Substance Abuse Care Facility or attending Provider must contact the utilization review administrator **within twenty-four (24) hours** of the first business day after the admission or when medically reasonable.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Mental Health/Substance Abuse Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Plan Participant's Mental Health/Substance Abuse Care Facility stay or use of other Mental Health/Substance Abuse services and coordinate with the attending Provider, Mental Health/Substance Abuse Care Facility and Plan Participant either the scheduled release or an extension of the Mental Health/Substance Abuse Care Facility stay or extension or cessation of the use of other Mental Health/Substance Abuse services.

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

Second And/Or Third Opinion Program

A Second Medical Opinion is a re-evaluation of a condition or health care treatment by an appropriately qualified Provider. The Provider must be either a psychiatrist or a specialist acting within his or her scope of practice and must possess the clinical background necessary for examining the Illness or condition associated with the request for a Second Medical Opinion. Upon completing the examination, the Provider's opinion is included in a consultation report.

Failure to comply with a request for a second and/or third opinion will reduce reimbursement received from the Plan.

Mental Health/Substance Abuse Case Management

Mental Health/Substance Abuse Case Management is a program whereby a Mental Health/Substance Abuse case manager monitors Plan Participants and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The Mental Health/Substance Abuse case manager consults with the Plan Participant, the Plan Participant's representative and the attending Provider in order to develop a plan of care for approval by the Plan Participant's attending Provider and the Plan Participant. This plan of care may include but is not limited to the following:

- personal support to the Plan Participant;
- contacting the family to offer assistance and support;
- monitoring Hospital or Mental Health/Substance Abuse Facility;

- determining alternative care options; and
- assisting in obtaining any necessary services.

Mental Health/Substance Abuse Case Management occurs when this alternate benefit will be beneficial to both the Plan Participant and the Plan.

The Mental Health/Substance Abuse case manager will coordinate and implement the Mental Health/Substance Abuse Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Mental/Behavioral Health and Substance Abuse Administrator, attending Provider, Plan Participant and Plan Participant's representative must all agree to the alternate treatment plan.

Once agreement has been reached, the Mental/Behavioral Health and Substance Abuse 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.

Coinsurance Payable by Plan Participants

Coinsurance is a percentage of allowed charges that the Plan Participant must pay before the Plan pays. The following chart shows the amount of Deductible and Coinsurance required.

The Deductibles listed in the chart are separate from the medical Deductible.

The Out-of-Pocket Maximums listed in the chart ***are*** separate maximums for Network and Non-Network expenses.

Benefit Description	Network Providers	Non-Network Providers
Lifetime Maximum	None	None
Plan Year Out-of-Pocket Maximum	Individual: $8,250 Family: $16,500	None None
Inpatient Services (30-day maximum per admit)		No benefit
Deductible	Plan Participant pays $500 per admit	N/A
Coinsurance	Plan pays 70%; Plan Participant pays 30% after Deductible	N/A
Maximum Benefit	N/A	N/A

Outpatient Services		
Deductible	None	None
Coinsurance	Plan pays 70%; Plan Participant pays 30%	Participant pays 50% of U & C
Maximum Benefit	None	$800 per Plan Year

Benefits

Benefit Payment

Each Plan Year, benefits will be paid for the Covered Charges of a Plan Participant that are in excess of any Coinsurance and Deductible. Payment will be made at the applicable rate in the schedule of benefits.

Benefits at the Network level require assessment by EAS and a referral to a Network Provider.

There are no inpatient benefits available for Non-Network Providers.

Out-Of-Pocket Maximum

Covered Charges are payable at the percentages shown each Plan Year until the Out-of-Pocket Maximum shown in the schedule of benefits is reached. Then, Covered Charges incurred by a Plan Participant will be payable at 100% (except for the charges excluded or any items noted below) for the remainder of the Plan Year.

When a family unit reaches the Out-of-Pocket Maximum, Covered Charges for that family unit will be payable at 100% (except for the charges excluded or any items noted below) for the remainder of the Plan Year.

Charges in excess of Usual and Customary **do not** count toward Out-of-Pocket Maximums.

Only Network expenses will apply toward the Network Out-of-Pocket Maximum and only Non-Network expenses will apply toward the Non-Network Out-of-Pocket Maximum.

The medical Out-of-Pocket Maximum is separate from the Mental/Behavioral Health and Substance Abuse Out-of-Pocket Maximum.

Maximum Benefit Amount

The maximum benefit amount is described in the Mental/Behavioral Health and Substance Abuse schedule of benefits.

Covered Charges

Covered Charges are the Usual and Customary Charges incurred for the treatment of Mental/Behavioral Health and Substance Abuse. 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.

Covered Charges for partial hospitalization and intensive outpatient services are included under outpatient services subject to a 30-visit maximum per Plan Year based on Medical Necessity.

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

- All treatment is subject to the benefit payment maximums shown in the Mental/Behavioral Health and Substance Abuse schedule of benefits.

Light Therapy Box for the treatment of Seasonal Affective Disorder (SAD). The following criteria applies:

- Must have a diagnosis of seasonal affective disorder (SAD).
- Must receive a recommendation for lightbox therapy from a Physician or primary therapist.
- The Plan Participant must obtain prior certification for the lightbox through the Mental/Behavioral Health and Substance Abuse Administrator. If prior certification is not obtained; benefits may not be payable for such services or benefits may be subject to reduced levels as outlined in the Mental/Behavioral Health and Substance Abuse section of the plan document.
- The maximum benefit reimbursement is $200.
- Limit of one lightbox purchase per lifetime.

Neuro-feedback Therapy. Neuro-feedback therapy (subject to a 30-visit maximum per authorization) is payable when prescribed and/or provided by a Mental/Behavioral Health and Substance Abuse Administrator Network Provider and Medically Necessary. In addition, the following criteria applies:

- Neuro-feedback therapy requires pre-certification by the Mental/Behavioral Health and Substance Abuse Administrator with the recommendation from a Network Provider.
- Neuro-feedback therapy is a covered benefit for the following diagnoses only:
    - Attention deficit hyperactivity disorder (ADHD)
    - Intractable depression
    - Post-traumatic stress disorder (PTSD)
- The Plan Participant must be in concurrent therapy with a Mental/Behavioral Health and Substance Abuse Administrator Network Provider.
- Neuro-feedback therapy must be provided through a Network Provider. There is no Non-Network benefit for neuro-feedback therapy.
- It will be the Plan Participant's responsibility to obtain prior certification for neuro-feedback therapy through the Mental/Behavioral Health and Substance Abuse Administrator. If prior certification is not obtained, benefits may not be payable for such services or benefits may be subject to reduced levels as outlined

in the Mental/Behavioral Health and Substance Abuse section of the plan document.

Additional **Preventive Services** covered under the Plan include evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF). These Preventive Services may require coordination of services between medical Covered Charges and Mental/Behavior Health and Substance Abuse Covered Charges. When the USPSTF recommendations and guidelines are updated, they will apply to this Plan. The updates will be effective on the first day of the Plan Year, one year after the updated recommendations or guideline is issued.

Exclusions

For all Mental/Behavioral Health and Substance Abuse Benefits shown in the schedule of benefits, a charge for the following is not covered:

- Acupuncture
- Court-ordered treatment, including behavioral/conduct disorder and domestic violence
- Custodial Care
- The following **diagnostic** categories:
  - Learning disorders
  - Mental retardation
  - Dyslexia
  - Chronic pain disorders
- Disability cases
- Family psychotherapy (without the patient present)
- Inpatient behavioral/conduct disorders
- Lifestyle and well-being programs that are primarily educational, including but not limited to:
  - Weight control
  - Marriage enrichment
  - Diet programs
  - Financial counseling
  - Vocational counseling
  - Wellness programs
- Medical-surgical care

  - Provided outside of a recognized alcoholism, other drug abuse, or psychiatric facility;
  - For medical services related to alcoholism, other drug abuse, or mental Illness (i.e., medical intervention as a result of an attempted suicide)

- Occupational therapy

- Residential treatment

- Treatment for non-compliant Plan Participants (i.e., two [2] or more uncompleted treatment episodes in the past twelve [12] months)

- Treatment initiated primarily as the result of criminal behavior, or court ordered treatment which is not determined to be Medically Necessary

- Treatment which is not expected to materially improve the Plan Participant's condition or symptoms

- Workers' compensation cases

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Coordination of Benefits

Coordination of Benefits. Coordination of benefits establishes the rules for the order of payment of Covered Charges when two (2) or more plans -- including Medicare -- are paying. When a Plan Participant is covered by this Plan and another plan, 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.

Note: There is no coordination of benefits on the Pharmacy plan. It is the responsibility of the Plan Participant to choose the plan that best fits their needs.

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

- Group or group-type plans, including franchise or blanket benefit plans.
- Blue Cross and Blue Shield group plans.
- Group practice and other group prepayment plans.
- Federal government plans or programs. This includes Medicare.
- 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.
- No-Fault Auto Insurance, by whatever name it is called, when not prohibited by law. No-Fault Automobile Insurance laws do not exist in Colorado.

Allowable charge. For a charge to be allowable it must be a Usual and Customary Charge incurred by the Plan Participant, and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other Network only plans: This Plan will not consider any charges in excess of what an HMO or Network Provider has agreed to accept as payment in full. Also, when an HMO or Network plan is primary and the Plan Participant does not use an HMO or Network Provider, this Plan will not

consider as an allowable charge any charge that would have been covered by the HMO or Network plan had the Plan Participant used the services of an HMO or Network Provider.

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

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier.

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

- 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.
- Plans with a coordination provision will pay their benefits up to the Allowable Charge:
  - The benefits of the plan which covers the person directly (that is, as an Employee, Plan Participant or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B").
  - The benefits of a benefit plan, which covers a person as an Active Employee, are determined before those of a benefit plan that covers that person as qualified beneficiary under COBRA. The benefits of a benefit plan that covers a person as a Dependent of an Active Employee are determined before those of a benefit plan which covers a person as a qualified beneficiary. 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.
  - When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
    - 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;
    - If both parents have the same birthday, the benefits of the benefit plan that has covered the parent for the longer time are determined before those of the benefit plan that covers the other parent.
      However, if the other plan does not have the rule described in (i) immediately above, but instead has a rule based upon gender of the parent, and if, as a result, the plans do not agree on the order of benefits determination, the rule in the other plan will determine the order of benefits.
  - When a child's parents are divorced or legally separated, these rules will apply:
    - 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.

- 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 step-parent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
- 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 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.
- 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.

– If there is still a conflict after these rules have been applied, the benefit plan which has covered the Plan Participant 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.

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

Claims determination period. Benefits will be coordinated on a 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 to the extent permitted by this Plan and HIPAA. 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 appropriate Claims 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 (insurance company or organization). 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.

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Prescription Drug

Schedule of Benefits

All benefits described in this schedule are subject to the Exclusions and Limitations described more fully herein including, but not limited to, the Pharmacy Benefit Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Customary; that services, supplies and care are not Experimental and/or Investigational.

Coinsurance and Copayments Payable by Plan Participants

The maximums listed below are **separate** from the medical Out-of-Pocket Maximum.

Benefit Description	Network Only
Prescription Drugs	
Out-of-Pocket Maximum	Individual: $1,500 Family: $3,000
Retail (up to a 34-day supply)	Generic: Plan Participant pays 10%, minimum $10 not to exceed cost of drug Preferred: Plan Participant pays 20%, minimum $20 not to exceed cost of drug Non-Preferred: Plan Participant pays 30%, minimum $40 not to exceed cost of drug
Mail Order (up to a 90-day supply)	Generic: You pay $25 Preferred: You pay $75 Non-Preferred: You pay $125

Pharmacy Benefit Plan Administrator

OptumRx
2441 Warrenville Road, Suite 610
Lisle, IL 60532-3642
1-800-880-1188
www.optumrx.com

Benefits

A Plan Participant should contact the Pharmacy Benefit Plan Administrator to obtain information, free of charge, about Plan coverage of a particular drug or any other aspect of Plan benefits or requirements.

There is no coordination of benefits on the Pharmacy plan. It is the responsibility of the Plan Participant to choose the plan that best fits their needs.

Pharmacy expenses paid by the Plan Participant do not count toward the medical Out-of-Pocket maximum.

All Prescription Drugs will be dispensed with a Generic equivalent unless the Provider indicates "dispense as written" on the written prescription. If a Plan Participant chooses a drug other than Generic without the Providers indication to "dispense as written", the Plan Participant will be responsible for the cost differential between the Generic equivalent and the brand drug.

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Plan Participants reduced fees for covered Prescription Drugs.

Copayments or Coinsurance

The Copayment or Coinsurance is applied to each covered Pharmacy drug or mail order drug charge and is shown in the Prescription Drug schedule of benefits. Any one Pharmacy prescription is limited to a thirty-four (34) day supply. Any one home delivery prescription is limited to a ninety (90) day supply.

If a Plan Participant does not present their ID card at the Pharmacy, the Plan Participant will have no pharmacy benefit coverage.

Home Delivery Drug Benefit Option

The home delivery drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, diabetes, etc.). Because of volume buying, OptumRx, the home delivery Pharmacy, may be able to offer Plan Participants significant savings on their prescriptions.

Retail Refill Allowance (RRA) Program

The Retail Refill Allowance (RRA) program allows a Plan Participant to fill a maintenance medication (as described under "Home Delivery Drug Benefit Option") two times at a participating retail Pharmacy at the retail Pharmacy Co-insurance level of benefit. On the third fill for each long-term medication at a retail Pharmacy (which has a maximum limit of a 34-day supply), the Plan Participant will pay a higher Copayment equal to the home delivery prescription Copayment.

Covered Prescription Drugs

For detailed information on specific covered Prescription Drugs, Plan Participants should contact the Pharmacy Benefit Plan Administrator.

- All drugs prescribed by a Provider that require a prescription either by federal or state law. This includes growth hormones (for children diagnosed with short stature due to growth hormone deficiency) and allergy injections, but excludes any drugs stated as not covered under this Plan.

- Oral contraceptives, transdermal contraceptives, interuterine contraceptives, and injectable contraceptives as provided in guidelines administered by the designated Pharmacy Benefit Plan Administrator and adopted by this Plan, but excludes any drugs stated as not covered under this Plan.

- All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

- Insulin and other diabetic supplies when prescribed by a Provider. A Plan Participant purchasing insulin or oral diabetic agents will be allowed to receive diabetic supplies (e.g. test strips, syringes) at $0 Copayment or Coinsurance on the same day.

- Drugs for cosmetic purposes for Plan Participants through age twenty-five (25) years (e.g., Retin-A)

- The following injectable drugs: Epinephrine, Etanercept (Enbrel), Glatiramer Acetate (Copaxone), Depreprovera (may be dispensed in up to a ninety [90] day supply), Interferon, and Sumatriptan (Imitrex).

- State restricted drugs (e.g., cough syrups containing codeine).

- **Appetite suppressants.** A charge for prescription appetite suppressants and weight loss agents. Certain appetite suppressants and weight loss agents will be covered as provided in guidelines administered by the designated Pharmacy Benefit Plan Administrator and adopted by this Plan.

- **Smoking/tobacco cessation.** A charge for Prescription Drugs and over-the-counter smoking/tobacco cessation products when prescribed by a Provider for Plan Participants, such as nicotine gum or smoking deterrent patches. Coverage will be provided based on guidelines administered by the designated Pharmacy Benefit Plan Administrator and adopted by this Plan. A quantity limit of two (2) cycles per year applies to all products. There will be a $0 Copayment or Coinsurance.

- Oral over-the-counter aspirin when prescribed by a Provider for Plan Participants as recommended by USPSTF. Excludes prescription aspirin products, non-oral aspirin products, or aspirin strengths greater than 325 mg. There will be a $0 Copayment or Coinsurance.

- Over-the-counter folic acid supplementation products containing 0.4 to 0.8 mg (400 to 800 mcg) of folic acid including prenatal vitamins containing folic acid when prescribed by a Provider for Plan Participants under age 55. Excludes prescription folic acid supplementation products. There will be a $0 Copayment or Coinsurance.

- Bowel preparation agents for colorectal cancer screening as recommended by USPSTF. This includes generic prescription bowel preparation agents and specific over-the-counter products prescribed by a Provider for adults 50 years of age or older with a quantity limit of one (1) product per year. There will be a $0 Copayment or Coinsurance.

- Breast cancer preventive medications as recommended by USPSTF for women at increased risk for breast cancer. Coverage will be provided based on guidelines administered by the designated Pharmacy Benefit Plan Administrator and adopted by this Plan. There will be a $0 Copayment or Coinsurance.

- Prescription iron supplementation products and over-the-counter iron supplementation products prescribed by a Provider for children ages six (6) months to twelve (12) months.

- Fluoride when prescribed by a Provider for Plan Participants through age five (5) years. There will be a $0 Copayment or Coinsurance.

- PrEP medication as recommended by USPSTF to prevent HIV. There will be a $0 Copayment or Coinsurance.

Limits To This Benefit

This benefit applies only when a Plan Participant incurs a covered Prescription Drug charge. The covered drug charge for any one (1) prescription will be limited to:

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

Exclusions

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

- **Administration.** Any charge for the administration or injection of a covered Prescription Drug.
- **Consumed on premises.** 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 (rest home, sanitarium, Skilled Nursing Facility) that has a facility for the dispensing of drugs and medicines on its premises.

- **Contraceptives.** Any charge for over-the-counter contraceptives or implants. Any charge for the "morning after pills" including Preven and Plan B. Oral contraceptives, contraceptive devices, or other contraceptive drugs which are not specifically covered herein.
- **Dietary and vitamin supplements.** A charge for dietary or vitamin supplements, except prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride, unless otherwise specified as a covered benefit herein.
- **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) contraceptive devices, therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- **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 or anti-wrinkle agents.
- **Experimental.** Experimental drugs and medicines even though a charge is made to the Plan Participant.
- **FDA.** Any drug not approved by the Food and Drug Administration.
- **Growth Hormones.** Except as described in the Covered Prescription Drugs above.
- **Immunization.** Immunization agents or biological sera.
- **Infertility.** A charge for Infertility medication.
- **Injectables.** A charge for injectables or any prescription directing administration by injection (other than insulin).
- **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to Investigational use".
- **Medical Exclusions.** A charge excluded under Medical Plan Exclusions.
- **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
- **Over-the-counter medications.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- **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 Provider.

Claim Procedure

Following is a description of how the pharmacy Claims are processed. A Claim is defined as any request for a pharmacy benefit, made by a Plan Participant or by a representative of a Plan Participant that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. "Days" means calendar days.

There are different kinds of Claims and each one has a specific guideline for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Pharmacy Benefit Plan Administrator.

The types of Claims are described below:

- **Non-Urgent Care Claims (Pre-service and post-service other than direct Claims)** A pre-service Claim is a request for coverage of a medication when your Plan requires you to obtain approval before a benefit will be payable. For example, a request for prior authorization is considered a pre-service Claim. For these types of Claims (unless urgent as described below) you will be notified of the decision not later than 15 days after receipt of a pre-service Claim that is not an urgent care Claim, provided you have submitted sufficient information to decide your Claim. A post-service Claim is a request for coverage or reimbursement when you have already received the medication. For post-service Claims, you will be notified of the decision no later than 30 days after receipt of the post-service Claim, as long as all needed information was provided with the Claim.

  If sufficient information to complete the review has not been provided, you will be notified that the Claim is missing information within 15 days from receipt of your Claim for pre-service and 30 days from receipt of your Claim for post-service. You will have 45 days to provide the information. If all of the needed information is received within the 45-day time frame, you will be notified of the decision not later than 15 days after the later of receipt of the information or the end of that additional time period. If you don't provide the needed information within the 45-day period, your Claim is considered "deemed" denied and you have the right to appeal as described below.

  If your Claim is denied, in whole or in part, the denial notice will include information to identify the Claim involved, the specific reasons for the decision, the Plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the Claims and appeals processes and any additional information needed to perfect your Claim. You have the right to a full and fair impartial review of your Claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your Claim. If you are not satisfied with the decision

on your Claim (or your Claim is deemed denied), you have the right to appeal as described below.

- **Urgent Care Claims (Expedited Reviews)**
  An urgent care Claim is defined as a request for treatment when, in the opinion of your attending Provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your Claim. In the case of a Claim for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the Claim provided there is sufficient information to decide the Claim.

  If the Claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your Claim that information is necessary to complete the Claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of receipt of the information. If you don't provide the needed information within the 48-hour period, your Claim is considered "deemed" denied and you have the right to appeal as described below.

  If your Claim is denied, in whole or in part, the denial notice will include information to identify the Claim involved, the specific reasons for the decision, the Plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the Claims and appeals processes and any additional information needed to perfect your Claim. You have the right to a full and fair impartial review of your Claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your Claim. If you are not satisfied with the decision on your Claim (or your Claim is deemed denied), you have the right to appeal as described below.

- **Direct Claims**
  Your Plan provides for reimbursement of prescriptions when you pay 100 percent of the prescription price at the time of purchase. The Claim will be processed based on your Plan benefit. To request reimbursement, you will send your Claim to:

  OptumRx
  Attn: Manual Claims Department
  P.O. Box 968022
  Schaumburg, IL 60196-8022

  You will be notified of the decision within 30 days of receipt of the Claim, as long as all needed information was provided with the Claim.

  If your Claim does not provide sufficient information for the Claim to be processed, you will be notified that more information is needed within 30 days of receipt of the

Claim. If your Claim provides sufficient information to determine the last day that your Plan allows you to submit the Claim for reimbursement (i.e., plan's stale date), then you will be notified that more information is needed and you will have until that date to submit the missing information. If you do not submit the information by the required date, your Claim is deemed denied and the appeal rights discussed below apply. If you do submit the information by the required date, you will be notified of the decision within 15 days after the information is received. If your Claim is missing information, and without the information the Claim's stale date cannot be determined, your Claim will be denied and you have the right to appeal the decision as described below.

If your Claim is denied, the denial notice will include information to identify the Claim involved, the specific reasons for the decision, the Plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the Claims and appeals processes and any additional information needed to perfect your Claim. You have the right to a full and fair impartial review of your Claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your Claim.

If you are not satisfied with the decision on your Claim or your Claim is deemed denied, you have the right to appeal this decision. See below for appeal instructions.

Appeal of Non-Urgent Care and Urgent Care Claims (Other than Direct Claims)

If a Plan Participant disagrees with a Claim determination, they may request a review to formally request an appeal.

The decision for appeals on review shall be made by the Third Party administrator designated by Poudre School District. For Pharmacy Benefit Claims appeals, the Third Party administrator shall be the Pharmacy Benefit Plan Administrator. These appeals should be sent directly to:

OptumRx
Prior Authorizations and Appeals Department
P.O. Box 5252
Lisle, IL 60532
Phone: 1-800-626-0072
Fax: 1-866-511-2202

Non-Urgent Claims Appeal

If you are not satisfied with the decision regarding your benefit coverage or you receive an adverse benefit determination following a request for coverage of a prescription benefit Claim (including a Claim considered "deemed" denied because missing information was not timely submitted), you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage

decision. An appeal may be initiated by you or your authorized representative (such as your Provider). To initiate an appeal for coverage, provide in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied and
- any additional information that may be relevant to your appeal

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request for pre-service Claims or 30 days of receipt of your written request for post-service Claims. If your appeal is denied, the denial notice will include information to identify the Claim involved, the specific reasons for the decision, the Plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the Claims and appeals processes and any additional information needed to perfect your Claim. You have the right to a full and fair impartial review of your Claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your Claim).

If you are not satisfied with the coverage decision made on your appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your Provider). To initiate a second level appeal, provide in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for pre-service Claims or 30 days of receipt of your written request for post-service Claims. If the appeal is denied, the denial notice will include information to identify the Claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the Plan in relation to your appeal, the Plan provisions on which the decision is based, a description of applicable external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the Claims and appeals processes. You have the right to a full and fair impartial review of your Claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your second level appeal, and present evidence and testimony as part of your appeal. You also have the right to request the diagnosis code and treatment code and

their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your Claim). If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e., your "final adverse benefit determination") or your initial benefit denial notice or any appeal denial notice (i.e., any "adverse benefit determination notice" or "final adverse benefit determination"), you have the right to an independent review by an external review organization. Details about the process to appeal your Claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. The right to an independent external review is only available for Claims involving medical judgment or rescission. For example, Claims based purely on the terms of the Plan (e.g., Plan only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment Claim.

Urgent Claims Appeal (Expedited Review)
You have the right to request an urgent appeal of an adverse benefit determination (including a Claim considered denied because missing information was not timely submitted) if your situation is urgent. An urgent situation is one where in the opinion of your attending Provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your Claim. To initiate an urgent Claim or appeal request, you or your Provider (or other authorized representative) must call **800-626-0072** or fax the request to **866-511-2202**. Claims and appeals submitted by mail will not be considered for urgent processing unless and until you call or fax and request that your Claim or appeal be considered for urgent processing. In the case of an urgent appeal (for coverage involving urgent care), you will be notified of the benefit determination within 72 hours of receipt of the Claim. If the appeal is denied, the denial notice will include information to identify the Claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the Plan in relation to your appeal, the Plan provisions on which the decision is based, a description of applicable external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the Claims and appeals processes. You have the right to a full and fair impartial review of your Claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your appeal, and present evidence and testimony as part of your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your Claim). If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond prior to issuance of any final adverse

determination. The decision made on your urgent appeal is final and binding. In the urgent care situation, there is only one level of Appeal prior to an external review.

If your appeal is denied and you are not satisfied with the decision of the appeal (i.e., your "final adverse benefit determination") or any appeal denial notice (i.e., "adverse benefit determination notice" or "final adverse benefit determination"), you have the right to an independent review by an external review organization.

In addition, in urgent situations where the appropriate timeframe for making a non-urgent care determination would seriously jeopardize your life or health or your ability to regain maximum function, you also have the right to immediately request an urgent (expedited) external review, rather than waiting until the internal appeal process, described above, has been exhausted, provided you file your request for an internal appeal of the adverse benefit determination at the same time you request the independent external review.

Details about the process to appeal you Claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below. The right to an independent external review is only available for Claims involving medical judgment or rescission. For example, Claims based purely on the terms of the Plan (e.g., Plan only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment Claim.

External Review Procedures

The right to an independent external review is only available for Claims involving medical judgment or rescission. For example, Claims based purely on the terms of the Plan (e.g., Plan only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment Claim. You can request an external review by an Independent Review Organization (IRO) as an additional level of appeal. Generally, to be eligible for an independent external review, you must exhaust the internal plan Claim review process described above, unless your Claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit Claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal in accordance with the above process and also request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the internal appeal process.

To file for an independent external review, your external review request must be received within 4 months of the date of the adverse benefit determination (If the date that is four months from that date is a Saturday, Sunday or holiday, the deadline is the next business day). Your request should be mailed or faxed to:

OptumRx
Prior Authorizations and Appeals Department
P.O. Box 5252
Lisle, IL 60532
Phone: 1-800-626-0072
Fax: 1-866-511-2202

Non-Urgent External Review
Once you have submitted your external review request, your Claim will be reviewed within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and you will be notified within 1 business day of the decision.

If your request is eligible to be forwarded to an IRO, your request will randomly be assigned to an IRO and your appeal information will be compiled and sent to the IRO within 5 business days. The IRO will notify you in writing that it has received the request for an external review and if the IRO has determined that your Claim involves medical judgment or rescission, the letter will describe your right to submit additional information within 10 business days for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Pharmacy Benefit Plan Administrator for reconsideration. The IRO will review your Claim within 45 calendar days and send you, the Plan and OptumRx written notice of its decision. If the IRO has determined that your Claim does not involve medical judgment or rescission, the IRO will notify you in writing that your Claim is ineligible for a full external review.

Urgent External Review
Once you have submitted your urgent external review request, your Claim will immediately be reviewed to determine if you are eligible for an urgent external review. An urgent situation is one where in the opinion of your attending Provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your Claim.

If you are eligible for urgent processing, your Claim will immediately be reviewed to determine if your request is eligible to be forwarded to an IRO, and you will be notified of the decision. If your request is eligible to be forwarded to an IRO, your request will randomly be assigned to an IRO and your appeal information will be compiled and sent to the IRO. The IRO will review your claim within 72 hours and send you, the Plan and OptumRx written notice of its decision.

Appeal of Direct Claims

If a Plan Participant disagrees with a Claim determination, they may request a review to formally request an appeal.

The decision for appeals on review shall be made by the Third Party administrator designated by Poudre School District. For Pharmacy Benefit Claims appeals, the Third Party administrator shall be the Pharmacy Benefit Plan Administrator. These appeals should be sent directly to:

OptumRx
Prior Authorizations and Appeals Department
P.O. Box 5252

Lisle, IL 60532
Phone: 1-800-626-0072
Fax: 1-866-511-2202

Direct Claims Appeal
To appeal a denied Claim or a Claim that is deemed denied, you must submit your request within 180 days of receipt of notice of the decision. An appeal may be initiated by you or your authorized representative (such as your Provider). To initiate an appeal, provide in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied and
- any additional information that may be relevant to your appeal including missing information

A decision regarding your appeal will be sent to you within 30 days of receipt of your written request. If your appeal is denied, the denial notice will include information to identify the Claim involved, the specific reasons for the decision, the Plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the Claims and appeals processes and any additional information needed to perfect your Claim. You have the right to a full and fair impartial review of your Claim. You have the right to review your file and the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your Claim).

If you are not satisfied with the decision made on the appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your Provider). To initiate a second level appeal, provide in writing:

- your name
- member ID
- phone number
- the prescription drug for which benefit coverage has been denied
- any additional information that may be relevant to your appeal

A decision regarding your request will be sent to you in writing within 30 days of receipt of your written request. If your appeal is denied, the denial notice will include information to identify the Claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the Plan in relation to your appeal, the Plan provisions on which the decision is based, a description of applicable external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the Claims and appeals processes. You

have the right to a full and fair impartial review of your Claim. You have the right to review your file, the right to receive, upon request and at no charge, the information used to review your second level appeal, and present evidence and testimony as part of your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to you if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of your Claim). If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal (i.e., your "final adverse benefit determination") or your initial benefit denial notice or any appeal denial notice (i.e., any "adverse benefit determination notice" or "final adverse benefit determination") does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), you may have the right to an independent review by an external review organization if the case involves medical judgment or rescission. Details about the process to appeal your Claim and initiate an external review will be described in any notice of an adverse benefit determination and are also described below.

External Review Procedures
The right to an independent external review is only available for Claims involving medical judgment or rescission. You can request an external review by an Independent Review Organization (IRO) as an additional level of appeal. Generally, to be eligible for an independent external review, you must exhaust the internal plan Claim review process described above, unless your Claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit Claims and appeals.

To file for an independent external review, your external review request must be received within 4 months of the date of the adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline is the next business day). Your request should be mailed or faxed to:

OptumRx
Prior Authorizations and Appeals Department
P.O. Box 5252
Lisle, IL 60532
Phone: 1-800-626-0072
Fax: 1-866-511-2202

Once you have submitted your external review request, your Claim will be reviewed within five business days to determine if it is eligible to be forwarded to an independent review organization (IRO) and you will be notified within one business day of the decision.

If your request is eligible to be forwarded to an IRO, your request will randomly be assigned to an IRO and your appeal information will be compiled and sent to the IRO within five business days. The IRO will notify you in writing that it has received the request for an external review and if the IRO has determined that your Claim involves medical judgment or rescission, the letter will describe your right to submit additional information within 10 business days for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Pharmacy Benefit Claims Administrator for reconsideration. The IRO will review your Claim within 45 calendar days and send you, the Plan and OptumRx written notice of its decision. If the IRO has determined that your Claim does not involve medical judgment or rescission, the IRO will notify you in writing that your Claim is ineligible for a full external review.

Final Decision
The decision as a result of the appeal process shall be final and binding upon all parties, including the applicant or petitioner and any person claiming under the applicant or petitioner. The provisions of the Claims appeal process shall apply to and include any and every claim to benefits from the Plan, and any claim or right asserted under this Plan document or against the Plan, regardless of the basis asserted for the claim and regardless of when the act or omission upon which the claim is based occurred.

Choosing the voluntary external appeal as the final level to determine an appeal will be binding in accordance with the IRO's decision.

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Qualifying Events (Qualified Status Changes)

Once enrolled in the Plan, a Plan Participant cannot make a change until the next annual Open Enrollment unless they experience a Qualifying Event. The change must follow the consistency rule outlined in Federal regulations, 26 CFR Part 1. A Qualifying Event is any of the following as considered by Federal regulations:

- a change in Employee's legal marital status (including marriage, death of a spouse, divorce, legal separation and annulment);
- a change in the number of the Employee's dependents (including birth, death, adoption, placement for adoption, and legal guardianship);
- a change in the employment status of the Employee, their spouse or Dependent (including the termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence, or a change in the Employee's employment status that changes eligibility under the Plan);
- a change in your Dependent's ability to satisfy or cease to satisfy the requirements for coverage (due to attainment of age);
- a change in the place of residence or work site of the Employee, their spouse or Dependent that results in a loss of coverage.

In addition to the above, elections may be changed if one or more of the following circumstances occur:

- the amount of an election for your child or foster child who is a dependent is required to be changed by a judgment, decree, or order resulting from a divorce, legal separation or change in legal custody.
- you, your spouse, or dependent becomes enrolled in or loses eligibility for Medicare (Part A or B) or Medicaid (other than coverage for pediatric vaccines).
- your spouse's coverage experiences a significant cost change or curtailment of coverage
- you, your spouse or dependent loses coverage under any group health coverage sponsored by a governmental or educational institution.
- coverage under a group health plan changes due to a special enrollment under HIPAA.
- you take a leave under the Family and Medical Leave Act (FMLA).

- you depart for or return from qualified military service under the Uniformed Services Employment and Reemployment Rights Act.

The chart below describes the changes an Employee may make to their benefits when a Qualifying Event is experienced. Chart may not be inclusive of all Qualifying Events identified by Federal regulations.

Qualifying Event	Changes You Can Make
Marriage, common law, domestic partnership, civil union	• Add your spouse and Dependent child(ren) • Change your coverage level • Remove your spouse or Dependent child(ren) • Stop coverage
Divorce, legal separation, annulment, termination of domestic partnership or civil union	• **MUST** drop your ex-spouse/partner and stepchild(ren) from coverage • Start coverage for yourself • Add your Dependent child(ren) to your coverage
Birth, legal guardianship, adoption, or placement for adoption of a child	• Add your new Dependent child to your coverage • Add spouse and Dependents to your coverage • Start coverage for yourself and Dependents • Drop coverage for yourself or any eligible Dependent child(ren) if you or they become covered under your spouse's plan
Dependent no longer eligible for coverage	• **MUST** drop your Dependent from coverage
Spouse gains group coverage through his/her employer	• Remove your spouse from your coverage • Remove your Dependent from your coverage • Stop coverage
Spouse loses group benefits	• Start coverage for yourself if you lose coverage provided by your spouse's employer • Add coverage for your spouse and/or Dependent child(ren)
Death of a Dependent or spouse	• Remove Dependent or spouse from coverage • Start coverage for yourself and Dependents if due to spouse's death • Add your Dependent to your coverage if due to spouse's death
Receipt of qualified medical child support order	• Add Dependent child(ren) to your coverage • Drop coverage for Dependent child(ren)
Employee's unpaid leave of absence	• Drop coverage for yourself, spouse, and/or Dependent child(ren)
Spouse's unpaid leave of absence	• Start coverage for yourself if you lose coverage provided by your spouse's employer • Add coverage for your spouse and/or Dependent child(ren)
Change in home address or work site	• Change plans if change results in loss of coverage
You, your spouse, or Dependent child(ren) becomes enrolled in Medicare or Medicaid	• Remove your spouse from your coverage • Remove your Dependent from your coverage • Stop coverage
You, your spouse, or Dependent child(ren) loses eligibility for Medicare or Medicaid	• Start coverage for yourself • Add coverage for your spouse and/or Dependent child(ren)
Change in employment which changes eligibility	• Add or drop spouse and Dependent child(ren) • Add or drop coverage for yourself

The benefit change must correspond to the situation. For example, if a spouse who is enrolled in the Plan gains benefit coverage through his/her employer, coverage can be discontinued under the Plan.

The Plan Administrator must be notified within thirty-one (31) days of the Qualifying Event to make the benefit change. If the change is not made within thirty-one (31) days, the change will not be allowed until the next annual Open Enrollment.

The following HIPAA special enrollment rights allow for sixty (60) days to notify the Plan Administrator to make a benefit change. If the change is not made within sixty (60) days, the change will not be allowed until the next annual Open Enrollment.

- Loss of eligibility for Medicaid or the Children's Health Insurance Program (CHIP)
- Gain eligibility under Medicaid or the Children's Health Insurance Program (CHIP)

If a spouse, domestic partner, partner in a civil union, or Dependent is no longer eligible, coverage will be terminated retroactive to the date eligibility was lost, regardless of when the loss of eligibility was reported. For events reported after thirty-one (31) days, no premiums will be refunded and you may be responsible for any Claims incurred during the ineligible period.

Financial hardships are not considered a Qualifying Event and do not justify a mid-year election change.

13

Third Party Recovery Provision

Right of Subrogation and Refund

When This Provision Applies. The Plan Participant may incur medical charges due to Injuries or Illness that 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 charges. Accepting benefits under this Plan for those incurred medical 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 that 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:

- automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and
- 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 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 charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical 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 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 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 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 Plan Participant 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.

Surrogacy Arrangements. In particular, but without limiting any other provision in this Third Party Recovery Provision, if a Plan Participant enters into a Surrogacy Arrangement, and receives benefits related to conception, pregnancy or delivery in connection with that arrangement ("Surrogacy Health Services") the following rules will apply:

- A "Surrogacy Arrangement" is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.
- By accepting Surrogacy Health Services, the Plan Participant automatically assigns to the Plan the right to receive payments that are payable to the Plan Participant or the Plan Participant's chosen payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses.
- The amount assigned to the Plan will not exceed the compensation or other payments the Plan Participant is entitled to receive under the Surrogacy Arrangement.
- To secure the Plan's rights, the Plan also will have a lien on those payments. Those payments shall first be applied to satisfy the Plan's lien. The assignment and lien will not exceed the total amount of the Plan Participant's obligation to the Plan under this section.
- Within 30 days after entering into a Surrogacy Arrangement, the Plan Participant must send written notice of the Surrogacy Arrangement, including the names and addresses of the other parties to the Surrogacy Arrangement, and a copy of any contracts or other documents explaining the Surrogacy Arrangement to the Plan. The Plan Participant must complete and send all consents, releases, authorizations, lien forms and other documents that the Plan determines are reasonably necessary to determine the existence of any rights the Plan may have under this section and to satisfy those rights. The Plan Participant may not agree to waive, release, or reduce the Plan's rights under this provision without the Plan's prior, written consent.
- If the Plan Participant's estate, parent, legal guardian, or conservator asserts a Claim against a Third Party based on the Surrogacy Arrangement, the Plan Participant's estate, parent, legal guardian, or conservator and any settlement or judgement recovered by the estate, parent, legal guardian or conservator shall be subject to the

Plan's liens and other rights to the same extent as if the Plan Participant had asserted the Claim against the Third Party.

- The Plan may assign its rights to enforce the liens and other rights.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical 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 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.

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 of all settlements.

14

Notice Of Right To Cobra Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, also referred to as the Public Health Services Act) requires that the Plan offer to Plan Participants the opportunity for a temporary extension of health coverage called "continuation coverage" where coverage under the Plan would otherwise end due to certain specific events listed below. Individuals who are eligible to continue coverage under these provisions are called "qualified beneficiaries."

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. The employer must notify the COBRA Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or

- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the COBRA Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

UCHealth Plan Administrators
1107 South Lemay Avenue, Suite #400
Fort Collins CO 80524

How is COBRA continuation coverage provided?
Once the COBRA Administrator receives 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 employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the COBRA Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only

available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the COBRA Administrator know about 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 Administrator.

Plan contact information
If any covered individual does not understand any part of this summary notice or has questions regarding the information or their obligations, please contact:

COBRA Administrator
UCHealth Plan Administrators
1107 South Lemay Avenue, Suite #400
Fort Collins CO 80524
970-224-4600 or 1-866-644-7873

or

PSD Benefits Department at 970-490-3680

15

HIPAA Privacy Notice

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research

- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on the last page of this section.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Other Important Information Regarding This Notice

- This notice is effective August 1, 2021
- It's important to note that these rules apply to the Poudre School District Health Plan ("The Plan"), not Poudre School District (PSD) as an employer/plan sponsor - that's the way the HIPAA rules work.
- The Plan may disclose protected health information (PHI) to a Business Associate of The Plan, if a Business Associate Agreement is in place. A Business Associate is any entity that performs a function on behalf of The Plan and that uses PHI in

doing so. Examples of Business Associates include The Plan's third-party administrators: UCHealth Plan Administrators, OptumRx, and Cigna.

- Employees of the plan sponsor (PSD), who administer and manage The Plan, and third-party administrators such as UCHealth Plan Administrators, OptumRx, or Cigna, may use your PHI only for appropriate plan purposes (such as for payment or health care operations), but not for employment-related purposes of PSD. These organizations must comply with the same confidentiality requirements that apply to The Plan.
- For some types of PHI, there may be additional restrictions on our uses and disclosures described within. For example, the following Colorado laws may apply:
    - 10-3-1104.5 (HIV testing)
    - 10-3-1104.7 (Genetic testing)
    - 12-43-218 (Psychotherapy records)
    - 19-1-308 (Parentage information/genetic testing information)
    - 19-4-106 (Artificial insemination)
    - 25-1-122.5 (Genetic testing)
    - 25-1-312 (Records of alcoholics)
    - 25-1-1108 (Records of drug abusers)
    - 27-10-120 (Records regarding mental health services);
    - 27-10-120.5 (Mental health information)
- Any requests pertaining to items under “Your Rights” must be made in writing to:

  PSD Privacy Officer
  Attn: Benefits Services OR emailed to
  PSDbenefits@psdschools.org
  2407 Laporte Avenue
  Fort Collins CO 80521
- For questions regarding this notice, please call 970-490-3435.

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HIPAA Privacy Compliance

To Allow Poudre School District to Obtain Protected Health Information from the Health Plan

Because, Poudre School District ("Plan Sponsor") is the sponsor of the PSD Health Plan ("Plan"), a group health plan subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and to the medical privacy regulations promulgated by the U.S. Department of Health and Human Services ("HHS"), found at 45 CFR, Parts 160-164; and

Because, the Plan reserves to Plan Sponsor complete discretion and authority to amend or terminate the Plan at any time; and

Because, Plan Sponsor wishes to obtain from the Plan "protected health information" (PHI), as defined at section 164.504 of the HIPAA regulations, and other health information; and the HIPAA regulations require that, in order for a group health plan to disclose PHI (for purposes beyond enrollment and disenrollment) to a plan sponsor, the plan documents under which the plan was established and is maintained must be amended to include specific provisions and limitations.

Therefore, the Plan is hereby amended, effective as of August 1, 2017, to include the following provisions:

- **Permitted Disclosure of Enrollment/Disenrollment Information.** Pursuant to Section 164.504(f)(1)(iii) of the HIPAA Privacy regulations, the Plan may disclose to Plan Sponsor information on whether an individual is enrolled in or has dis-enrolled from the Plan.

- **Permitted uses and disclosures of PHI:** The HIPAA Privacy Rule permits the Plan to use or disclose PHI for the following purposes, to the extent that they are not inconsistent with HIPAA:
  - pursuant to a valid signed Authorization by the individual to whom the PHI pertains,

- for purposes of "treatment, payment or health care operations" (TPO) as stated in the Privacy Notice,
- directly to the individual to whom the PHI pertains, or
- other purposes relating to the Plan administration, which are approved in writing by the Plan administrator or the Plan privacy officer.

- **Required Uses and Disclosures of PHI.** The Plan and Plan Sponsor may use or disclose PHI for the following required purposes:
  - for certain public health and safety purposes (such as reporting abuse or communicable diseases),
  - as required by law,
  - as part of a legal or regulatory proceeding, in response to lawfully executed process, such as a court order or subpoena, or
  - for law enforcement.

- **Disclosure Permitted only Pursuant to Certification:** The Plan will disclose PHI to Plan Sponsor only for purposes of plan administration (such as payment or health care operations) and only after Plan Sponsor amends the Plan document, certifies in writing that Plan documents have been amended, and agree to comply with the conditions mandated by the HIPAA Privacy Rule regarding the use and disclosure of PHI and the adequate separation between The Plan and Plan Sponsor.

- **Plan Sponsor's Use or Disclosure of PHI:** Plan Sponsor agrees to:
  - Not use or further disclose PHI other than as permitted or required by the Plan or as required by law,
  - Ensure that any agents or subcontractors to whom Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to Plan Sponsor with respect to PHI,
  - Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of Plan Sponsor,
  - Report to the Plan any use or disclosure of PHI that is inconsistent with the permitted or required uses or disclosures of which Plan Sponsor becomes aware,
  - Report to the Plan any security incident of which Plan Sponsor becomes aware with such frequency and at such times as agreed to by the Plan and Plan Sponsor,
  - Make PHI available to the Plan participants for the purposes of the rights of access and inspection in accordance with HIPAA,
  - Make PHI available to the Plan participants for the purposes of amendment and, on notice, amend the Plan participant's PHI in accordance with HIPAA,
  - Make available the information required to provide an accounting of disclosure in accordance with HIPAA,
  - Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA,
  - If feasible, return or destroy all PHI received from the Plan that Plan Sponsor still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such

return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible, and
- Ensure that adequate separation between the Plan and Plan Sponsor is established in accordance with the following requirements: Plan Sponsor's employees and other persons under the control of Plan Sponsor listed below will have access to PHI solely for the purposes specified herein and only for the Plan administration functions performed on behalf of the Plan. Other Plan Sponsor employees will not have access to PHI.

- **Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage:** Plan Sponsor hereby authorizes the Plan, through the Plan Administrator or the Third-Party administrator, to disclose PHI to current and potential stop-loss carriers, excess loss carriers for underwriting and other purposes to obtain and maintain stop-loss coverage related to benefit claims under the Plan. Such disclosures shall be made in compliance with HIPAA.

- **Classes of Employees with Access to PHI:** The following employees (or classes of employees) of, or other persons under the control of, Plan Sponsor will have access to PHI solely for the purposes specified below, and only for plan administration functions performed on behalf of The Plan. Other employees of Plan Sponsor shall not have access to PHI.

  - **Benefits Services:** Employees who work in Benefits Services will have access to PHI to the extent necessary to assist employees and their family members or their representatives if they request such assistance in getting benefits claims and payments resolved and also in the following situations:

    - to the extent necessary to determine whether stop-loss payments from the stop-loss carrier were accurately determined and if such payment appropriately reimburses Plan Sponsor for amounts it paid on behalf of The Plan. It may also include filing of the initial claim;
    - to the extent necessary to work with Plan Sponsor's Subrogation Entity to help The Plan obtain reimbursement when appropriate;
    - for activities related to coding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance);
    - for activities related to the creation, renewal or replacement of a contract for health insurance, TPA, or health benefits;
    - to the extent necessary to correspond with other group health plans on coordination of benefits issues;
    - legal proceedings and HHS investigations; and
    - enrollment documents and payroll deductions for benefits coverage.

  - **Records Department:** Employees who work in the records department will have access to PHI to the extent necessary to scan the participant's enrollment forms and other pertinent forms that may contain PHI into their personal file held in the electronic data management system.

- **Information Systems Department:** Employees who work in the Information Systems department will have access to PHI to the extent necessary to assist in the operational functions of the computer systems, servers, e-mails, etc. as members of the workforce of Plan Sponsor.

- **Finance Department:** Employees who work in the Finance department will have access to PHI to the extent necessary to audit the invoices for claims payable by Plan Sponsor.

- **Executive Director of Human Resources:** This employee, as the supervisor to the Benefits Manager, will have access to PHI to the extent necessary to assist the Privacy Official in the grievance/complaint and/or disciplinary procedures with employees of Plan Sponsor who may be subject to these regulations.

- **Employee Assistance Services Plan:** Employees who perform functions for the Employee Assistance Services Plan will have access to PHI in order to perform administrative work related to the Employee Assistance Services Plan, to provide counseling and support for persons who use the Employee Assistance Services Plan and to analyze clinical and cost data to evaluate the effectiveness of the Employee Assistance Services Plan's program.

In addition to the foregoing, Plan Sponsor shall ensure that each of its employees and agents, including its committees, that receive PHI in the course of providing services or performing functions for the Plan shall not use or disclose that PHI in the provision of other services or performance of other functions for Plan Sponsor.

- **Sanctions on Employees Who Fail to Comply:** If any of the employees or individuals under the Plan Sponsor's control (listed above) fails to comply with these provisions regarding use or disclosure of PHI, Plan Sponsor shall impose reasonable sanctions on such individual(s) as necessary, in Plan Sponsor's discretion, to end such non-compliance. If appropriate, such sanctions shall be imposed progressively (for example, an oral warning, a written warning, transfer to another department, and termination); or, in Plan Sponsor's discretion, an individual who violates privacy rules could be immediately terminated.

- **Grievance Procedure:** The following procedures apply for resolving issues of alleged noncompliance with the privacy requirements: Any plan participant who feels the Plan has unlawfully used or disclosed his/her PHI may file a complaint with the Plan's Privacy Officer, Benefits Manager. The Privacy Official will then follow the grievance procedures outlined in the HIPAA policies and procedures manual stating the Board Policies of Poudre School District grievance and complaint procedures will be followed.

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Legal Notices

Newborns' and Mothers' Health Protection Act of 1996

The Newborns' and Mother's Health Protection Act of 1996 (NMHPA), which was signed into law in the fall of 1996, became effective September 1, 1997. This law provides certain protection for mother and infants, and specifically requires that:

"Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother of newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods."

New Dependents are covered by Poudre School District's health plan from the moment of birth **only** if they are enrolled within thirty-one (31) days of birth. If an Employee needs to add a newborn to their health plan, they must complete the online enrollment process available through UCHealth Plan Administrators. The Employee must complete the enrollment process to add their newborn even if they already have other Dependent children on the health plan.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and

- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following Deductibles and Coinsurance apply:

- PPO1 Plan
    - Individual Network Deductible: $500
    - Network inpatient services and Network outpatient services: Plan Participant pays 30% after Deductible
- PPO2 Plan
    - Individual Network Deductible: $1,000
    - Network inpatient services and Network outpatient services: Plan Participant pays 30% after Deductible

If you would like more information on WHCRA benefits, call your plan administrator at 970-224-4600.

Family and Medical Leave Act of 1993

Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave in a 12-month period to eligible employees for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent, who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits and Protections

During FMLA leave, the employer must continue the employee's health insurance coverage as if the employee were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements
An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- have worked for the employer for at least 12 months;
- have at least 1,250 hours of service in the 12 months before taking leave;* and
- work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

***Special hours of service requirements apply to airline flight crew employees.**

Requesting Leave
Generally, employees must give 30 days' advance notice of the need to take FMLA leave. If it is not possible to give 30 days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide sufficient information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for the leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities
Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

An employee may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

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Responsibilities for Plan Administration

Plan Administrator. Poudre School District PPO-2 Health Plan is a benefit plan of Poudre School District, the Plan Administrator, also called the Plan Sponsor. An individual or individuals may be appointed by the Poudre School District Board of Education to act on behalf of the Plan Administrator and serve at the convenience of the Employer. The appointed individuals for the medical benefits will be the Benefits Manager and the Poudre School District Benefits Committee, and the appointed individual for the Mental/Behavior Health and Substance Abuse benefits will be the Employee Assistance Service Manager. If the appointed individuals resign, die or are otherwise removed from the positions, the Poudre School District Board of Education shall appoint new individuals as soon as reasonably possible.

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

Service of legal process may be made upon the Plan Administrator.

Duties of the Plan Administrator

- To administer the Plan in accordance with its terms.
- To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- To decide disputes which may arise relative to a Plan Participant's rights.
- To prescribe procedures for filing a Claim for benefits and to review Claim denials.
- To keep and maintain the Plan documents and all other records pertaining to the Plan.
- To appoint a Claims Administrator to pay Claims.
- To perform all necessary reporting.

- To establish and communicate procedures to determine whether a medical child support order is qualified.
- To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

Plan Administrator Compensation. The Plan Administrator serves without compensation from the Plan; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

Payment of Benefits

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

Plan is Not an Employment Contract

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

Clerical Error

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

In Cases of Plan Reimbursement

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

In Cases of Covered Employee Premiums

If due to a clerical error, a Covered Employee does not contribute the correct amount of premiums due for Plan coverage elected by the Covered Employee, the Plan retains a contractual right to any underpayment of premiums by the Covered Employee. The Covered Employee will be required to pay any underpayment to the Plan, and the Employer may reduce the Covered Employee's regular wages to cover any such underpayment.

If due to a clerical error, a Covered Employee does not contribute the correct amount of premiums due for Plan coverage elected by the Covered Employee, the Plan retains a contractual right to any overpayment of premiums by the Covered Employee. The Employer will be required to reimburse any overpayment to the Covered Employee. The Employer will reimburse the Covered Employee through the Covered Employee's regular payroll cycle to cover any such overpayment.

Amending and Terminating the Plan

The Employer fully intends to continue this Plan, but reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason. The authority to end the Plan lies with the Employer and shall be affected by a written resolution adopted by the Board of Education.

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

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Defined Terms

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

Academic Year is the District's contract year currently in effect.

Active Employee is a person who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer.

Allogeneic Bone Marrow or Stem Cell Transplant means matched donor bone marrow or stem cells that are supplied by a blood relative of a Plan Participant or by a person who is not a blood relative of a Plan Participant and transplanted to the Plan Participant.

Autologous Bone Marrow or Stem Cell Transplant means the bone marrow or stem cells are harvested from a Plan Participant's body and transplanted back to the Plan Participant.

Behavioral Services 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.

Birthing Center is an alternative licensed non-Hospital facility that provides family oriented maternity care for women judged to be at low risk of experiencing obstetrical complications.

Board of Education is the Poudre School District Board of Education.

Brand Name means a trade name medication.

Child Find is Child Find (34CFR 300.125).

Claim means any request for a Plan benefit, made by a Plan Participant or by a representative of a Plan Participant that complies with the Plan's reasonable procedure for making benefit Claims.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, or the Public Health Service Act, which provides for continuation coverage for group health plans of certain state and local government employers, whichever is applicable.

Coinsurance is a percentage of allowed charges that the Plan Participant must pay before the Plan pays.

Copayment is a fixed amount that the Plan Participant must pay before the Plan pays.

Covered Charges are the Usual and Customary Charges that are incurred for Medically Necessary services and supplies rendered in the care of a Plan Participant for which benefits are provided in accordance with applicable Plan provisions. These items are noted under Covered Charges in the Medical Benefits section of this document. A Covered Charge must be incurred while the Plan Participant is covered under the Plan and a charge is incurred at the time the service is rendered or the item is provided for which a charge is made.

Covered Employee is an Active Employee who has met the eligibility requirements and has met the enrollment requirements specified in the Plan.

Custodial Care is any skilled or non-skilled health services, or personal comfort or convenience related services, which provides general maintenance, supportive, Preventative and/or protective Care.

Custodial Care:

- Does not seek a cure
- Can be provided in any setting
- May be provided between periods of acute or intercurrent health care needs
- Is care provided to an individual whose health services requirements are stabilized and whose current medical condition is not expected to significantly and objectively improve or progress over a specified period of time

Custodial Care may include the supervision or participation of Providers, licensed nurse, or registered therapist as necessary or desirable services. The mere participation of these professionals does not preclude the services as being custodial in nature. If a trained non-medical person can safely and effectively perform the nature of the services, the services are custodial. Further, Custodial Care and the nature of those services are not altered by the availability of the non-medical person. Custodial Care may also be referred to as maintenance, domiciliary, respite, and/or convalescent care.

Deductible is the amount of a Covered Charge that a Plan Participant is responsible for paying during each Plan Year before benefits become payable by the Plan.

Dependent is any one of the following persons:

- A Covered Employee's spouse
  The term "Spouse" shall mean the person to whom the Covered Employee is legally married to under the laws of a state or nation. This includes common law marriages. The Plan Administrator may require documentation proving a legal marital relationship.

- A Covered Employee's domestic partner
  The term "Domestic Partner" shall mean a same gender or opposite gender individual who is at least eighteen years of age and who:
  - Is not married to any other person (nor can the Covered Employee be married to any other person);
  - Is not in a domestic partnership with another person;
  - Is not in a civil union with another person;
  - Is not related to the Covered Employee by blood to a degree of closeness that would prohibit legal marriage;
  - Is engaged in an exclusive committed relationship with the Covered Employee;
  - Currently shares a residence with the Covered Employee;
  - Is jointly responsible with the Covered Employee for living expenses

- A Covered Employee's partner in a civil union
  The term "Partner in a Civil Union" shall mean a person who has established a civil union relationship. A "Civil Union" means a relationship established between two eligible persons pursuant to state statutes that entitles them to receive benefits and protections and be subject to the responsibilities of spouses.

- A Covered Employee's children including children of a Spouse, Domestic Partner and a Partner in a Civil Union from birth to the limiting age of twenty-six (26) years.

  The term "children" shall include biological children, adopted children or children placed with a Covered Employee in anticipation of adoption or Foster Children. Stepchildren may also be included as long as a biological parent remains married to the Covered Employee and also resides in the Covered Employee's household.

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

  If a Covered Employee is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents. The Plan Sponsor may require legal documentation proving legal guardianship.

  Any child of a Plan Participant who is an alternate recipient under a qualified medical

child support order shall be considered as having a right to Dependent coverage under this Plan. To the extent required under Colorado Revised Statute Section 14-14-112 and to the extent the order meets the requirements of the Statute, the Plan will recognize medical child support orders.

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

  After such two (2) year period, the Plan Sponsor may require subsequent proof not more than once each year. The Plan Sponsor reserves the right to have such Dependent examined by a Provider of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the Covered Employee's home, but who are not eligible as defined; the legally separated or divorced former spouse of the Employee; any person who is on active duty in any military service of any country; parents of the Employee; spouses of children covered under the Plan; children of children covered under the Plan unless they meet one of the definitions of Eligible Classes of Dependents as defined above, or any person who is covered under the Plan as an Active Employee.

Durable Medical Equipment means items of medical equipment owned or rented that are intended for temporary therapeutic use or are placed in the home of the Plan Participant to facilitate treatment and/or rehabilitation. Generally, these are items that can withstand repeated use, are primarily and customarily used to serve a medical purpose, are usually not useful to an individual in the absence or Illness or Injury.

Eligible Employee is an Active Employee who has met the eligibility requirements as specified in the eligibility section of this document.

Emergency or Emergency Services are those health care services provided to evaluate and treat medical conditions of recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the condition could result in: 1) placing the individual's life in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Employer is Poudre School District.

Enrollment Date is the first day of coverage or, the first day following the waiting period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Exclusion is any provision of this agreement whereby coverage for a specific service, condition, or drug is entirely eliminated regardless of Medical Necessity.

Experimental and/or Investigational means any treatments, procedures, devices and/or drugs that:

- cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use,
- is the subject of a current Investigational new drug or new device application on file with the FDA,
- is being provided pursuant to a Phase I or Phase II clinical trial or as the Experimental or research arm of a Phase III clinical trial,
- is being delivered pursuant to a written protocol which describes among its objectives, determinations of safety, efficacy, or efficacy in comparison to conventional alternative, or toxicity,
- is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services,
- the predominant opinion among experts as expressed in the public authoritative literature is that usage should be substantially confined to research settings,
- the predominant opinion among experts as expressed in the public authoritative literature is that further research is necessary in order to define safety, toxicity, effectiveness or effectiveness compared with conventional alternatives, or
- is not Investigational in itself pursuant to the above, and would not be Medically Necessary, but for the provision of a drug device, treatment or procedure which is Investigational or Experimental.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Formulary is a list of Prescription Drugs that provide Providers with choices of effective medications from which to prescribe.

Foster Child (Children) is a child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a Covered Employee has assumed a legal obligation.

Generic drug means a Prescription Drug that 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.

Head Start is the Head Start Act (42 U.S.C. 9840), as amended.

Home Health Care is Skilled Nursing Care at home when prescribed by a participating Provider and deemed Medically Necessary for treatment of a covered Illness or Injury.

Home Health Care Agency is an organization whose main function is to provide Home Health Care Services and Supplies, and 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 is a formal written plan made by the Plan Participant's attending Provider. A Home Health Care Plan must:

- be reviewed at least every thirty (30) days
- state the diagnosis
- certify that the Home Health Care is in place of Hospital confinement
- specify the type and extent of Home Health Care required for the treatment of the Plan Participant.

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 except as stated herein); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital. Skilled Nursing Care at home when prescribed by a participating Provider and deemed Medically Necessary for treatment of a covered Illness or Injury.

Hospice is a system, both inpatient and outpatient, of supportive and palliative family-centered care designed to assist the terminally ill individual to be comfortable and to maintain a satisfactory lifestyle through the terminal phases of dying.

Hospice Care Plan is a plan of care for a terminal Plan Participant with a life expectancy of approximately six (6) months or less that is established and conducted by a Hospice Agency and supervised by a Provider.

Hospice Care Services and Supplies are those services and supplies 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 (2) unrelated persons whose life expectancy is less than six (6) months.

Hospital is a facility licensed and operated pursuant to law which primarily engages in providing health services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic, and surgical facilities (including a surgical facility which has a bona fide arrangement, by agreement or otherwise, with an accredited Hospital to perform such surgical procedures) by, or under the supervision of a staff of Providers and which has twenty-four (24) hour nursing services. A Hospital is not primarily a place for rest or Custodial Care of the aged, and is not a nursing home, convalescent home or similar situation.

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

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

Illness means bodily sickness, disease or Pregnancy (including complications), behavioral disorders and congenital abnormalities in a newborn child. Illness must be medically diagnosed and receive treatment by a Provider.

Infertility means the ability or diminished ability to produce offspring or when a couple fails to achieve Pregnancy during one (1) year of unprotected intercourse, or when a woman repeatedly fails to carry a Pregnancy to fetal viability.

Injury is a condition, which results independently of Illness, and all other causes and is a result of an externally violent force.

Late Enrollee(s) means Plan Participants who are not enrolled when they are initially eligible. They can be enrolled if they lose coverage through another group insurance plan. Loss of coverage is defined as loss due to death, divorce, loss of job or termination of benefits by Employer. Such Employee or Dependent will be allowed to enroll within thirty-one (31) days of the loss of coverage with the satisfactory proof of coverage loss. Otherwise, they can only be added at Open Enrollment. Plan Participants who are not enrolled when they are initially eligible will be considered a "Late Enrollee."

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.

Level of Care means the intensity of effort required to diagnose, treat, preserve or maintain any Plan Participant's current physical or emotional status. Terms commonly used to identify levels of care include: acute, chronic, Emergency, rehabilitation, intensive, Custodial, domiciliary, maintenance, Skilled Nursing, private duty nursing, and Hospice.

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.

Limits (Limitations) are any provisions, other than an Exclusion, which restrict coverage under this agreement, regardless of Medical Necessity.

Location of Care is the setting in which covered services, appropriate for the Plan Participant's current level of care are provided. Terms commonly used to identify locations include: Provider office, outpatient department or facility, Emergency room or facility, general/acute care Hospital, rehabilitation Hospital, psychiatric Hospital, specialty Hospital, Skilled Nursing Facility and home.

Medical Care Facility is the setting in which covered services, appropriate for the Plan Participant's current Level of Care, are provided. Terms commonly used to identify locations of care include: Provider office, outpatient department or facility, Emergency room or facility, general/acute care Hospital, rehabilitation Hospital, psychiatric Hospital, specialty Hospital, Skilled Nursing Facility and home.

Medically Necessary (Medical Necessity) means that care and treatment that:

- Is recommended or approved by a Plan Participant's Provider,
- Is consistent with Plan Participant's diagnosis and which, in accordance with generally accepted standard/conventional medical practice, could not have been omitted without adversely affecting Plan Participant's condition or the quality of medical care rendered,
- Is demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating and diagnosing the condition or illness for which their use is proposed,
- Is consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical associations, the American Academies or Colleges of various physician specialties, National Institute of Health ("NIH"), Food and Drug Administration ("FDA"), Center for Medicare and Medicaid Services ("CMS"), and other applicable organizations,
- Is not performed mainly for the convenience of the Plan Participant or Provider of medical services; or is not Custodial Care,
- Is not Experimental and/or Investigational, or conducted for research purposes,
- Is rendered safely in the most cost-efficient manner and type of setting appropriate for the delivery of health service,
- Is a service, treatment, drug, medical device, test, medical technology or supply covered by the Plan,
- Is a service or item that its provision constitutes a medically appropriate course of treatment for the Plan Participant.

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

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

Mental Disorder (Mental Health) is mental health and Substance Abuse conditions as outlined in the American Psychiatric Associations Diagnostic Criteria DSM, which can negatively impact a person's normal level of functioning in the areas of psychological, social or occupational functioning.

Mini or Reduced Intensity or Non-myeloablative Allogeneic Bone Marrow or Stem Cell Transplant means the use of less radiation and less chemotherapy as compared to Allogeneic Bone Marrow or Stem Cell Transplant, immediately prior to transplantation of Bone Marrow or Stem Cells to the Plan Participant.

Morbid Obesity is a chronic condition that is associated with an increased risk of mortality or morbidity with a body mass index (BMI) of 40 or greater or with a BMI of 35 or greater with at least one (1) additional major risk factor or co-morbidity.

Network Coverage Area is the geographic area that includes Larimer, Weld, Adams, and Boulder counties in Colorado.

Network (Participating) Providers are Providers, Provider specialists, Hospitals, Skilled Nursing Facilities, extended care facilities, individuals, organizations, agencies or other Providers who have entered into a contractual arrangement with the Poudre School District to provide health services to Plan Participants. Poudre School District may contract with a Provider for a specified Plan Participant, a specified period of time and/or a specified service. In that case, the Provider is a Participating Provider, only for the service(s) contracted and/or for the designated period.

No-Fault Automobile Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents. No-Fault Automobile Insurance laws do not exist in Colorado.

Non-Network Providers are licensed Providers and/or health care institutions that have not contracted to supply health care services to Plan Participants.

Non-Renewed Employee is a licensed Employee on a probationary teacher contract whose employment contract is not renewed. The Non-Renewal action requires Board of Education action and notification to the impacted Employee per Colorado Revised Statute 22-63-101.

Nurse Case Management is a program whereby a nurse case manager monitors Plan Participants and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The nurse case manager consults with the Plan Participant, the authorized representative, and the attending Provider in order to develop a plan of care for approval by the Plan Participant's attending Provider and the Plan Participant or the Plan Participant's representative. This plan of care may include but is not limited to the following:

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

Open Enrollment is the period designated each year by the Employer when an Employee may change elections to their health and welfare plans. The designated period will be specified and communicated by the Employer.

Out-of-Pocket Maximum is the greatest amount a Plan Participant will be required to pay on Covered Charges during a Plan Year, including Deductibles, before the Plan will pay 100% of Covered Charges thereafter in the Plan Year unless otherwise stated.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Provider to a person

not admitted as a registered bed patient; or services rendered in a Provider's office, laboratory or X-ray facility, a Location of Care, or the Plan Participant's home.

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.

Plan means Poudre School District PPO-2 Health Plan including Prescription Drug benefits, which is a benefits plan for Eligible Employees (and their Dependents) of Poudre School District and is described in this document.

Plan Administrator is Poudre School District. Poudre School District may appoint an individual or individuals to act on behalf of the Plan Administrator. The appointed individuals will include the Benefits Manager, the Poudre School District Benefits Committee, and the Employee Assistance Service Manager. In addition, Poudre School District hires Third-Party administrators to oversee the application of the benefit and prescription plan.

Plan Participant is any Eligible Employee or Dependent who is enrolled and covered under this Plan.

Plan Sponsor is Poudre School District (the Employer).

Plan Year is the twelve (12) month period beginning on August 1 and ending July 31.

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

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription." Such drug must be Medically Necessary in the treatment of a Illness or Injury.

Preventative Care or Preventive Medicine means the branch of medicine concerned with preventing the occurrence of both mental and physical Illness and disease.

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

Qualifying Event (Qualified Status Change) is any of the following as considered by Federal regulations:

- a change in Employee's legal marital status (including marriage, death of a spouse, divorce, legal separation and annulment);
- a change in the number of the Employee's dependents (including birth, death, adoption, placement for adoption, and legal guardianship);

- a change in the employment status of the Employee, their spouse or Dependent (including the termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence, or a change in the Employee's employment status that changes eligibility under the Plan);
- a change in your Dependent's ability to satisfy or cease to satisfy the requirements for coverage (due to attainment of age);
- a change in the place of residence or work site of the Employee, their spouse or Dependent that results in a loss of coverage.

In addition to the above, elections may be changed if one or more of the following circumstances occur:

- the amount of an election for your child or foster child who is a dependent is required to be changed by a judgment, decree, or order resulting from a divorce, legal separation or change in legal custody.
- you, your spouse, or dependent becomes enrolled in or loses eligibility for Medicare (Part A or B) or Medicaid (other than coverage for pediatric vaccines).
- significant cost change or curtailment of coverage
- you, your spouse or dependent loses coverage under any group health coverage sponsored by a governmental or educational institution.
- coverage under a group health plan changes due to a special enrollment under HIPAA.
- you take a leave under the Family and Medical Leave Act (FMLA).
- you depart for or return from qualified military service under the Uniformed Services Employment and Reemployment Rights Act.

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 charges covered by the Plan. Recoveries further includes, but is not limited to, Recoveries for medical 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.

Routine Preventive Care is routine care by a Provider that is not for an Injury or Illness.

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.

Second Medical Opinion is a re-evaluation of a condition or health care treatment by an appropriately qualified Provider. The Provider must be either a primary care physician or a specialist acting within his or her scope of practice, and must possess the clinical background necessary for examining the Illness or condition associated with the request for a Second Medical Opinion. Upon completing the examination, the Provider's opinion is included in a consultation report.

Skilled Nursing Care is Home Health Care Services that:

- Can only be provided by an RN or LPN

- Can produce the best possible and most timely outcome for a disease process and/or treatment regimen according to a professional assessment and plan
- Cannot be made available outside of the home because of the immediate homebound nature of the Plan Participant
- Can furnish reliable information to the Provider sufficient for proper determination of the status of the Plan Participant's condition and the Level of Care required for that condition

Skilled Nursing Facility is a facility that provides a pattern of health care in which a Plan Participant is treated for an ongoing condition as a result of an acute Injury or Illness.

Special Enrollment Period will occur when an Employee declines coverage for themself or their Dependents because of other health insurance coverage and then loses that coverage due to the exhaustion of COBRA benefits 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. The Special Enrollment Period will begin as of the date the other coverage ends and will end thirty-one (31) days later. In addition, an Employee that has acquired a new Dependent as a result of marriage, domestic partnership, civil union relationship, birth, adoption, or placement for adoption or foster care and the Dependent is eligible to enroll, may enroll under change of status provisions.

Staffed-Out Employee is a classified Employee subject to building staffing with less than six (6) years of continuous employment with the district who is laid off due to enrollment fluctuation or staffing allocation decisions at the site.

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

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

Surrogacy Arrangement is an arrangement in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Surrogacy Health Services means the benefits related to conception, pregnancy or delivery that a Plan Participant who has entered into a Surrogacy Arrangement receives.

Tandem Transplant or Planned Multiple Transplants means a Plan Participant receives two (2) Planned Boned Marrow or Stem Cell Transplants:

- An Autologous Bone Marrow or Stem Cell Transplant, followed by a second Autologous Bone Marrow or Stem Cell Transplant two to six months after the first transplant. The second transplant is performed after recovery from the first transplant

- An Autologous Bone Marrow or Stem Cell Transplant, followed by a Mini Allogeneic Bone Marrow or Stem Cell Transplant two to four months after the first transplant. The second transplant is performed after recovery from the first transplant.

Terminated Employee is a person who is no longer performing duties of a job for the Employer or receiving pay from the Employer and has terminated employment with the Employer.

Third Party means any Third Party including another person, business entity, any party or insurer obligated to make payments.

Total Disability (Totally Disabled) means: In the case of a Dependent child, the complete inability as a result of Injury or Illness to perform the normal activities of a person of like age and sex in good health.

Transplant Case Management includes the Plan definition of Case or Medical Cost Management, any applicable transplant medical management program, pre-certification or utilization review, and approval of all Plan Participant's medical needs from the referral for evaluation to one (1) year after transplant date.

Transplant Case Manager coordinates all the activities of Transplant Case Management, and works closely with the Plan Participant, Plan Participant's transplant team, other physicians, the Plan and Transplant Network to ensure that Plan Participant obtains quality and cost-effective care.

Transplant Network means the group of select providers for transplants, as described in the Medical Benefits section.

Transplant Network Provider means those providers selected as Network Providers for transplants, as described in the Medical Benefits section.

Urgent Care is a facility for health care services used to prevent the serious deterioration of a Plan Participant's health resulting from an unforeseen Illness or Injury for which treatment cannot be delayed.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994.

USPSTF means the United States Preventive Services Task Force.

Usual and Customary Charge is a charge which is not higher than the usual charge made by the Provider of the care or supply and does not exceed the usual charge made by most Providers of like service in the same area. The Plan benefit will be based on actual charge billed if it is less than the Usual and Customary Charge.

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Fraudulent Acts

The Plan may refuse to renew the coverage of an Eligible Employee or Dependent for fraud or intentional misrepresentation of a material fact by that individual. The Plan reserves the right to recoup any benefit payments paid on the members behalf, and/or to rescind enrollment under the Plan retroactively as if it never existed.

Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards

The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to a Plan Participant will include, but not be limited to, the following actions, when intentional:

- Use of the Identification Card prior to your Effective Date;
- Use of the Identification Card after your date of termination of coverage under the Plan;
- Obtaining other benefits for persons not covered under the Plan;
- Obtaining other benefits that are not covered under the Plan.

The fraudulent or intentionally unauthorized, abusive, or other improper use of Identification Cards by any Plan Participant can result in, but is not limited to, the following sanctions being applied to all Plan Participants covered under your coverage:

- Denial of benefits;
- Cancellation of coverage under the Plan for **all** participants under your coverage;
- Recoupment from you or any of your covered Dependents of any benefit payments made;
- Pre-approval of medical services for all Participants receiving benefits under your coverage;
- Notice to proper authorities of potential violations of law or professional ethics

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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 Employer and contributions made by Covered Employees. The Plan is not insured.

Plan Name:

Poudre School District PPO-2 Health Plan

Tax ID Number:

84-6013733

Plan Effective Date:

August 1, 2021

Plan Year Ends:

July 31st

Employer Information:

Poudre School District
2407 LaPorte Avenue
Ft. Collins, Colorado 80521
(970) 482-7420

Plan Administrator:

Poudre School District
2407 LaPorte Avenue
Ft. Collins, Colorado 80521

(970) 482-7420

Agent for Service of Legal Process:

Poudre School District
2407 LaPorte Avenue
Ft. Collins, Colorado 80521

Medical Benefits Claims Administrator:

UCHealth Plan Administrators
1107 South Lemay Avenue, Suite #400
Fort Collins, Colorado 80524
(970) 224-4600 or (866) 644-7873 toll free
http://tpa.uchealth.org

Mental/Behavioral Health and Substance Abuse Administrator:

Employee Assistance Services
2850 McClelland Drive, Suite 2200
Fort Collins, Colorado 80525
(970) 488-4925

Pharmacy Benefit Plan Administrator

OptumRx
2441 Warrenville Road, Suite 610
Lisle, IL 60532-3642
1-800-880-1188
www.optumrx.com

COBRA Administrator:

UCHealth Plan Administrators
1107 South Lemay Avenue, Suite #400
Fort Collins, Colorado 80524 (970) 224-4600 or (866) 644-7873 toll free
http://tpa.uchealth.org