Summary Plan Description for School District No.1 Colorado

*School District No.1 is domiciled in, and subject to the laws of Colorado. This health plan is effective 07/01/2023 and the plan number is 501.

Contents

Introduction

School District No.1 maintains the School District No.1 Welfare Benefit Plan (the "Plan") for the exclusive benefit of its eligible employees and their eligible family members. This document summarizes important information about the Plan.

Plan Provisions

Receive Information About Your Plan and Benefits

Contact your plan sponsor to obtain any information about the plan including plan documents or other needed information about the plan.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for twelve (12) months (eighteen (18) months for late enrollees) after your enrollment date in your coverage.

Amendments

The Plan Sponsor may unilaterally change the Plan upon plan renewal. Amendments may be made during the term of the Plan if provided in writing and agreed to by the party against whose interest the modification operates. An exception may be made during the term of the Plan if the modification is effective uniformly among all plans within the particular product or service, or if mandated by law.

No Assignability

The Plan may designate an affiliated company to administer some or all of the benefit plan. However, Members have no right to assign any obligations under the Plan.

Availability of Summary Plan Description for Review

Members may request a hard copy of the Summary Plan Description from the Plan Sponsor.

No Vested Rights

Members are only entitled to receive benefits from the Plan while the Plan is in effect. Members do not have any permanent or vested interest in any benefits under the Plan, and benefits may change or terminate as the Plan is renewed, modified or terminated from year to year. Members only have rights to benefits under the Plan when they are properly enrolled and recognized by the Plan as Members. Unless otherwise expressly stated in the Plan, all benefits end when the Plan ends. Members have no right to receive any care, services, treatments, drugs, medications, supplies, or equipment from or through the Plan except in strict compliance with the Plan.

Acceptance of the Plan

As a condition to receiving Coverage from the Plan, Members are presumed and required to accept, comply with, and agree to, the terms of the Plan. Enrollees are also presumed to agree to the terms of the Plan on behalf of eligible Dependents who enroll as Members.

The Plan Determines Eligible Services

Merely because a physician or other Provider orders or recommends care, services, treatments, drugs, medications, supplies, or equipment for a Member does not mean that the Plan will recognize the procedure as being either Medically Necessary or covered by the Plan. This is true whether the physician or other Provider is a Contracted or a non-contracted Provider.

Benefits under the Plan will be paid only if the Plan decides that the Member is entitled to them. The Plan also has discretion to determine Eligibility for benefits, to require verification of any claim for Eligible Benefits and to interpret the terms and conditions of the benefit plan.

Provider Agency

Providers contracting with the Plan are independent contractors and not Employees or agents of the Plan. The Plan does not control the manner in which Contracted Providers provide professional services. Such Providers are entitled and required to exercise independent professional medical judgment in providing care and services to Members. The Plan does not promise, represent, warrant, or otherwise guarantee that care or services provided to Members by Providers will achieve any particular result or be provided in any particular manner or at any particular level of care.

It is understood and agreed that the Plan and Claims Administrator will not be liable for any claim or demand on account of injuries or damages of any kind arising out of or in any manner connected with any conditions or injuries suffered by a Member and resulting from care or services rendered, withheld, covered, limited, excluded, or otherwise provided or not under the Plan. All Members agree that Providers are solely responsible to Members for care or services rendered, limited, or withheld by such Providers.

Managed Care

Members agree to the managed care features that are a part of the Plan in which they are enrolled.

Benefits are Limited

Coverage under this Summary Plan Description is limited in defined ways. It is the responsibility of each Member to know the requirements, conditions, Limitations and Exclusions that apply to their Coverage, and to know the Limitations and requirements that apply to their choice of Providers and Hospitals and the timing of their health care services.

Members are responsible for payment for any care, service, treatment, drug, medication, supply, or equipment that they obtain that is not covered or limited by the Plan, or is obtained from Providers or Hospitals that are not authorized to be paid by the Plan. Members are not responsible to pay for claims that are the responsibility of the Plan.

Excess Funding

Excess funding will be used to offset future Plan costs or Member costs.

Plan Funding

Funding is derived first from the contributions made by the covered employees and then from general assets of the Plan Sponsor. The level of Member contributions will be set by School District No. 1, City and County of Denver. Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received.

Fiduciary

Plan Sponsor has contracted with a Claims Administrator on behalf of the Plan but the Claims Administrator is not a Plan Sponsor or Fiduciary of the Plan as defined by Federal law. The Claims Administrator administer the claims of the Plan on behalf of the Plan Sponsor in accordance with industry standards. The Plan Sponsor issues the Plan as an employer funded plan.

Notice of COBRA Rights

Your Employer or COBRA plan administrator should provide you and your Dependents notice of your rights and obligations under the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) to temporarily continue health and /or dental Coverage if you are an Employee of an Employer with twenty (20) or more Employees and you or your eligible Dependents, (including newborn and /or adopted children) in certain instances would lose Plan Coverage. Both you and your spouse should take the time to read this notice carefully. If you have any questions, please call

the Employer or COBRA plan administrator.

Compliance Responsibilities

Each party is responsible for its own compliance with applicable laws, rules and regulations.

Changes in Member Contact Information

It is the Member's responsibility to keep the Plan informed of any change of address, phone number, and email address of the Enrollee or any eligible Dependent. Members should keep copies of any notices sent to the Plan.

Requests for Information

As a condition of receiving benefits under this Plan, Members shall provide the Plan with all information at the Plan's request, including, but not limited to, providing releases for prior Medical Records. Failure by a Member to provide information to the Plan at the Plan's request under this section shall be a breach of this Plan and may result in forfeiture of benefits, termination of Coverage, or the Plan having the right to hold payment of claims for the Member or the Member's dependents until the requested information is received by the Plan.

Notices

Any notice required of the Plan will be sufficient if mailed by first class mail or sent electronically, to the Member or Enrollee at the address appearing on the records of the Plan. Notice to Members may be accomplished through electronic means so long as the Member has given permission to receive electronic notifications. Notice to an eligible Dependent will be sufficient if given to the Enrollee under whom the Member is enrolled. Any notice to the Plan will be sufficient if mailed to the principal office of the Claims Administrator in Utah. Each Enrollee agrees to promptly notify his/her Dependents of all benefit and other plan changes.

Qualified Beneficiary

A Qualified Beneficiary is an individual who is covered under the Employer group health plan the day before a COBRA Qualifying Event.

Who Can Be Covered under COBRA

Enrollees

If you have group health Coverage with the Plan, you have a right to continue this Coverage if you lose Coverage or experience an increase in the cost of the premium because of a reduction in your hours of employment or the voluntary or involuntary termination of your employment for reasons other than gross misconduct on your part.

Spouse of Enrollees

If you are the spouse of an Employee covered by the Plan, and you are covered the day prior to experiencing a Qualifying Event, you are a "Qualified Beneficiary" and have the right to choose continuation Coverage for yourself if you lose group health Coverage under the Plan for any of the following five (5) reasons:

1. The death of your spouse;
2. The termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse;
4. Your spouse becoming entitled to Medicare; or
5. The commencement of certain bankruptcy proceedings, if your spouse is retired.

Dependent Children

A Dependent child of an Employee who is covered by the Plan on the day prior to experiencing a Qualifying Event, is also a "Qualified Beneficiary" and has the right to continuation Coverage if group health Coverage under the Plan is lost for any of the following seven (7) reasons:

1. The death of the covered parent;
2. The termination of the covered parent's employment (for reasons other than gross misconduct) or reduction in the covered parent's hours of employment;
3. The covered parents' divorce or legal separation;
4. The covered parent becoming entitled to Medicare;
5. The Dependent losing coverage because he/she obtain the age of 26 and cease to be a "Dependent child" under the Plan;
6. The commencement of certain bankruptcy proceedings, if the covered parent is retired; or
7. A child born to, or placed for adoption with, the covered Employee during a period of continuation Coverage is also a Qualified Beneficiary.

Secondary Event

A Secondary Event, per COBRA, means one Qualifying Event occurring after another. It allows a Qualified Beneficiary who is already on COBRA to extend COBRA Coverage under certain circumstances, from eighteen (18) months to thirty-six (36) months of Coverage. The Secondary Event extends Coverage for up to 36 months from the date of the original Qualifying Event.

Member Duties Under COBRA

It is the responsibility of the covered Employee, spouse, or Dependent child to notify the Employer or Claims Administrator in writing within sixty (60) days of a divorce, legal separation, child losing Dependent status or secondary qualifying event, under the group health/dental plan in order to be eligible for COBRA continuation Coverage.

In addition, the covered Employee or a family member must inform the Plan of a determination by the Social Security Administration that the covered Employee or covered family Member was disabled during the sixty (60) day period after the Employee's termination of employment or reduction in hours, within 60 days of such determination and before the end of the original eighteen (18) month continuation Coverage period. (See "Special rules for disability," below.) If, during continued Coverage, the Social Security Administration determines that the Employee or family Member is no longer disabled, the individual must inform the Plan of this redetermination within thirty (30) days of the date it is made.

Enrollee Monthly Contribution

The Enrollee shall share contribution amounts with the Plan Sponsor. If the Enrollee has questions about their contributions, they may see the Plan Sponsor to view the Employee Benefit Booklet.

Plan Sponsor's Duties

The Plan Sponsor has the responsibility to notify the Claims Administrator of the Employee's death, termination of employment, reduction in hours, or Medicare eligibility. Notice must be given to the Claims Administrator within sixty (60) days of the occurrence of the above-listed events. When the Plan Sponsor is notified that one of these events has happened, the Plan Sponsor will notify you and your Dependents that you have the right to choose continuation Coverage.

Election of Continuation Coverage

Members have sixty (60) days from either termination of Coverage or date of receipt of COBRA election notice to elect COBRA. If no election is made within 60 days, COBRA rights are deemed waived and will not be offered again. If the Member chooses continuation Coverage, the Plan Sponsor is required to give the Member Coverage that, as of the time Coverage is being provided, is comparable to the Coverage provided under the Plan to similarly situated Enrollees or family Members. If the Member does not choose continuation Coverage within the time period described above, the Plan Coverage will end.

When and How you Must Give Notice

The Qualifying Event You experience determines Your notice requirements and the amount of time You may retain COBRA coverage.

You, Your spouse, or child must notify the Company's Human Resources Department of a divorce or legal separation, or a child losing dependent status within sixty (60) days of the event. (The Plan is required to provide notice to You and/or Your Enrolled Dependents of the right to elect COBRA coverage due to any of the other Qualifying Events.) Your spouse, or child may give written notice of the Qualifying Event to Health Equity at 15 W. Scenic Pointe Drive, Suite 100, Draper, Utah 84020. The written notice must provide the individual's name and current mailing address, the specific Qualifying Event, and the date of the Qualifying Event. If written notice is not provided to the Human Resources Department within 60 days after the date of the Qualifying Event, all rights of

that individual to elect COBRA coverage will be lost.

Once the Plan is properly notified of a Qualifying Event, it will send You and/or Your Enrolled Dependents information concerning continuation options, including the necessary COBRA continuation election forms. You and/or Your Enrolled Dependents will have 60 calendar days from the later of the date of the Qualifying Event or when You and/or Your Enrolled Dependent receive notice from the Plan in which to make an election.

If You or one of Your Enrolled Dependents qualifies for a Social Security Disability extension (described below), You must provide written notice to the Company's Human Resources Department within 60 days of the date the Social Security Administration determination is made and while still within the eighteen (18) month COBRA Continuation period following a termination or reduction of hours Qualifying Event. You must also provide a written notice to the Company's Human Resources Department within 30 days if a final determination is made that You are no longer disabled.

If You experience a Second Qualifying Event (described below), You must provide a written notice to the Company's Human Resources Department within 60 days of the second Qualifying Event and during the original 18-month COBRA coverage period (or 29-month period if there has been a disability extension), in order to extend COBRA coverage to 36 months.

COBRA Premium Payments

Payments must be made retroactively to the date of the qualifying event and paid within forty-five (45) days of the date of election. There is no grace period on this initial premium. Subsequent Payments are due on the first of each month with a thirty (30) day grace period. Delinquent Payments will result in a termination of Coverage. However, claims may not be paid during the entire grace period when premiums have not been paid.

Delinquent Payments will result in a termination of Coverage on the last day of the grace period. The amount a qualified beneficiary may be required to pay may not exceed one hundred two (102%) percent (or, in the case of an extension of continuation Coverage due to a disability, one hundred fifty (150%) percent) of the cost to the group health plan (including both Employer and Employee contributions) for Coverage of a similarly situated plan participant or beneficiary who is not receiving continuation Coverage. Claims paid in error by ineligibility under COBRA will be reviewed for collection. Ineligible premiums paid will be refunded. Employer is not permitted to exceed the minimum requirements of COBRA.

How Long Coverage May Last

The law requires that you be afforded the opportunity to maintain COBRA continuation Coverage for thirty-six (36) months, unless you lose group health Coverage because of a termination of employment or reduction in hours. In that case, the required COBRA continuation Coverage period is eighteen (18) months. Additional qualifying events (such as a death, divorce, legal separation, or Medicare entitlement) may occur while the continuation Coverage is in effect. Such events may

extend an 18-month COBRA continuation period to 36 months, but in no event will COBRA Coverage extend beyond 36 months from the date of the event that originally made the Employee or a qualified beneficiary eligible to elect COBRA Coverage. You should notify your Employer if a second qualifying event occurs during your COBRA continuation Coverage period.

Special Rules for Disability

If the Employee or covered family Member is disabled at any time during the first sixty (60) days of COBRA continuation Coverage, the continuation Coverage period may be extended to twenty nine (29) months for all family Members, even those who are not disabled. The criteria that must be met for a disability extension is:

1. Employee or family Member must be determined by the Social Security Administration to be disabled.
2. Must be determined disabled during the first 60 days of COBRA Coverage.
3. Employee or family Member must notify the Claims Administrator of the disability no later than 60 days from the later of:
    - the date of the Social Security Administration disability determination;
    - the date of the Qualifying Event;
    - the loss of Coverage date; or
    - the date the Qualified Beneficiary is informed of the obligation to provide the disability notice.

Employee or family Member must notify Employer within the original 18-month continuation period.

If an Employee or family Member is disabled and another qualifying event occurs within the 29-month continuation period (other than bankruptcy of your Employer), then the continuation Coverage period is thirty-six (36) months after the termination of employment or reduction in hours.

Continuation Coverage May Be Terminated

The law provides that your continuation Coverage may be cut short prior to the expiration of the 18, 29, or 36-month period for any of the following reasons:

1. Your Employer no longer provides group health Coverage to any of its Enrollees.
2. The premium for continuation Coverage is not paid in a timely manner (within the applicable grace period).
3. The individual becomes covered, after the date of election, under another group health plan (whether or not as an Employee) that does not contain any Exclusion or Limitation with respect to any preexisting condition of the individual.
4. The date in which the individual becomes entitled to Medicare, after the date of election.
5. Coverage has been extended for up to twenty-nine (29) months due to disability (see “Special rules for disability”) and there has been a final determination that the individual is no longer disabled.

6. Coverage will be terminated if determined by the Plan that the Employee or family Member has committed any of the following: fraud upon the Plan, forgery or alteration of prescriptions; criminal acts associated with COBRA Coverage; misuse or abuse of benefits; or breach of the conditions of the Plan. You do not have to show that you are insurable to choose COBRA continuation Coverage. However, under the law, you may have to pay all or part of the premium for your continuation Coverage plus two percent (2%). This notice is a summary of the law and therefore is general in nature. The law itself and the actual COBRA plan provisions must be consulted with regard to the application of these provisions in any particular circumstance.

Separate Election

If there is a choice among types of Coverage under the COBRA plan, each of you who is eligible for continuation of Coverage is entitled to make a separate election among the types of Coverage. Thus, a spouse or Dependent child is entitled to elect continuation of Coverage even if the covered Employee does not make that election. Similarly, a spouse or Dependent child may elect a different Coverage from the Coverage that the Employee elects.

The Plan's Employee Responses

Without the consent of the Plan Administration, individual Enrollees of the Plan do not have the authority to:

1. Modify the terms and conditions of this Plan;
2. Extend or modify the benefits available under this Plan, either intentionally or unintentionally;
3. Waive or modify any Exclusion or Limitation; or
4. Waive compliance with the Plan requirements, such as the use of Contracted Providers or the necessity of obtaining Preauthorization's.

Your Duties under COBRA

It is the responsibility of the covered Enrollee, spouse, or Dependent child to notify the Employer or Claims Administrator in writing within sixty (60) days of a divorce, legal separation, child losing Dependent status or other qualifying event, under the Plan in order to be eligible to make changes under the Plan.

COBRA Premium Payments

Payments must be made retroactively to the date of the qualifying event and paid within 45 days of the date of election. There is no grace period on this initial premium other than allowed under federal rules. Subsequent Payments are due on the first of each month with a thirty (30) day grace period. Delinquent Payments will result in a termination of Coverage. However, claims may not be paid during the entire grace period when premiums have not been paid.

Schedule of Benefits for School District No.1 Welfare Benefit Plan

Deductible

The deductible is the amount in a plan year that you are responsible before the Plan begins to pay benefits. The deductible does not apply for benefits shown as not applicable to the deductible below such as for preventive services.
The deductible amount on this policy is:

$3,000 for individual policies and $6,000 for family policies for In Network
$5,000 for individual policies and $10,000 for family policies for Out of Network

For individual policies, once the deductible is met, benefits will become payable. For family policies, benefits become payable for any individual that has met the individual deductible amount. Benefits become payable for all covered family members once the family deductible has been met.

Coinsurance

Coinsurance is the amount, represented as a percentage, which **you** are responsible for after the deductible is met. The remaining amount is paid by the Plan.

The In Network Coinsurance amount for this policy is:	20%
The Out of Network Coinsurance amount for this policy is:	50%

Maximum Out of Pocket (MOOP)

The Maximum Out of Pocket is the limit for which you are responsible for. This limit doesn't include any services that are not eligible, such as dental services or any amount above the Maximum Allowable Fee. Once you reach the MOOP, eligible benefits will be paid at 100% for the remainder of the plan year.

The Maximum Out of Pocket for this policy is:

$3,500 for individual policies and $7,000 for family policies for In Network
$10,000 for individual policies and $20,000 for family policies for Out of Network

For individual policies, once the Maximum Out of Pocket is met, eligible benefits will be paid at 100% for the remainder of the plan year. For family policies, eligible benefits will be paid at 100% for the remainder of the plan year for any individual that has met the individual Maximum Out of Pocket amount, even if it is less than the family deductible, eligible benefits will be paid at 100%

for the remainder of the benefit year for that individual. Eligible benefits will be paid at 100% for the remainder of the plan year once all amounts met towards Maximum Out of Pocket for all family members combined equals the family Maximum Out of Pocket amount.

The following chart gives information about cost sharing for your plan. However, please see the Plan Documents for more details including limitation, exclusions, and prior authorization requirements that may not be listed here.

HSA Eligible plans

This plan has been designed to meet the IRS requirements to be compatible with Health Savings Accounts (HSA). An HSA is a tax favored savings account used in conjunction with High Deductible Health Plans (HDHPs) as defined by the IRS. You can use HSA dollars to pay for qualified health expenses such as your deductible, dental services, vision services, medications including some over the counter medications, and other expenses that may not be covered by your health plan. Dollars used from your HSA for health expenses are tax free.

Some basic rules regarding HSAs include:
HSA funds belong to you and carry over from year to year even if you no longer have a High Deductible Health Plan (HDHP).
Money contributed to your HSA may be a tax deduction when contributed on your behalf.
Any earnings in your HSA are tax free.
After age 65, the funds can be used for any purpose, and you only pay income tax on the amount taken out of the account when the funds are not used for medical expenses.

See Your Employee Benefit Guide, IRS publication 502 and Publication 969 for more information about HSAs.

Services			
Inpatient Service	**In Network**	**Out of Network**	**Benefit Notes/Limitations**
Inpatient Hospital Services (e.g., Hospital Stay)			Daily hospital room and board, and other misc. costs. Facility benefits must be preauthorized.
Inpatient Physician and Surgical Services	20% After Deductible	50% After Deductible	
Skilled Nursing Facility			Skilled Nursing Facility limited to 30 days per Plan year. Facility benefits must be preauthorized.
Transplant			
Outpatient Service	**In Network**	**Out of Network**	**Benefit Notes/Limitations**
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)			Facility benefits must be preauthorized.
Outpatient Surgery Physician/Surgical Services			

Dialysis Hospice Services Home Health Care Services	20% After Deductible in hospital 10% After Deductible in ambulatory surgical center	50% After Deductible	Hospice services are limited to 6 months per every 3 years. Home Health Care Services are limited to 30 visits per Plan year. A visit is defined as up to 4 hours.
Professional Services	**In Network**	**Out of Network**	**Benefit Notes/Limitations**
Primary Care Visit to Treat an Injury or Illness Specialist Visit Other Practitioner Office Visit (Nurse, Physician Assistant)	20% After Deductible 20% After Deductible 20% After Deductible	50% After Deductible	Services must be rendered by a professional working within the scope of their license to be eligible.
Preventive Care	**In Network**	**Out of Network**	**Benefit Notes/Limitations**
Preventive Care/Screening/Immunization Contraceptives	No Cost	No Cost Up to Allowed Amount	Preventive Care and screenings are covered as required by the Affordable Care Act and may change from time to time. Contraceptives must be FDA approved to be eligible for coverage.

Diagnostic Lab and Imaging	In Network	Out of Network	Benefit Notes/Limitations
Imaging (CT/PET Scans, MRIs)	20% After Deductible	50% After Deductible	
Laboratory Outpatient and Professional Services	20% After Deductible		
X-rays and Diagnostic Imaging			
Urgent and Emergency Care	**In Network**	**Out of Network**	**Benefit Notes/Limitations**
Emergency Transportation/Ambulance	20% After Deductible up to a maximum of $500	20% After Deductible up to a maximum of $500	Emergency Transportation is limited to the nearest facility equipped to adequately care for needed emergency services.
Emergency Room Services	20% After Deductible	20% After Deductible	Emergency Services are covered only in case of emergency as determined by the Plan.
Urgent Care Centers or Facilities	20% After Deductible	50% After Deductible	
Maternity Services	**In Network**	**Out of Network**	**Benefit Notes/Limitations**
Prenatal and Postnatal Care	20% After Deductible	50% After Deductible	
Delivery and All Inpatient Services for Maternity Care			Home births are not covered
Mental Health/Substance Abuse Disorders	**In Network**	**Out of Network**	**Benefit Notes/Limitations**
Mental/Behavioral Health Outpatient Services	20% After Deductible	50% After Deductible	Facility charges require prior authorization.
Mental/Behavioral Health Inpatient Services	20% After Deductible		
Substance Abuse Disorder Outpatient Services	20% After Deductible		
Substance Abuse Disorder Inpatient Services	20% After Deductible		
Pharmacy	**In Network**	**Out of Network**	**Benefit Notes/Limitations**
Generic Drugs 1-30 days	20% After Deductible	Not covered	Some medications require quantity limitations. Some medications may require you to try other more effective medications before a medication will be eligible for coverage. Check the formulary for more details.
Generic Drugs 31-90 days	20% After Deductible		
Preferred Brand Drugs 1-30 days	20% After Deductible	Not covered	
Preferred Brand Drugs 31-90 days	20% After Deductible		
Non-Preferred Brand Drugs 1-30 days	20% After Deductible	Not covered	
Non-Preferred Brand Drugs 31-90 days	20% After Deductible		
Specialty Drugs 1-30 days	20% After Deductible	Not covered	
Specialty Drugs 31-90 days	20% After Deductible		

Habilitative and Rehabilitative Services	In Network	Out of Network	Benefit Notes/Limitations
Outpatient Rehabilitation Services Habilitation Services Rehabilitative Speech Therapy Rehabilitative Occupational and Rehabilitative Physical Therapy	20% After Deductible	50% After Deductible	Services have quantity limitations of 60 visits combined per policy year.
Chiropractic Services	20% After Deductible		Limited to 25 visits per policy year.
Vision Services	**In Network**	**Out of Network**	**Benefit Notes/Limitations**
Routine Eye Exam for children	No cost	50% After Deductible	One routine eye exam per year.
Other Services	**In Network**	**Out of Network**	**Benefit Notes/Limitations**
Allergy Testing	20% After Deductible	50% After Deductible	
Autism Spectrum Disorder	20% After Deductible	50% After Deductible	Treatment subject to review every 3 months
Chemotherapy	20% After Deductible	50% After Deductible	
Diabetes Care Management	20% After Deductible	50% After Deductible	
Diabetes Education	20% After Deductible	50% After Deductible	
Durable Medical Equipment	20% After Deductible	50% After Deductible	
Infertility Treatment	20% After Deductible	50% After Deductible	Limited to diagnostic services only.
Infusion Therapy	20% After Deductible	50% After Deductible	
Inherited Metabolic Disorder - PKU	20% After Deductible	50% After Deductible	
Nutritional Counseling	20% After Deductible	50% After Deductible	
Prosthetic Devices	20% After Deductible	50% After Deductible	
Radiation	20% After Deductible	50% After Deductible	
Reconstructive surgery	20% After Deductible	50% After Deductible	Limited per Women's Health and Cancer Rights Act.

Notice of Women's Health and Cancer Rights Act (WHCRA)

In accordance with the Women's Health and Cancer Rights Act of 1998, the Plan covers mastectomy in the treatment of cancer and Reconstructive Surgery after a mastectomy. If you are receiving benefits in connection with a mastectomy, Coverage will be provided according to the Plan's Medical Case Management criteria and in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction on the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical Complications in all stages of mastectomy, including

lymphedemas.

Coverage of mastectomies and breast reconstruction benefits are subject to applicable Deductibles and Coinsurance Limitations consistent with those established for other benefits. Following the initial reconstruction of the breast(s), any additional modification or revision to the breast(s), including results of the normal aging process, will not be covered. All benefits are payable according to the Outline of Coverage, based on this plan. Regular Preauthorization requirements apply.

Definitions

Accident, Accidental

Shall be defined to employ result language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization. The definition shall not be more restrictive than the following: "injury" or "injuries" means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause and that occurs while the insurance is in force.

Ambulatory Surgical Facility

Any licensed establishment with an organized medical staff of physicians, with permanent facilities equipped and operated primarily for the purpose of performing Ambulatory Surgical Procedures and with continuous physician services whenever a Member is in the facility but does not provide services or other accommodations for Members to stay overnight.

Coinsurance

The percentage portion of the cost of Eligible Benefits that a Member is obligated to pay under the Plan, after Deductible.

Community Standard

The standard accepted for consensus decisions will be determined by published peer-reviewed medical data, in journals sponsored by professional societies and associations, patterns of care within the Plan database, professional review organizations, and consultations with experts who are Board Certified by the American Board of Medical Specialists. The Community Standard is not necessarily a prevailing level of practice.

Complication

A medical condition, illness, or injury related to, or occurring as a result of another medical condition, illness, injury, Surgical Procedure, or drug.

Contracted Hospital

A Hospital with whom the Plan has a current contractual agreement to render care to covered Members for a specific fee.

Contracted Provider

A Provider with whom the Plan has a current contractual agreement to render care to covered Members for a specific fee.

Coordination of Benefits

The Coordination of Eligible Benefits between two or more plans under which an individual is covered after primary and secondary Coverage determination is made.

Cosmetic Procedure

Any procedure performed to improve appearance or to correct a deformity without restoring a physical bodily function.

Coverage

The eligibility of a Member for benefits provided under this Plan, subject to the terms, conditions, Limitations and Exclusions of this the Plan.

Services must be provided:

- When this Plan is in effect; and
- Prior to the date that termination occurs.

Custodial Care

Services, supplies, or accommodations for care rendered which:

1. Do not provide treatment of injury or illness;
2. Could be provided by persons without professional skills or qualifications;
3. Are provided primarily to assist a Member in activities of daily living;
4. Are for convenience, contentment, or other non-therapeutic purposes; or
5. Maintain physical condition when there is no prospect of affecting remission or restoration of the Member to a condition in which care would not be required.

Deductible

The amount paid by a Member for eligible charges before any benefits will be paid under the Plan.

Dependent

"Dependent" means:

The Enrollee's lawful spouse under State Law.

Children or stepchildren of the Enrollee up to the age of twenty-six (26) who have a Parental Relationship with the Enrollee. Adequate legal documentation may be requested. Once properly enrolled, a child's coverage may continue until the end of the month of their 26th birthday.

Legally adopted children, who are adopted prior to turning 18 years old, foster children, and children through legal guardianship up to the age of 26 are eligible subject to the Plan receiving adequate legal documentation. (Legal guardianship must be court appointed.)

A dependent may remain covered on the Plan beyond the age of 26 if the dependent is unable to engage in substantial gainful employment to the degree that the child can achieve economic independence due to medically determinable physical or mental impairment which has lasted or is expected to last for no less than twelve (12) months. Mental impairment may include an intellectual disability, organic brain syndrome, emotional or mental illness. Physical impairment means a physiological disorder, condition, or disfigurement, or anatomical loss affecting one or more of the following systems: neurological, musculoskeletal, special sense, respiratory, speech, cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin, or endocrine system. Periodic documentation is required but no more often than every (2) years unless there was a change in the Dependent's condition related to their disability. Enrollee must furnish written notification of the disability to the Plan no later than thirty-one (31) days after the date the Coverage would normally terminate. In the notification, the Enrollee shall include the name of the Dependent, date of birth, marriage status, and details concerning the condition that led to the Dependent's physical or mental disability; Income, if any, earned by the Dependent; and the capacity of the Dependent to engage in employment, attend school, or engage in normal daily activities. If proof of disability is approved, the Dependent's Coverage may be continued as long as he/she remains disabled and unable to earn a living, and as long as none of the other causes of termination occur.

When an Enrollee or their lawful spouse are required by a court or administrative order to provide health coverage for a child, the child will be enrolled in your coverage according to Plan guidelines and only to the minimum extent required by applicable law. A Qualified Medical Child Support Order (QMCSO) can be issued by a court of law or by a state or local child welfare agency. If ordered, an Enrollee and their Dependent child may be enrolled without regard to annual enrollment restrictions. The effective date for a qualified order will be the start date indicated in the order.

In the event of divorce, Dependent children for whom the Enrollee is required to provide medical insurance as ordered in a divorce decree may continue Coverage. The former spouse and/or stepchildren may not continue Coverage. The Plan will not recognize Dependent eligibility for a

former spouse or stepchildren unless the Plan receives a valid court order. Stepchildren who no longer have a Parental Relationship with an Enrollee will no longer be eligible to receive benefits under the Plan.

Dependent does not include an unborn fetus.

Device

Any instrument, apparatus, appliance, material, or other article, whether used alone or in combination, including the software necessary for its proper application intended by the manufacturer to be used for the purpose of:

1. Diagnosis, prevention, monitoring, treatment, or alleviation of illness or injury;
2. Diagnosis, monitoring, treatment, alleviation, or compensation for a handicap;
3. Investigation, replacement, or modification of the anatomy or of a physiological process, or;
4. Which does not achieve its principal intended action in or on the human body by pharmacological, immunological, or metabolic means, but which may be assisted in its function by such means.

Durable Medical Equipment

Medical equipment that is all of the following:

1. Used only to benefit in the care and treatment of an Illness or injury;
2. Durable and useful over an extended period of time;
3. Used only for a medical purpose rather than convenience or contentment;
4. Is prescribed by a Provider; and
5. Not used by other family members for nontherapeutic purposes.

Elective Treatment

Nonemergency services that can be scheduled forty-eight (48) hours or more after diagnosis.

Eligible Benefit

Medical expenses which are covered under the Plan.

Emergency Care

Means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of medicine and health, would reasonably expect the absence of immediate medical attention through a hospital emergency department to result in:

1. placing the insured's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

Employee

An Employer's Employee who is eligible for Coverage under the Health Benefit Plan.

Employer

Any entity which has an employee-employer relationship with the Enrollees for which they are providing health benefit coverage. An Employer may also be referred to as the Plan Sponsor.

Enrollee

An Employee of the Plan Sponsor that enrolls on behalf of themselves and other Members (if applicable) and is approved by the Plan to obtain the health benefits provided by the Plan. An Enrollee must complete all other requirements to properly enroll in this plan. The terms Member and Enrollee may be used interchangeably except where it is necessary to highlight the differences between the Enrollee and their dependent Members in the Plan.

Enrollment

The process whereby an Enrollee makes written application for Coverage directly or indirectly by agent or exchange to the Plan, subject to specified time periods and Plan provisions.

Excepted Benefits

Benefits not subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). They are as follows Coverage for Accident, or disability income insurance; Coverage issued as a supplement to liability insurance; liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; Coverage for onsite medical clinics; similar insurance Coverage under which benefits for medical care are secondary or incidental to other insurance benefits. The following benefits are not subject to requirements if offered separately limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community based care, or any combination; other similar limited benefits. The following benefits are not subject to requirements if offered as independent non-coordinated benefits Coverage only for a specified disease or illness; Hospital indemnity or other fixed indemnity insurance. The following benefits are not subject to requirements if offered as a separate insurance policy Medicare supplemental Health insurance (as defined under section 1882(g)(1) of the Social Security Act), Coverage supplemental to the Coverage provided under Chapter 55 of Title 10, United States Code, and similar supplemental Coverage provided.

Exclusions

Those services or supplies incurred by the Member, which are not eligible under the Plan.

Experimental, Investigational, or Unproven

"Experimental Treatment" is defined as medical treatment, services, supplies, medications, drugs, or other methods of therapy or medical practices, which are not accepted as a valid course of treatment by the Utah Medical Association, the U.S. Food and Drug Administration, the American Medical Association, or the Surgeon General.

Coverage for members participating in approved clinical trials may be eligible for benefits. The term “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

FEDERALLY FUNDED TRIALS- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

- The National Institutes of Health.
- The Centers for Disease Control and Prevention.
- The Agency for Health Care Research and Quality.
- The Centers for Medicare & Medicaid Services.
- Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs.
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- The Department of Veterans Affairs.
- The Department of Defense.
- The Department of Energy.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

For experimental services, regular cost sharing of similar services will apply.

FDA Approved

Pharmaceuticals, Devices, or Durable Medical Equipment which have been approved by the FDA for a particular diagnosis.

Formulary

A list of selected prescription medications reviewed by an independent Pharmacy and

Therapeutics (P&T) Committee. The P&T Committee is an independent group of accomplished health care professionals comprised of physicians with various medical specialties and clinical pharmacists who assist in developing the Formulary. The P&T Committee reviews medications in all therapeutic categories relevant to the prescription drug benefit and evaluates them based on safety and efficacy. The Committee reviews new and existing drugs on a regular basis and the Formulary is revised accordingly.

Global Fee

An amount negotiated for a specific procedure (such as an organ transplant) including multiple Providers, within a specified time frame.

High Deductible Health Plan

A plan with a lower premium and higher deductible than a traditional health plan, which is compatible with a Health Savings Account as defined by and in accordance with Federal Law.

Hospice Care

A program of supportive care that addresses the spiritual, social, and psychological needs of terminally ill patients and their families. The Global per diem benefit for Hospice includes home care nursing, nursing aides, oral medication, Durable Medical Equipment, social worker, counseling, respite care, physical, occupational, and speech therapies provided for purposes of symptoms control or to enable the patient to maintain activities of daily living and basic functional skills.

Hospital

A Hospital is defined as:

1. An institution which is operated to care for and treat sick or injured persons as in-patients.
2. Any other institution which is operated pursuant to laws pertaining to hospitals in the jurisdiction in which it is located, under the supervision of a staff of physicians and with twenty-four (24) hour per day nursing service.
3. Specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including x-ray and laboratory) on its premises, under its control, or through a written agreement or with a specialized Provider of those facilities.

In no event shall the term Hospital include a facility operated primarily as an outpatient or free standing unit, or a convalescent nursing home or an institution or part thereof which is used principally as a convalescent, rest, or nursing facility or facility for the aged, or which furnishes primarily domiciliary or Custodial Care, including training in the routines of daily living, or which is operated primarily as a school. Hospitals are considered Providers in accordance with this the Plan.

Immediate Family Member

Immediate Family Members are considered to be (for purposes of the Plan) spouse, children, son-in-law, daughter-in-law, brother, sister, brother-in-law, sister in law, mother, father, mother-in-law, father-in-law, stepparents, stepchildren, grandparents, grandchildren, uncles, aunts, nieces, nephews, domestic partners, and adult designees.

Industrial Claim

An illness or injury arising out of or in the course of employment covered by the Worker's Compensation Fund or Employer Liability laws.

Life Threatening

The sudden and acute onset of an illness or injury where delay in treatment would jeopardize the Member's life or cause permanent damage to the Member's health such as, but not limited to, loss of heartbeat, loss of consciousness, limb threatening or organ threatening, cessation or severely obstructed breathing, massive and uncontrolled bleeding. The determination of a Life Threatening event will be made by the Plan on the basis of the final diagnosis and medical review of the records. The Plan reserves the right to solely determine whether or not a situation is Life Threatening.

Limitations

Provisions in the Plan indicating services or supplies that are not fully covered or covered only when specific criteria is met.

Maximum Allowable Fee

1. The maximum fee allowable for a given procedure, established by the Plan and accepted by Contracted Providers. In the case of non-network Providers, the Plan will determine the maximum allowable fee per the Plan. The Maximum Allowable Fee is determined by the Usual & Customary method.

Medical Case Management

The active involvement by request of the Plan of a nurse coordinator or case manager working with the Member, Member's family and Provider(s) to coordinate a comprehensive, medically appropriate treatment plan with prudent use of benefit dollars.

Medical Records

Medical reports, clinical information, and Hospital records relating to the care, treatment, and relevant medical history of the Member.

Medically Necessary/ Medical Necessity

Means (a) health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (i) in accordance with generally accepted standards of medical practice in the United States; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; (iii) not primarily for the convenience of the patient, physician, or other health care Provider; and (iv) covered under the Plan; (b) when a medical question-of-fact exists medical necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective. (i) For interventions not yet in widespread use, the effectiveness shall be based on scientific evidence. (ii) For established interventions, the effectiveness shall be based on: (A) scientific evidence; (B) professional standards; and (C) expert opinion.

Member

An Enrollee, an Enrollee's spouse, an Enrollee's Dependents who are enrolled in active Coverage. A Member may also be referred to as You or Employee in the Plan Documents.

Mental Health

Mental Health Coverage shall include behavioral health and mental disorders not otherwise defined as surgical or medical in nature, or as described in the ICD (International Classification of Disease) except where otherwise described or excluded in the Plan.

Package Fee

The cost benefit of "package" surgical services, which include the operation per se; local infiltration, metacarpal/digital block or topical anesthesia when used and normal, uncomplicated follow-up care. Normal, uncomplicated follow-up care would cover the period of Hospitalization and office follow-up for progress checks or any service directly related to the Surgical Procedure as per standard medical guidelines. The only exception would be if the service relates to Complications, exacerbations or recurrences of other diseases or injuries requiring additional or separate services. When an additional Surgical Procedure(s) is carried out within the listed period of follow-up care for a previous Surgery, the follow-up periods will continue concurrently to their normal termination.

Parental Relationship

The relationship between a natural child or stepchild and a parent while the child or stepchild is dependent on the parent for Coverage. Stepchildren will no longer be eligible to receive benefits when the marriage between their natural parent and the Enrollee stepparent is terminated for any reason.

Payment

Amount paid by the Enrollee for the purchase of a health benefits plan.

Preauthorization

The administrative process whereby a Member and Provider can learn, in advance of treatment, the level of benefits provided by the Plan for the proposed treatment plan. The process, prior to service, that the Member and the treating Provider must complete in order to obtain authorization for specified benefits of this Plan which may be subject to Limitations and to receive the maximum benefits of this Plan for Hospitalization, Surgical Procedures, Durable Medical Equipment, pharmaceutical drug products, or other services as required. Preauthorization does not guarantee payment should Coverage terminate, should there be a change in benefits, should benefit limits be used by submission of claims in the interim, or should actual circumstances of the case be different than originally submitted.

Preauthorization Process

To obtain Preauthorization, a Member's physician may obtain a Preauthorization form at the Claim's Administrator's website or may contact the Plan's Customer Service to start the Preauthorization process. The Provider will be directed to the Plan's pharmacy Preauthorization phone line. Approval or denial will be communicated to the Provider's office. Members may also phone the Plan's Customer Service Department to receive an update on the status of the physician's request. Preauthorization does not guarantee payment. Coverage is subject to eligibility, benefit Coverage and Preauthorization requirements.

Pre-Notification

The process the Member must follow in order to notify the Plan of any impending Hospital admission as required by the Plan.

Primary Care Provider

A Provider acting within the scope of the Provider's practice limited to the following:

- Family Practice (FP)
- Internal Medicine (IM)
- Pediatrician (MD)
- Obstetrics and Gynecology (OBGYN) Gynecologist (GYN)
- Geriatrician (MD)
- Osteopath (DO)
- Advanced Practical Registered Nurse (APRN) Nurse Practitioner (NP)
- Certified Nurse Midwife (CNM)
- and other Providers performing services for Members for the above Provider types including:

- Registered Nurse (RN)
- Physician's Assistant (PA)

Provider

A licensed practitioner of the healing arts acting within the scope of the Provider's practice and licensing.

Reconstructive Surgery

Non-Cosmetic Surgery performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, which restores bodily function.

Rehabilitation/Habilitation Therapy

The treatment of disease, injury, developmental delay or other cause, by physical agents and methods to assist in the Rehabilitation/habilitation of normal physical bodily function, that is goal oriented and where the Member has the potential for functional improvement and ability to progress.

Skilled Nursing Facility

An institution, or distinct part thereof, that is licensed pursuant to state law and is operated primarily for the purpose of providing skilled nursing care for individuals recovering from illness or injury as an inpatient, and has organized facilities for medical treatment and provides twenty four (24) hour nursing service under the full time supervision of a physician or a graduate registered nurse; maintains daily clinical records on each patient and has available the services of a physician under an established agreement; provides appropriate methods for dispensing and administering drugs and medicines; and has transfer arrangements with one or more Hospitals, a utilization review plan in effect, and operation policies developed in conjunction with the advice of a professional group including at least one Provider. Short Stay Acute Care Hospital (STACH), Long-term Acute Care Hospital (LTACH) and Hospice are generally considered Skilled Nursing facilities. A Skilled Nursing Facility is not generally considered a rest home, home for the aged, or a place for the treatment of mental disease, drug addiction, or alcoholism.

Specialist

A Provider acting within the scope of the Provider's practice, limited to all other provider types not defined as Primary Care Providers.

Specialty Drug

Drugs determined by the Plan and its pharmacy benefit manager to be payable only through the Specialty Drug Program based on one or more of the following:

- Special administration requirements.
- Special handling requirements.
- Special clinical support requirements.
- Product accessibility.
- High cost of medication.
- Availability of medication through the Plan's Specialty Drug vendor.
- Other drugs at the Plan's discretion.

Subrogation

The Plan's right to recover payments it has made on behalf of a covered Member because of an injury caused by a liable party.

Surgical Procedure or Surgery

Cutting, suturing, treating burns, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electrocauterizing, tapping (paracentesis), applying plaster casts, administering pneumothorax, or endoscopy.

Totally Disabled

Totally Disabled or Total Disability shall mean an individual who: (i) is not engaged in employment or occupation for which he is or becomes qualified by reason of education, training or experience; and (ii) is unable to perform all of the substantial and material duties of his or her regular occupation. (b) the Plan may require care by a physician other than the Member or a member of the Member's immediate family. (c) The definition of Totally Disabled does not exclude benefits based on the individual's: (i) ability to engage in any employment or occupation for wage or profit; (ii) inability to perform any occupation whatsoever, any occupational duty, or any and every duty of his occupation; or (iii) inability to engage in any training or rehabilitation program.

Unbundling

The practice of using numerous procedure codes to identify procedures that normally are covered by a single code. (Also known as "fragmentation," "exploding," or "a la carte" medicine).

Urgent Condition

An acute health condition with a sudden, unexpected onset, which is not Life threatening but which poses a danger to the health of the Member if not attended by a physician within twenty four (24) hours; e.g., serious lacerations, fractures, dislocations, marked increase in temperature, etc.

Usual & Customary

Usual and Customary shall mean the most common charge for similar services, medicines or supplies within the area in which the charge is incurred. (b) In determining whether a charge is

usual and customary, the Plan shall consider one or more of the following factors: (i) the level of skill, extent of training, and experience required to perform the procedure or service; (ii) the length of time required to perform the procedure or services as compared to the length of time required to perform other similar services; (iii) the severity or nature of the illness or injury being treated; (iv) the amount charged for the same or comparable services, medicines or supplies in the locality; the amount charged for the same or comparable services, medicines or supplies in other parts of the country; (v) the cost to the Provider of providing the service, medicine or supply; and (vi) other factors determined by the Plan to be appropriate.

Verbal Preauthorization

Prior approval obtained by calling the Plan's Customer Service in advance of treatment as required for some specific services and as documented by the Plan.

Waiting Period

Waiting Period is a time that an employee is employed before they are eligible for the Employer's health plan. Waiting periods may not be longer than ninety (90) days from the time the employee is hired or otherwise eligible before they are eligible.

Family Medical Leave Act

If an Enrollee is on a leave required by the Family Medical Leave Act (FMLA), the Plan will administer their coverage as follows:

- The Enrollee and their enrolled Dependents may continue their coverage to the extent required by the FMLA as long as the Enrollee arranges with School District No.1 to pay the applicable employee contributions towards the cost of coverage while out on approved FMLA leave of up to 12 weeks (unless the Employer agrees to permit the Enrollee to make contributions before or after leave);
- If the Enrollee's contributions are not paid during their FMLA-protected leave, their coverage will be terminated (unless the Enrollee has arranged with the Employer to pay the Enrollee's contributions upon their return to work). Upon the Enrollee's return to work, the Enrollee and any previously enrolled Dependents who are still eligible will be prospectively reinstated on the first (1st) of the month following thirty (30) days from the date the Enrollee returns to employment. The Plan will not be responsible for any claims incurred by the Enrollee or their Dependents during this break in coverage.

Enrollment, Eligibility & Termination

General

Employees and their Dependents are eligible for Coverage as set forth herein. All eligible Enrollees are required to enroll by completing and submitting a Large Group Enrollment Form, by completing an electronic Enrollment form through the Plan's online Enrollment portal, or by

completing a form provided by the Employer. All information gathered and the information contained on the Enrollment form is incorporated into the Plan.

Eligibility

The eligibility of Employees and eligible Dependents is determined based on the Employer's personnel policies and the Employee's representations made on their verified individual Enrollment form, which form is a part of the Plan. Copies of Member's completed Enrollment forms are available upon request. Members who commit fraud or any other crime against the Plan are not eligible for Coverage. This Summary Plan Description provides for general eligibility requirements, any variation from this language must be documented and acknowledged by both the Plan Sponsor and the Member.

School District No.1 personnel policies state that for Employees to be eligible for benefits, they must work at least twenty (20) hours per week. School District No.1 waiting period for newly eligible employees is the first of the month following the Employee's hire date.

Enrollment period

An Enrollee must enroll during initial enrollment or during the annual enrollment period as set forth by the Plan rules of their employer or during a special enrollment period defined below. Newly eligible Dependents may be enrolled within thirty (30) days from the date of birth, or placement in your home, or from the date of marriage. For such Dependents, Coverage will become effective on the date of the event including birth, placement in home, or the date of marriage. If not enrolled during this time period, Dependents must wait until the next annual Enrollment period to enroll and Coverage will become effective on the Enrollee's annual renewal date. Coverage is effective July 1st for those who obtain coverage at the annual enrollment period.

Special Enrollment

Eligible persons who do not enroll themselves or their eligible Dependents during the initial Enrollment period, may enroll in Coverage prior to the next annual Enrollment period if they meet the qualifications for a Special Enrollment period. The Plan shall allow special Enrollment in the following circumstances:

Loss of Other Coverage

When an employee covered under an employer-sponsored health plan dies, legally separates, loses employer contributions, or divorces, the covered spouse and dependent children must enroll in this Coverage within sixty (60) days after the date the other Coverage is lost. Proof of loss of the other Coverage (Certificate of Creditable Coverage) must be submitted to the Plan at the time of application. Proof of loss of other Coverage or other acceptable documentation must be submitted before any benefits will be paid on applicable Members. In the absence of a Certificate of Creditable Coverage, the Claims Administrator will accept the following:

- A letter from a prior employer indicating when Group coverage began and ended;

- Any other relevant documents that evidence periods of Coverage; or;
- A telephone call from the other Insurer to the Plan verifying dates of Coverage.

Family Status Change

The Plan shall also allow an Enrollee and/or Dependents to enroll if the Enrollee gains an eligible Dependent through marriage, birth, adoption or placement for adoption. At the time the Enrollee enrolls his/her Dependents, the Enrollee may also be enrolled. In the case of birth or adoption of a child, the Enrollee may also enroll the Enrollee's eligible spouse, even if he/she is not newly eligible as a Dependent. However, special Enrollment is permitted only when the Enrollment takes place within thirty (30) days of the marriage, birth, adoption or placement for adoption. Any Plan benefits applicable to dependents of the Enrollee are applicable on the same basis to:

- A newly born child from the moment of birth; and
- An adopted child:
    - Beginning from the moment of birth, if placement for adoption occurs within thirty (30) days of the child's birth; or
    - Beginning from the date of placement, if placement for adoption occurs thirty (30) days or more after the child's birth.

The Plan must receive a copy of the adoption/placement papers before a Dependent who has been adopted or placed for adoption can be enrolled in Coverage. If a divorce decree is set aside by a court of competent jurisdiction, the Plan shall treat the Dependent(s) as eligible for reenrollment on the date the decree was set aside. Dependent(s) shall not be eligible during the time the divorce decree was in effect.

Legal Guardianship

Dependent children who are under age twenty-six (26) and who are placed under the legal guardianship (through testamentary appointment or court order) of the Enrollee or the Enrollee's lawful spouse are eligible to be enrolled for Coverage. The Enrollee must enroll any such children within thirty (30) days of receiving legal guardianship.

Military Activation

Military Leave Members called to active duty in the military are excluded from Coverage under this Summary Plan Description, unless proper application for continuation of Coverage is made pursuant to the Uniformed Services Employment and Re-employment Act (USERRA) of 1994. Members may elect to continue Coverage for Dependents that were covered under the Plan at the time of the Member's call to active duty at the group rate. The Member is responsible to ensure that the Member's share of Payment for Coverage is made in a timely manner. If Payment is not received by the date it is due or during the allowed grace period, Coverage will be cancelled. The Employer must continue paying the Employer share of the group rate. If the Member elects not to continue Coverage for themselves in whole or for their Dependents, Coverage may be reinstated within ninety (90) days of discharge without being subject to a waiting period.

Special Enrollment Rights Through Children's Health Insurance Program Reauthorization Act (CHIPRA)

When an Employee or dependent's Medicaid or CHIP coverage is terminated they are permitted Special Enrollment rights. When an Employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State Children's Health Insurance Plan (CHIP) under title XXI of the Social Security Act and coverage of the Employee or dependent is terminated as a result of loss of eligibility, a group health plan must allow Special Enrollment. The Employee or dependent must request Special Enrollment within sixty (60) days after the date of termination of Medicaid or CHIP coverage.

Upon Eligibility for Employment Assistance under Medicaid or CHIP. When an Employee or dependent becomes eligible for premium assistance, with respect to coverage under the group health plan or health insurance coverage under a Medicaid plan or State CHIP plan, the group health plan must allow Special Enrollment. The Employee or dependent must request Special Enrollment within sixty (60) days after the Employee or dependent is determined to be eligible for assistance.

How long After Special Enrollment before Member is Covered?

It depends on what triggers the Member's right to special enrollment. If the special enrollment was a result of a:

1. birth,
2. adoption,
3. marriage, or
4. placement for adoption.

The coverage will begin no later than the day of the event.

If the special enrollment was due to:

1. marriage or
2. loss of eligibility for other coverage.

Then the Member's new coverage will begin on the first day of the first month after the Plan receives the enrollment request. For example, if the Plan receives the request on January 3, coverage would begin on February 1.

Coverage End Dates

Coverage for a Member will terminate if the Member ceases to be eligible for the following reasons:

1. Dependent child turns age 26 – Coverage will continue through the end of the month of their birthday.

2. Divorce – Coverage will terminate for ex-spouses and stepchildren at the end of the month following the date on the court signed divorce decree.
3. Death of Enrollee – Coverage will terminate at the end of the last day of the month.
4. Termination of Employment – Coverage will terminate at the end of the last day of the month.
5. Legal Separation- Coverage will terminate for the legally separated spouse and stepchildren at the end of the month following the date on the court signed separation decree.

Termination of Coverage

It is the Enrollee's responsibility to make written notification when a Dependent is no longer eligible for Coverage. The Plan will not refund Payments made for ineligible Dependents. The Enrollee will be held responsible to reimburse the Plan for the claims processed beyond eligible service dates.

The Plan shall have the right to deny claims, terminate any or all Coverages of a Member and seek reimbursement of claims paid upon the determination by the Plan that the Member has committed any of the following:

1. Fraud upon the Plan or its Administrator;
2. Forgery or alteration of prescriptions;
3. Criminal acts associated with Coverage;
4. Misuse or abuse of benefits; or
5. Breached the conditions of the Plan.

Notification of Termination

It is the Plan Sponsor's responsibility to give written notification of termination to each Employee or group Member thirty (30) days before the day on which the Plan terminates; and to notify each Employee or group Member of the Employee's or group Member's rights to continue coverage upon termination.

Liability for Services After Termination

All care, services, treatments, drugs, medications, supplies, or equipment obtained after the date of termination are the responsibility of the Member or the subsequent carrier or other Provider of Coverage, and not the responsibility of the Plan, no matter when the condition arose and despite care or treatment anticipated or already in progress.

Correction of Payment in Error

The Plan shall have the right to pay to any organization making payments under other plans that should have been made under this Plan, any amount necessary to satisfy the payment of claims under this Plan. Amounts so paid by the Plan shall be considered benefits paid under this Plan, and the Claims Administrator shall be fully discharged from liability under this Plan to the extent

of such payments. Corrections will be made a maximum of twenty-four (24) months from date of service except in the cases of Medicaid, Medicare, CHIP, or any other state or federal healthcare program, or when ordered by a hearing officer or court of competent jurisdiction. Medicaid, Medicare, CHIP, and any other state or federal healthcare program may be recovered up to thirty-six (36) months following the date of service.

Coordination of Benefits with Other Insurance

The Coordination of Benefits provision applies when an Enrollee or the Enrollee's covered eligible Dependents have health care Coverage under more than one health benefit plan, except those specifically excluded in Coordination of Benefits will be administered in accordance with Utah Insurance Code rules. When an Enrollee or Enrollees covered Eligible Dependents have health Coverage under more than one benefit plan, one plan shall pay benefits as the primary plan and the other plan shall pay benefits as the secondary plan.

The Enrollee must inform the Plan of other medical Coverage in force. If applicable, the Enrollee will be required to submit court orders or decrees. Enrollees must also keep the Plan informed of any changes in the status of other Coverage.

Order of Benefit Determination

The Plan determines the order of benefits using applicable state and federal law.

Coordination of Benefits Rules

When the Plan is the primary plan, its Eligible Benefits are paid before those of the other health benefit plan and without considering the other health plan's benefits. When the Plan is the secondary plan, its Eligible Benefits are determined after those of the other health benefit plan and may be reduced to prevent duplication of benefits. When secondary, the Plan calculates the amount of Eligible Benefits it would normally pay in the absence of the primary plan coverage, including Deductible, Coinsurance, and the application of credits to any Plan maximums. The Plan then determines the amount the Member is responsible to pay after the primary carrier has applied its allowed contracted amount. The Plan will then pay the amount of the Member's responsibility after the primary plan has paid, up to the maximum amount it would have paid as the primary carrier. In no event will the Plan pay more than the Member is responsible to pay after the primary carrier has paid the claim. Medical and pharmacy claims will be subject to all plan provisions as described in this Plan, including, but not limited to, Preauthorization/Pre-notification requirements, benefit Limitation, step therapy requirements, quantity level rules, etc., regardless of whether the Plan is the primary or secondary payer.

Coverage under the Plan is primary only when required to be primary by law or by this the Plan. If the other health benefit plan does not have rules for Coordination of Benefits, then Coverage under the other plan will be primary to Coverage under the Plan.

When a payment between the Plan and a Provider/facility has been coordinated incorrectly, the

Plan will make proper payment adjustments if the request is submitted to the Plan according to the following schedule:

1. Twenty-Four (24) months from date the claim was processed by the Plan for coordination of benefit errors. This timeframe shall apply to Coordination of Benefits for commercial insurance coverage, not including Government coverage such as Medicare, Medicaid, CHIP;
2. Thirty-Six (36) months from date the claim was processed by the Plan. This timeframe shall apply to Coordination of Benefits for government/federal health care insurance programs such as Medicare, Medicaid, CHIP, or any other state or federal health care program;
3. Within twelve (12) months of the amount improperly paid for any other reason not identified above.

Dual Coverage

When a Dependent enrolls on a second Welfare Benefit Plan through the Plan Sponsor creating "dual Coverage" (a combination of two or more Welfare Benefit plans through the same employer), eligible Benefits will be adjudicated in the same order as any other Coordination of Benefits.

No Coordination of Benefits with Other Types of Plans

The Plan does not coordinate with school plans, sports plans, Accident only Coverage, specified disease Coverage, nursing home or long-term care plans, disability income protection Coverage, Veterans Administration plans, or Medicare Advantage Supplement plans.

Coordination of Benefits with Medicare

The Plan's Coordination of Benefits with Medicare and its status as primary or secondary payer shall be determined in accordance with applicable Medicare laws and regulations. When the Plan is secondary to Medicare, benefits otherwise payable under the Plan shall be reduced so that the sum of benefits payable under the Plan and Medicare shall not exceed the total allowable expenses of the primary plan.

General Provisions of The Plan

This Summary Plan Description contains only a general description of the benefits eligible under this health benefit plan. The term Plan refers to the complete description of benefits available in the Plan documents maintained by the Plan solely for use by its Members. The Plan does not authorize any other use of the Plan. This Plan and the applicable Outline of Coverage for your Employer group's Eligible Benefits are intended to work in conjunction with one another.

Authorization to Obtain/Retain/Share Information

By enrolling with the Plan and accepting or receiving services and/or benefits through the Plan, all Members agree that the Plan and Providers are authorized to obtain, retain and share information (including but not limited to sensitive medical information contained in Medical Records) necessary or reasonably believed to be necessary to properly diagnose and treat Members, in order to process and evaluate claims for services rendered. The Plan will maintain the confidentiality of such information in its possession as regulated by 45 CFR 160 and 164 as amended. Upon receiving appropriate documentation, the Plan may provide a custodial parent information regarding claims payment for the covered Dependent.

Excess Payment or Mistaken Payments

The Plan will have the right to recover any payment made in excess of the Plan's obligations under this Plan, whether such payment was made in error or otherwise. Such right will apply to payments made to Members, Providers or Facilities. If an excess payment is made by the Plan, the Member agrees to promptly refund the amount of the excess. The Plan may, at its sole discretion, offset any future payment against any excess or mistaken payment already made to a Member or for a Member to a Provider or Facility. The making of a payment in error or under a mistaken understanding of the relevant facts is not recognition by the Plan that the service in question is covered under the Plan. If a claim incurred due to false pretenses, whether intentional or not, false representation, or actual fraud is discovered, the Plan may deny or seek reimbursement for payment.

Medical Case Management

Medical Case Management is designed to enhance the value of medical care in cases of complex medical conditions or injudicious use of medical benefits. Under Medical Case Management, a nurse case manager will work with the Member, the Member's family, Providers, outside consultants and others, to coordinate a comprehensive, medically appropriate treatment plan. Failure to abide by the treatment plan may result in a reduction or denial of benefits. Claims will be paid according to CPT, RBRVS, global fee, and industry standards and guidelines. The Plan, at its own discretion, may require a Member to obtain Preauthorization for any and all benefits in coordination with Medical Case Management, if the Plan has determined such action is warranted by the Member's claims history.

Continuity of Care

A Member qualifies for protection and is a continuing care patient if he or she is receiving care from a network Provider for:

1. a serious and complex condition,
2. a course of institutional or inpatient care from a Provider or facility,
3. a nonelective surgery from the Provider or facility, including receipt of post-operative care with respect to a surgery,
4. pregnancy and is undergoing a course of treatment for the pregnancy, or
5. a determined terminal illness and is receiving treatment for such illness from a Provider or facility, and such Provider or facility's contract to be a network Provider terminates or

expires for any reason other than fraud, then the Plan shall meet all of the following requirements:

- the Plan must notify each Member under the Plan who is a continuing care patient that he or she is protected for continuing care at the time the Provider or facility's contract terminates. The Plan shall notify the enrolled Member of his or her right to elect continued transitional care from such Provider or facility.
- the Plan shall provide an enrolled Member with an opportunity to notify the Plan or insurer of the individual's need for transitional care.
- the Plan must permit the individual to elect to continue to have the benefits provided under such plan or such coverage under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan had the Provider or facility's contract not terminated.

The transitional coverage shall continue beginning on the date the Member receives notice of the contract termination and shall continue until the earlier of ninety (90) days after the Member's receipt of such notice, or the date such individual is no longer qualified as a continuing care patient with respect to that health care Provider or facility. Federal law requires the health care Provider caring for the continuing care patient to accept payment from such plan for services and items furnished to the continuing care patient as payment in full for such items and services and to maintaining compliance with all policies, procedures, and quality standards imposed by the Plan.

Ban on Surprise Billing

Federal law protects Members from surprise billing or balance billing when they see an out of network Provider at an in-network facility, ambulatory surgical center, or during Emergency services. Surprise billing or balance billing is when a Provider bills a Member for the difference between the Provider's charge and the allowed amount. For example, if the Provider's charge is $100 and the allowed amount is $70, the Provider may bill the Member for the remaining $30. Out-of-network Providers are prohibited from balance billing Members in these circumstances. More information about balance billing protections can be found on the Claim Administrator's website.

Covered Benefits

Contracted Providers

The Plan offers quality medical care in the state of Colorado through Contracted Providers. For emergencies and some limited benefits outside the state of Colorado, the Plan has contracted with a network administrator to secure discounts with Provider networks. It is the Member's responsibility to use Contracted Providers. Failure to use Contracted Providers may result in a reduction or denial of benefits. The Plan will make available a current list of Contracted Providers at the Claim Administrator's website or by contacting the Plan. The Plan reserves the right to make changes to the Provider list at any time during a plan year without notice.

When an in-network Provider is not available or the covered person is outside the service area, the Plan will ensure that the covered person is able to obtain covered benefits at a cost that is not greater than if the benefit were obtained from network Providers. In the event a network Provider is not available within our access standards, Members should call the Plan to make arrangements to see another Provider .

In general, the Member is responsible to pay the specified Coinsurance(s) at the time of service and the balance will be paid by the Plan according to plan benefits. The Member's Plan Identification/Prescription must be presented at each visit. The Provider will have a release form that authorizes the Plan to obtain necessary information. This form must be signed by the Member. The Plan will make Provider lists/directories for the applicable health provider network utilized by the Plan available upon requests without charge.

Process for Determining Maximum Allowable fee for a Non-Network Provider

Maximum allowable fee for a covered expense for emergency care services provided by non-contracted Providers in a Hospital's emergency department is an amount equal to the greatest of:

- The fee negotiated with contracted Providers;
- The fee calculated using the same method to determine maximum allowable fee for a covered expense, other than emergency care services provided by non-contracted Providers;
- The fee paid by Medicare for the same services; or
- A Qualified Payment Amount in accordance with the No Surprises Act.

Maximum allowable fee for a covered expense for nonemergency care services provided by non-contracted Providers is an amount equal to:

- A percentage of the fee paid by Medicare for the same services. When a fee paid by Medicare is not available, another appropriate benchmark will be used such as Medicaid.
- The fee negotiated with Provider.

Out-of-State/Out-of-Network Coverage

Medical Services received from non-contracted Providers will be paid by the Plan in accordance with the benefit schedule, up to the in-network allowable fee schedule.

Medical Services received from non-contracted Providers will be paid by the Plan in accordance with the benefit schedule.

In the case of inpatient hospitalization in a non-Contracted medical facility, the Member will be transferred to a Contracted medical facility as soon as medically possible, in coordination with the Plan's Medical Case Management.

Out-of-Country/Out-of-Network Coverage

If a Member is traveling outside of the United States and receives medical services for Emergent/Urgent Care from a non-contracted Provider, the services will be allowed by the Plan at the Maximum Allowable Fee as determined by the Plan, or negotiated fees and paid by the Plan at the amount specified for Contracted Providers by the Member's applicable Outline of Coverage. In emergency situations, Members may pay for a medical services for Emergent/Urgent Care and mail a reimbursement form along with a receipt to the Plan for any eligible reimbursement. Reimbursement forms may be obtained from the Claim Administrator's website. All out-of-country procedures, services, or care that are not Urgent or Life threatening are excluded.

Hospital Benefits

See applicable Outline of Coverage for applicable Deductible and Coinsurance amounts.

Inpatient Hospitalization

Charges for Medically Necessary inpatient Hospitalization (semiprivate room, ICU, and eligible ancillaries) are payable after applicable Deductible and Coinsurance. Hospital admissions require Pre-notification. When a Hospital stay spans an old and new plan year, charges billed on the hospital claim will be based on the old plan year provisions. Eligible ancillary services such as Inpatient Physician visits, diagnostic tests, laboratory tests, etc. performed during the hospital stay but billed separately from the hospital will apply to the benefits in effect under the Plan year on the actual date of service billed.

Outpatient Facility Benefits

Charges for Medically Necessary Surgical Procedures performed in an Ambulatory Surgical Facility, whether freestanding or Hospital based, are payable after applicable Deductible and Coinsurance.

Emergency Room Services

Medically Necessary emergency room facility services are payable after applicable Deductible and Coinsurance. Each follow up visit in the emergency room will require an additional emergency room Deductible and Coinsurance. When emergency room treatment results in an inpatient admission (within twenty-four (24) hours), benefits are payable as an inpatient stay.

Maternity Benefits

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 48 hours (or 96 hours as applicable). In any case, plans may not, under Federal law, require that a Provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Chiropractic Benefits

Chiropractic Benefits for the correction of nerve interference (by manual or mechanical means) resulting from or related to the distortion, misalignment, or partial dislocation in the vertebral column are covered except for the following:

1. Chiropractic appliances;
2. Services for treatment of non-neuromusculoskeletal disorders;
3. Services for children ages six (6) and under; and
4. Services for children ages seven (7) through twelve (12) unless:
    a. The child has a specific chronic neuromusculoskeletal diagnosis causing significant and persistent disability;
    b. Other conservative therapies have been tried and have failed to relieve the patient's symptoms; and
    c. Improvement is documented within the initial two weeks of chiropractic care.

Urgent Care Facility

Medically Necessary Urgent care facility services are payable, after applicable Deductible and Coinsurance.

Limitations Relating to All Inpatient and Outpatient Hospital/Facility and Emergency Room Services

The following are Limitations of the Plan:

1. Emergency Care will only be covered for conditions which the person was treated manifested itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health (or the health of an unborn child) in serious jeopardy, serious impairment of bodily function, or serious dysfunction of bodily organs.
2. Charges for ambulance services, physician's Hospital or emergency room visits, specialty medications, and Durable Medical Equipment billed on the Hospital bill are payable separately, subject to applicable plan provisions and specified Deductibles and Coinsurances.
3. Newborn nursery room charges are separate from the mother's claim and the child must be enrolled to be eligible.
4. When an inpatient Hospital stay can be shortened or charges reduced by transfer to a transitional care unit or Skilled Nursing Facility, the Plan may require the patient to be

transferred for Coverage to continue. This benefit is only available through concurrent Medical Case Management and approval by the Plan.
5. Inpatient benefits for Mental Health require Preauthorization.
6. Human Pasteurized Milk is a covered benefit for Newborn ICU babies whose mother's milk supply is inadequate, and in cases of extreme immaturity. Requires Preauthorization.
7. Inpatient Rehabilitation and Skilled Nursing Facility stays are limited to thirty (30) days per plan year combined.

Surgical Benefits

See applicable Outline of Coverage for specific Deductible and Coinsurance amounts. Medically Necessary Surgical Procedures are payable, after applicable Deductible and Coinsurance when performed in a physician's office, in a Hospital, or in a freestanding Ambulatory Surgical Facility. the Plan pays for an assistant surgeon when Medically Necessary. Services of a co-surgeon, when required and in the absence of an assistant surgeon, are payable up to the combined total amount eligible per Maximum Allowable Fee for the surgeon and an assistant's fee, divided equally. Charges for an assistant surgeon (MD) are allowable up to twenty percent (20%) of Maximum Allowable Fee. Charges for a certified assistant surgical nurse, or physician's assistant at Surgery in lieu of an assistant surgeon (MD) are allowable up to ten percent (10%) of Maximum Allowable Fee.

Second Opinion and Surgical Review

A second opinion evaluation for Surgery is payable (office consultation only). Available Medical Records, including x-rays, should be forwarded to the Provider for the second opinion evaluation.

Limitations Relating to Surgery

The following are Limitations of the Plan:

1. Multiple Surgical Procedures during the same operative session are allowable at one hundred (100%) of Maximum Allowable Fee for the primary procedure and fifty percent (50%) of Maximum Allowable Fee for all additional eligible procedures. Incidental procedures are excluded.
2. Surgical benefits are payable based on surgical Package Fees to include the Surgery and postoperative care per CPT guidelines and RBRVS guidelines.
3. Breast Reconstructive Surgery is an Eligible Benefit as allowed under WHCRA. Requires written Preauthorization through Medical Case Management.
4. Maxillary/Mandibular bone or Calcitite augmentation surgery is covered when a Member is edentulous (absence of all teeth) and the general health of the Member is at risk because of malnutrition or possible bone fracture. If the Member elects a more elaborate or precision procedure, the Plan may allow payment for the standard Calcitite placement towards the cost and the Member will be responsible for the difference. Quadrant or individual tooth areas or osseous implants are not eligible. Preauthorization is required.
5. Circumcision is covered for newborns, if the recipient is not a newborn, then circumcision

is subject to a preauthorization.
6. Blepharoplasty (or other eyelid Surgery) requires a preauthorization and is only approved for medical necessity.
7. Lipoma excision requires a preauthorization and is only approved for medical necessity.

Accidental Dental Coverage

Initial treatment of an Accidental injury to sound natural teeth when received within seventy-two (72) hours of the onset of an Accidental injury is considered Medically Necessary.

Covered treatments include the following:
1. Extraction of teeth needed to avoid infection of teeth damaged in the injury;
2. Suturing;
3. Reimplanting and stabilization of dislodged teeth;
4. Repositioning and stabilization of partly dislodged teeth; and
5. Dental x-rays to access the degree of damage caused by the accident.

Anesthesia Benefits

See applicable Outline of Coverage for specific Deductible and Coinsurance amounts. The charges for Medically Necessary anesthesia administered by a Provider (MD or CRNA) in conjunction with Medically Necessary Surgery are payable, after applicable Deductible and Coinsurance.

Limitations Relating to Anesthesia

The following are Limitations of the Plan:

1. Anesthesia must be administered by a qualified licensed practitioner other than the primary surgeon. Exceptions:
   a. A Provider in a rural area, when an anesthesiologist is not available, may administer anesthesia and will be paid up to 20% of the eligible Surgery fee.
   b. Anesthesia performed by an oral surgeon in conjunction with an eligible medical Surgical Procedure.
2. Anesthesia for labor and delivery is payable on a sliding scale with one base rate (first hour—full time, second hour—half time, quarter time for every hour thereafter).
3. An epidural block during labor is not payable to the delivering Provider in addition to an anesthesiologist fee.
4. Moderate sedation (conscious sedation) is included in standard colonoscopy and EGD surgery and shall not be reimbursed separately.

Medical Visit Benefits

See applicable Outline of Coverage for specific Deductible and Coinsurance amounts. Medically Necessary medical visits, including visits in the Provider's office, telemedicine with approved telemedicine services, urgent care facility, emergency room, Hospital, or the Member's home, are

payable, after applicable Deductible and Coinsurances. The Plan pays for other outpatient or office services such as chemotherapy, office Surgery, labs and x-rays, blood "factor" replacement, etc., after applicable Deductible and Coinsurances.

Limitations Relating to Medical Visits

The following are Limitations of the Plan:

1. Physical therapy visits may be payable up to Plan limits when medically Necessary. See applicable Outline of Coverage for Plan limits.
2. Pelvic floor therapy visits may be payable up to Plan limits when medically Necessary. See applicable Outline of Coverage for Plan limits.
3. Outpatient occupational therapy for fine motor function may be payable up to Plan limits when medically Necessary. See applicable Outline of Coverage for Plan limits.
4. Only one (1) medical, psychiatric, or physical therapy visit per day for the same diagnosis when billed by Providers of the same specialty for any one Member is allowable. Same day visits by a multidisciplinary team are eligible with applicable Deductible and Coinsurance(s) per Provider.
5. Therapeutic injections in the Provider's office will not be eligible if oral medication is an effective alternative.
6. Gamma globulin injections require a preauthorization and are only approved for medical necessity. Depending on the diagnosis, these drugs may be required to be obtained through the Specialty Drug Program. No benefits are payable for prophylactic purposes or other diagnoses.
7. After hours and/or holidays are payable only when special consultation is Medically Necessary beyond normal business hours or "on call" or shift work requirements.
8. Cardiac Rehabilitation, Phase 2, following heart attack, cardiac Surgery, severe angina (chest pain), and Pulmonary Rehabilitation, Phase 2, resulting from chronic pulmonary disease or Surgery, are payable up to five (5) visits combined per plan year.
9. Hepatitis B immunoglobulin is covered if there is a documented exposure or if in conjunction with an eligible liver transplant.

Diagnostic Testing, Lab and X-Ray Benefits

See applicable Outline of Coverage for specific Deductible and Coinsurances. Benefits for Medically Necessary laboratory, x-ray, CT, MRI, MRA, and ultrasound services are payable. A fee for transportation of x-ray equipment is payable when appropriate. Lab and x-ray in conjunction with office Surgery are payable after applicable Deductible and Coinsurances.

Limitations Relating to Diagnostic Testing, Lab and X-Ray

The following are Limitations of the Plan:

1. Lab and x-rays are only eligible for diagnosing or treating symptomatic illness and

must be specific to the potential diagnosis.

2. Laboratory typing/testing for organ transplant donors is eligible only when recipient is an eligible Member, covered under the Plan, and the transplant is eligible.

Mental Health Benefits

Mental Health benefits will follow the same cost sharing as other related benefits. They are subject to different but no more restrictive quantitative and qualitative standards that are appropriate for these types of benefits in accordance with The Mental Health Parity, Addiction Equity Act and Medical Necessity.

Facility and Hospital Services-Mental Health Benefits

Medically Necessary services from Contracted Hospitals, inpatient treatment centers, inpatient pain clinics, day treatment facilities or intensive outpatient programs are payable after applicable Deductible and Coinsurances and must be Preauthorized through the Plan. See applicable Outline of Coverage for further details. Failure to Preauthorize will result in reduction or denial of benefits. Charges for the full Hospital stay will be prorated into a per diem rate, or as Contracted with specific Providers, for adjudication of daily benefits.

Day treatment or intensive outpatient program may be considered in lieu of inpatient care with two (2) or more days applicable to one (1) inpatient day based on Provider agreements or Preauthorization. Electro Convulsive Therapy is eligible under Medical benefits. Eating disorders, such as anorexia and/or bulimia, are payable under medical benefits when Life Threatening, as determined by the Plan. When the condition is no longer Life Threatening, benefits are payable under Mental Health and require Preauthorization. Inpatient Provider visits Hospital visits are payable after applicable Deductible and Coinsurance(s).

Outpatient Provider Visits-Mental Health Benefits

Outpatient treatment by a licensed psychologist, licensed clinical social worker, medical Provider or licensed psychiatric nurse specialist is eligible. See applicable Outline of Coverage for further details. Eligible neuropsychological evaluations and testing are payable as medical benefits. Eligible medical management to monitor use of psychotropic drugs is payable as a medical benefit.

Ambulance Benefits

See applicable Outline of Coverage for specific Deductible and Coinsurances. Benefits for eligible ambulance services, including air transport, are payable after applicable Deductible and Coinsurance.

Limitations Relating to Ambulance Benefits

The following are Limitations of the Plan:

1. Benefits are only eligible when ambulance services are necessary due to a medical emergency.
2. Only services to transport to the nearest Hospital where proper medical care is available are eligible.
3. Benefits will be payable for air ambulance only in Life threatening emergencies when a Member could not be safely transported by ground ambulance, and only to the nearest facility where proper medical care is available. If emergency is considered to be non-Life-threatening by the Plan, air ambulance charges will be payable at ground transport rates.

Home Health and Hospice Care Benefits

See applicable Outline of Coverage for specific Deductible and Coinsurances. When Preauthorized, Medically Necessary skilled home health, home IV therapy and Hospice services are payable at plan benefits. Hospice benefits may be approved when a Member is no longer receiving any curative treatment, and is only receiving palliative care for pain relief, symptom control and comfort.

Limitations Relating to Home Health and Hospice Care Benefits

The following are Limitations of the Plan:

1. Total Enteral Nutrition (TEN) formula requires Preauthorization.
2. Physical and/or occupational therapy performed in the home is subject to the outpatient plan limits. See applicable Outline of Coverage for details.
3. A home visit by a Licensed Clinical Social Worker is payable from outpatient Mental Health benefits. See applicable Outline of Coverage for details.
4. Skilled Nursing visits are subject to plan Limitations. One (1) Skilled Nursing visit is defined as up to four (4) hours. See applicable Outline of Coverage for details.
5. Hospice services are subject to plan Limitations. See applicable Outline of Coverage for details.

Adoption Benefits

Adoption benefits for legal or agency fees may be available, subject to Plan Limitations. (See applicable Outline of Coverage for details). The adoption benefit is treated as other claims and is subject to cost sharing. The adoption benefit credits courts costs, fees, agency costs, attorney fees up to a maximum amount of $4,000 per adoption. The Adoption Benefit is effective the day that the adoption becomes final and will be paid when all decrees, final orders, and other documents have been provided by the Member.

The Adoption benefits eligible under the Outline of Coverage are the maximum (but not the minimum) benefits the Plan will allow per adoption, even if the Member is enrolled in more than one plan (Dual Coverage), or is also insured by another health insurance. If more than one child

from the same birth (ex. twins) is placed for adoption with the Enrollee, only one Adoption benefit is payable. The maximum benefit is subject to the same deductible, coinsurance, and/or copayments normally applied to maternity care services under the Plan.

Autism Spectrum Disorder

Benefits for the diagnosis and treatment of Autism Spectrum Disorder are eligible for coverage. See applicable Outline of Coverage for specific Deductible and Coinsurances. Cost sharing shall be similar to other treatments from similar type Providers.

Limitations Relating to Autism Spectrum Disorder

1. Behavioral health treatments are covered but coverage will be periodically reviewed for medical necessity.
2. A health care Provider shall submit a treatment plan for autism spectrum disorder to the Plan within fourteen (14) business days of starting treatment for an individual. If an individual is receiving treatment for an autism spectrum disorder, the Plan shall have the right to request a review of that treatment not more than once every three (3) months. A review of treatment may include a review of treatment goals and progress toward the treatment goals. The Plan may make a determination to stop treatment as a result of the review if it is shown that the treatment is either inappropriate or ineffective for the specific member.

Prescription and Specialty Drug Benefits

See applicable Outline of Coverage for specific Deductible and Coinsurances. The Plan pharmacy benefit provides pharmacy and injectable Coverage through the Plan pharmacy network. Go to the Claim Administrator's website or contact the Plan to learn more about the cost of your medication.

Members will receive a pharmacy identification card upon Enrollment in the Plan's Pharmacy program. The identification card will only list the Enrollee's name but will provide Coverage for each enrolled family Member. Members need to present their pharmacy card or provide their Plan identification number to a participating pharmacy along with an eligible prescription and any applicable Deductible and Coinsurance to receive their prescription medication.

Covered Formulary Drugs

- Select generic drugs.
- Insulin and diabetic supplies.
- Select brand name drugs.
- Select Specialty injectables.
- Select Specialty oral drugs.

Preauthorization for Prescription and Specialty Medications

The Plan has chosen specific prescription drugs and injectables to require Preauthorization. These medications were chosen due to their high potential for safety issues, adverse reactions, contraindications, misuse, opportunity to use first line therapy and cost. Go to the Claim Administrator's website or contact the Plan's Customer Service for a complete list of medications that require Preauthorization.

To obtain Preauthorization, a Member's physician may obtain a Preauthorization form at the Claim Administrator's website or may contact the Plan's Customer Service to start the Preauthorization process. The Provider will be directed to the Plan's pharmacy Preauthorization phone line. Approval or denial will be communicated to the Provider's office. Members may also phone the Plan's Customer Service Department to receive an update on the status of the physician's request. Preauthorization does not guarantee payment. Coverage is subject to the Plan's eligibility, benefit Coverage and Preauthorization requirements.

Quantity Levels and Step Therapy

Medications may have specific limits. The Plan establishes quantity levels based on criteria that includes the maximum dosage levels indicated by the drug manufacturer, duration of therapy, FDA, and the cost of the drug. Members must obtain Preauthorization for any quantity that exceeds the Plan quantity level limit. Go to the Claim Administrator's website, Drug Coverage, for a complete list of medications that require a quantity level limit.

For some disease states and some drug categories, one or more medications must be tried before a drug will be covered under the pharmacy or injectable benefit. Step therapy ensures that a Member receives the most clinically appropriate and cost-effective medication. Step therapy is based on current medical studies, generic availability, and cost of the medication and FDA recommendations.

Pharmacy Coordination of Benefits with Carriers

The Plan will coordinate pharmacy benefits with insurance carriers when claims meet the requirements listed and will be paid in accordance with the coordination of benefits outlined in this Plan.

If the Plan is the secondary pharmacy benefit, Members must purchase their prescription medications through their primary insurance carrier. The Plan will coordinate Coverage of eligible Deductible and Coinsurances and unpaid claim amounts if the pharmacy claim meets the Plan's pharmacy benefit requirements, Coverage rules, Preauthorization requirements and quantity levels. Most pharmacies have the ability to process the secondary pharmacy claims electronically at the point of sale. Members will be required to pay the applicable deductible and copayment amounts after both claims are processed. If the pharmacy is unable to coordinate electronically, the Member must submit an original itemized receipt (a pharmacy printout is not a valid receipt) and a claim form to the Plan. If the primary insurance did not provide any coverage of the claim, the Member must pay for the prescription at the point of sale and provide an explanation of

payment or denial from their primary insurance carrier. Members may obtain a claim form at the Claim Administrator's website or by contacting the Plan's Customer Service. Reimbursement will not exceed the Plan's normal discounted rate or any Limitation required by the pharmacy benefit. If the primary insurance requires a Deductible or out-of-pocket maximum, the Plan will recognize the pharmacy claim as unpaid by the primary insurance until the Deductible or out-of-pocket maximum is met. The Claim Administrator will administer the claim as a primary health plan and reimburse minus the patient's required retail Deductible and Coinsurance.

If a Member's Coordination of Benefits request is for a specialty medication, the Plan will administer their Coordination of Benefits claim under their retail or medical specialty benefit.

Out of Area Prescriptions or Other Cash Purchases

If Members are traveling outside the service area, they may contact the Plan's Customer Service Department for the location of the nearest Contracted pharmacy in the United States. In emergency situations, Members may pay for a prescription and mail a reimbursement form along with a receipt to the Plan for reimbursement. Reimbursement forms may be obtained from the Claim Administrator's website.

Specialty and Injectable Drugs

Specialty oral and injectable drugs are typically bio engineered medications that have specific shipping and handling requirements or are required by the manufacturer to be dispensed by a specific facility. The Plan may require that specialty medications be obtained from a designated pharmacy or facility for coverage.

The Plan's specialty pharmacy will coordinate with the Member or their Provider to provide delivery to either the Member's home or their Provider 's office. Preauthorization may be required.

Limitations Relating to Prescription Drug Benefits

The following are Limitations of the Plan:

1. Drug quantities, dosage levels and length of therapy may be limited to the recommendations of the drug manufacturer, FDA, clinical guidelines, or the Plan's Pharmacy and Therapeutics Committee.
2. Anabolic steroid Coverage will be limited to hypogonadism or HIV and cancer wasting.
3. A medication in a different dosage form or delivery system that contains the same active ingredient as an already covered drug may be restricted from Coverage.
4. When a medication is dispensed in two different strengths or dosage forms, a separate Deductible and Coinsurance will be required for each dispensed prescription.
5. If a Member is required by the FDA to be enrolled in a manufacturer Access or Disease Management Program, Coverage may be limited to Member's participation.
6. Medication quantities and availability may be restricted to a lower allowed day supply when a

manufacturers' package size cannot accommodate the normal allowed pharmacy benefit day supply.

7. Cash paid and Coordination of Benefits claims will be subject to the Plan's preauthorization, step therapy, and benefit Coverage and quantity levels. The Plan will reimburse up to the Plan's Contracted rate and the Plan's benefit rules.

The Plan will have the ability to limit the availability and filling of any medication, Device or supply. The Pharmacy or Case Management Department may require the following tools:

1. Require prescriptions to be filled at a specified pharmacy.
2. Obtain services and medications in dosages and quantities that are only Medically Necessary as determined by the Plan.
3. Obtain services and medications from only a Specified Provider.
4. Require participation in a specified treatment for any underlying medical condition.
5. Require completion of a drug treatment program.
6. Adhere to the Plan Limitation or program to help reduce or eliminate drug abuse or dependence.
7. Deny medications or quantities needed to support any dependence, addiction or abuse if a member misuses the health care system to obtain drugs in excess of what is Medically Necessary.

Retail prescriptions are not refillable until seventy five percent (75%) of the total prescription supply within the last one hundred eighty (180) days is used. Twenty-three (23) days must pass at a local pharmacy before a prescription can be refilled.

Members may request and gain access to clinically appropriate drugs not covered by the Plan based on exigent circumstances as required in 45 CFR 156.122.

Durable Medical Equipment/Supply Benefits

See applicable Outline of Coverage for specific Deductible and Coinsurances. Durable Medical Equipment requires prior authorization. Please call the Plan for prior authorization and for any questions regarding Durable Medical Equipment. Coverage is provided when the equipment is:

1. Medically Necessary;
2. Prescribed by a Provider and approved by the Plan; and
3. Used for medical purposes rather than for convenience or comfort.

The Plan will allow the cost of standard conventional equipment or supplies necessary to treat the medical condition. Additional charges for more elaborate or precision equipment or supplies shall be the responsibility of the Member.

If Durable Medical Equipment will be required for longer than sixty (60) days, it requires Preauthorization for review of continued rental versus purchase. The total benefits allowable for rental and/or subsequent purchase may not exceed one hundred percent (100%) of the allowable

purchase price of the equipment.

Limitations Relating to Durable Medical Equipment/Supply Benefits

The following are Limitations of the Plan:

1. One (1) lens for the affected eye following eligible corneal transplant Surgery. Contact lenses for documented Keratoconus may be approved as Medically Necessary.
2. One (1) pair of ear plugs within sixty (60) days following eligible ear Surgery.
3. Continuous Passive Motion (CPM) machine rentals may be approved for up to twenty-one (21) days rental only for total knee or shoulder arthroplasty.
4. All prosthetics must be prior authorized. Artificial eye prosthetic, when made necessary by loss from an injury or illness, the maximum prosthetic benefit available is one (1) in a five (5) year period. The maximum breast prosthetic benefit available is one (1) per affected breast in a two (2) year period.
5. Wheelchairs require Preauthorization through Medical Case Management and are limited to one (1) power wheelchair in any five (5) year period.
6. Knee braces are limited to one (1) per knee in a three (3) year period.
7. Machine rental or purchase for the treatment of sleep disorders require a Preauthorization.

Preventive Services

Under the Affordable Care Act, the Plan offers preventive services covered at no cost to you when received from a Contracted Provider. If these services are received from a non-contracted Provider they will be allowed up to the Maximum Allowable Fee and paid by the Plan at the allowed amount specified for non-contracted Providers by the Member's applicable Benefit Summary, if the Member's plan allows the use of non-contracted Providers. If the Member's plan does not allow the use of non-contracted Providers, the services will be denied by the Plan.

The Plan processes claims based on the Provider's clinical assessment of the office visit. If a preventive item or service is billed separately, cost sharing may apply to the office visit. If the primary reason for your visit is seeking treatment for an illness or condition, and preventive care is administered during the same visit, cost sharing may apply.

Certain screening services such as a colonoscopy or mammogram may identify health conditions that require further testing or treatment. If a condition is identified through a preventive screening, any subsequent testing, diagnosis, analysis, or treatment are not considered preventive services and are subject to the appropriate cost sharing.

Covered Preventive Services for Adults

Preventive office visits including the following services, once per plan year unless otherwise noted:

1. Abdominal aortic aneurysm onetime screening for men who meet the age qualifications and who have ever smoked.
2. Alcohol misuse screening and counseling.
3. Anemia screening on a routine basis for pregnant women.
4. Aspirin use to prevent cardiovascular disease and colorectal cancer for adults who meet the age qualifications with a cardiovascular risk.
5. Bacteriuria urinary tract or other infection screening for pregnant women.
6. Blood pressure screening.
7. BRCA counseling about genetic testing for women at higher risk.
8. Breast cancer mammography screenings for women who meet the age qualifications, once per plan year.
9. Breast cancer chemoprevention counseling for women at higher risk.
10. Breast feeding interventions to support and promote breastfeeding.
11. Cervical cancer screening, once per plan year.
12. Chlamydia infection screening.
13. Cholesterol screening, once per plan year.
14. Colorectal cancer screening for adults who meet the age qualifications.
15. Depression screening.
16. Diabetes screening.
17. Diet counseling for adults at higher risk for chronic disease.
18. Falls prevention with exercise or physical therapy and vitamin D use for adults who meet the age qualifications, living in a community setting.
19. Gonorrhea screening.
20. Hepatitis B screening for pregnant women at their first prenatal visit.
21. Hepatitis C screening for adults at increased risk, and one (1) time for everyone who meet the age qualifications.
22. HIV screening.
23. HIV PREP Antiretroviral Medication for members who meet the qualifications.
24. Immunizations vaccines for adult's doses, recommended ages, and recommended populations vary:
    - Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza, Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella (Chickenpox).
25. Lung cancer screening for adults who meet the age qualifications and are at high risk for lung cancer.
26. Obesity screening and counseling.
27. Osteoporosis screening for women who meet the age qualifications.
28. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
29. Sexually transmitted infection prevention counseling.
30. Statin prevention medication for adults who meet the age qualifications and are at high risk.
31. Syphilis screening.
32. Tobacco use screening, including Tobacco Cessation in accordance with Utah Insurance

Department Bulletin 2015-11.

33. Tuberculosis screening for certain adults without symptoms at high risk.
34. Type 2 Diabetes screening for adults with high blood pressure.
35. Breastfeeding supplies, including Breast Pump.
36. FDA approved contraceptive methods and counseling.
37. HPV DNA testing for women who meet the age qualifications, once per plan year.
38. Obesity Prevention for women who meet the age qualifications with normal or overweight BMI.

Covered Preventive Services for Children

1. Alcohol, tobacco, and drug use assessments.
2. Autism screening for children who meet the age qualifications.
3. Behavioral assessments.
4. Bilirubin concentration screening for newborns.
5. Blood pressure screening
6. Blood screening for newborns.
7. Cervical dysplasia screening for sexually active females.
8. Congenital hypothyroidism screening for newborns.
9. Depression screening for adolescents who meet the age qualifications.
10. Developmental screening for children who meet the age qualifications, and surveillance throughout childhood.
11. Dyslipidemia screening for children at higher risk of lipid disorders.
12. Gonorrhea preventive medication for the eyes of all newborns.
13. Hearing screening.
14. Height, weight and Body Mass Index measurements for children.
15. Hematocrit or hemoglobin screening.
16. Hemoglobinopathies or sickle cell screening for newborns.
17. Hepatitis B screening for adolescents at high risk, including adolescents from countries with 2% or more Hepatitis B prevalence, and U.S.-born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence: who meet the age qualifications.
18. HIV screening.
19. HIV PREP Antiretroviral Medication for members who meet the qualifications.
20. Hypothyroidism screening for newborns.
21. Immunizations, vaccines for children who meet the age qualifications — doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis, Haemophilus influenza type b, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus, Influenza, Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus, Varicella.
22. Iron Supplements for children who meet the age qualifications at risk for anemia.
23. Lead screening.
24. Obesity screening and counseling.
25. Oral health risk assessment for children who meet the age qualifications.

26. Phenylketonuria (PKU) screening for this genetic disorder in newborns.
27. Preventive office visits with medical history for all children throughout development (as recommended by the American Academy of Pediatrics).
28. Sexually transmitted infection (STI) prevention counseling.
29. Skin Cancer screening and counseling.
30. Tuberculin testing for children at higher risk of tuberculosis.
31. Routine vision acuity screening for children who meet the age qualifications, once per plan year.
    - Glasses (both lenses and frames), or contact lenses instead of glasses.
32. Fluoride varnish for children who meet the qualifications.

Preauthorization Limitations

Certain medical services require Pre-notification or Preauthorization by the Plan before being eligible for payment. While many Contracted and non-contracted Providers will Preauthorize or Pre-notify on your behalf, it is the Member's responsibility to ensure that the Plan has received notice and/or granted approval for any service requiring Pre-notification or Preauthorization prior to the services being received. If the Member does not Preauthorize or Pre-notify services that require such approval, benefits may be reduced or denied by the Plan.

The following services require Pre-notification by calling the Plan's Customer Service:

1. All inpatient Hospital admissions
2. All inpatient Hospital Rehabilitation admissions
3. Skilled Nursing Facilities
4. All inpatient admissions

To receive maximum benefits, a Member must call for Pre-notification before being admitted to a Hospital as described below:

Elective Treatment

Treatment for a medical condition that can be scheduled in advance without causing harm or suffering to the Member's health. At least five (5) working days before the admission date or Surgery, call the Plan.

Urgent Treatment

Treatment for a medical condition that, if left untreated, may cause unnecessary suffering or prolonged treatment to restore Member's health. At least three (3) working days before the admission date or Surgery, call the Plan.

Emergency Treatment

Treatment for a medical condition of an unforeseen nature that, if left untreated, may

cause death or permanent damage to the Member's health. Members do not have to obtain prior authorization prior to admission for Emergency Treatment.

Inpatient Treatment for Mental Health

Call the Plan within the time specified above for the type of treatment. See applicable Outline of Coverage for further details. Failure to call will result in a denial of benefits.

Out of Area Hospital Admission

Requires Pre-notification by the Member, the physician, the Hospital, or, in an emergency, a responsible person. Call the Plan within the time specified above for the type of treatment. Failure to call will result in a reduction or denial of benefits. See applicable Outline of Coverage for specific penalties.

Newborns' Act Disclosure

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

Preauthorization Requirements

The following service requires verbal Preauthorization by calling the Plan's Customer Service:

- Any inpatient maternity stay that exceeds forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following delivery by Cesarean section.

The following is a list of the most common services requiring written Preauthorization. It is not all inclusive. All services are subject to a utilization review in accordance with the Plan. Call the Plan if you have any questions regarding Preauthorization:

1. Surgery that may be partially or wholly cosmetic.
2. Coronary CT angiography.
3. Organ or tissue transplants.
4. Implantation of artificial Devices.
5. Cochlear implants.
6. Durable Medical Equipment with a purchase price over $1000 or any rental of more than sixty (60) days.
7. Botox injections.

8. All out-of-state, out-of-network surgeries/procedures or inpatient admissions that are not Urgent or Life threatening.
9. Wound care, except for the diagnosis of burns.
10. Home health and Hospice Care.
11. Intrathecal pumps.
12. Spinal cord stimulators.
13. Implantable medications, excluding contraception.
14. Certain prescription and Specialty Drugs.
15. Continuous glucose monitoring Devices and supplies.
16. Dialysis when using non-contracted Providers.
17. Human pasteurized milk.
18. Stereotactic radiosurgery.
19. Magnetoencephalography (MEG)/ magnetic source imaging.
20. Breast reconstruction surgery.
21. Virtual colonoscopy.
22. Transnasal endoscopic microsurgery.
23. Endovenous ablation therapy (Radiofrequency or laser).
24. Anesthesia during standard colonoscopy or EGD surgery, other than moderate. sedation (conscious sedation).
25. Enteral Nutrition.

Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician. For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Covered Services

All Covered Services are subject to ordinary cost sharing and are limited to once per lifetime.

- **Below waist surgery:**
    - Assigned at birth male –clitoroplasty, labiaplasty, penile skin inversion, vagina construction, bilateral orchiectomy, penile amputation, urethromeatoplasty, plastic repair of introitus, vaginoplasty
    - Assigned at birth female – hysterectomy, salpingo-oophorectomy, colpectomy, phalloplasty, urethroplasty, scrotoplasty, plastic glans formation, Insertion of penile and testicular prosthesis
- **Above waist surgery:**
    - Assigned at birth male –Tracheal shave and facial hair removal. Medically Necessary breast augmentation if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment is not sufficient for comfort in the social role
    - Assigned at birth female – Mastectomy with chest reconstruction and nipple/areola reconstruction or breast reduction
- Voice therapy lessons

Gender Affirming Surgery Limitations and Exclusions

- The following services are exclusions under the policy:
- Reversal of genital surgery or surgery to revise secondary sex characteristics
- Above waist
    - Assigned at birth male - lipoplasty of the waist, face lifts, blepharoplasty, collagen injections
    - Assigned at birth female - liposuction and cosmetic chest reconstruction, pectoral implants
- Blepharoplasty
- Rhinoplasty
- Voice modification surgery
- Abdominoplasty
- Below waist Surgery
    - Assigned at birth female - liposuction to reduce fat in hips thighs and buttocks, calf implants
    - Assigned at birth male - Electrolysis or laser hair removal, except for facial hair removal or when used to prepare the perineum for SRS (Sexual Reassignment Surgery) and pharmaceuticals such as Vaniqa
- Cosmetic Surgery – Surgery or other Services that are intended primarily to change or maintain your appearance, voice, or other characteristics, except for the covered gender affirming surgery Services listed.
- Sperm procurement and storage in anticipation of future infertility, Gamete preservation and storage in anticipation of future infertility, Cryopreservation of fertilized embryos in anticipation of future infertility, unless specifically listed as a separate benefit.
- Referrals outside US.
- Other surgeries which have no Medically Necessary role in gender identification and are considered cosmetic in nature including but not limited to:
    - Abdominoplasty.
    - Blepharoplasty.
    - Breast enlargement, including augmentation mammoplasty and breast implants.
    - Body contouring, such as lipoplasty.
    - Brow lift.
    - Calf implants.
    - Cheek, chin, and nose implants.
    - Injection of fillers or neurotoxins.
    - Face lift, forehead lift, or neck tightening.
    - Facial bone remodeling for facial feminizations.
    - Hair removal, except as part of a genital reconstruction procedure by a Physician for the treatment of gender dysphoria.
    - Hair transplantation.
    - Lip augmentation.
    - Lip reduction.
    - Liposuction.
    - Mastopexy.

- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's apple).
- Voice modification surgery.

Clinical Indications for Procedure

Gender-affirming surgery or other procedure covered by this guideline is indicated for 1 or more of the following:

- Gender incongruence in adult (18 years of age or older), as indicated by ALL of the following:
  - Marked and sustained gender incongruence as assessed and documented (over a minimum of 36 months) by clinician experienced in care of transgender and gender-diverse (TGD) people
  - Gender incongruence not due to reversible cause (e.g., psychosis)
  - Patient able to grant informed consent (able to understand risks of adverse events, complications, procedure options, benefits, irreversibility, and reproductive impact)
  - No other physical or mental illness that will interfere with adherence to short-term and long-term postoperative treatment
  - Stable on gender-affirming hormone treatment (GAHT) for at least 6 months unless contraindicated.-
  - Social transition (e.g., name change, pronoun change, communication of affirmed gender identity to others) in place for a sustained period of time (usually 12 months or more)

- Gender-affirming procedure needed, as indicated by 1 or more of the following:
  - **Masculinization or defeminization** procedure, as indicated by 1 or more of the following:
    - Chest (top) surgery (e.g., mastectomy)
    - Genital surgery (e.g., metoidioplasty, phalloplasty, scrotoplasty, vaginectomy, testicular prosthesis, penile prosthesis)
    - Hysterectomy with or without oophorectomy
  - **Feminizing or demasculinizing** procedure, as indicated by 1 or more of the following:
    - Breast augmentation (after completion of estrogen therapy induced native breast development)
    - Genital surgery (e.g., vaginoplasty, vulvoplasty)
    - Orchiectomy

Intersex Benefits

Person with sexual anatomy that is not typically male or female (termed differences in sexual differentiation or intersex), as indicated by 1 or more of the following diagnosis:

- Chromosomal abnormality
- SRY gene negativity in XY chromosome individual

- Hermaphroditism
- Congenital adrenal hyperplasia
- Other diagnosis of ambiguous genitalia in a newborn
- AND 1 or more of the following
    - Surgery necessary due to anatomic variation that poses risk to physical health (e.g., urinary obstruction)
    - Surgery appropriate due to multidisciplinary team evaluation and family or guardian agreement that surgery is advantageous prior to ability of patient to have input or to assent (e.g., infant child)
    - Surgery appropriate due to multidisciplinary team evaluation and family or guardian agreement that surgery is advantageous with assent of pediatric patient (e.g., patient input as to sexual anatomy is desired)

Maximum Out-of-Pocket Benefits

The Plan has set limits for maximum out-of-pocket expense for Members. After the Member's share of eligible expenses exceed specified amounts, the Plan will pay further Eligible Benefits incurred during the remaining plan year at one hundred percent (100%) of Maximum Allowable Fee. See applicable Outline of Coverage for specific out-of-pocket limits.

Subrogation and Contractual Reimbursement Contractual Reimbursement

The Member agrees to seek recovery from any person(s) who may be obligated to pay damages arising from occurrences or conditions caused by the person(s) for which Eligible Benefits are provided or paid for by the Plan and promises to keep the Plan informed of his/her efforts to recover from those person(s). If the Member does not diligently seek such recovery, the Plan, at its sole discretion, reserves the right to pursue any and all claims or rights of recovery on the Member's behalf.

In the event that Eligible Benefits are furnished to a Member for bodily injury or illness, the Member shall reimburse the Plan with respect to a Member's right (to the extent of the value of the Benefits paid) to any claim for bodily illness or injury, regardless of whether the Member has been "made whole" or has been fully compensated for the illness or injury. The Plan shall have a lien against any amounts advanced or paid by the Plan for the Member's claim for bodily injury or illness, no matter how the amounts are designated, whether received by suit, settlement, or otherwise on account of a bodily injury or illness. The Plan's right to reimbursement is prior and superior to any other person or entity's right to the claim for bodily injury or illness, including, but not limited to, any attorney fees or costs the Member chooses to incur in securing the amount of the claim.

No judgment against any party will be conclusive between the Member and the Plan regarding the liability of the party or the amount of recovery to which the Plan is legally entitled unless the judgment results from an action of which the Plan has received notice and has had a full opportunity to participate.

Acceptance of Benefits and Notification

Acceptance of the benefits hereunder shall constitute acceptance of the Plan's rights to reimbursement or Subrogation rights as explained above.

Recoupment of Benefit Payment

In the event the Member impairs the Plan's reimbursement or Subrogation rights under the Plan through failure to notify the Plan of potential liability, settling a claim with a responsible party without the Plan's involvement, or otherwise, the Plan reserves the right to recover from the Member the value of all benefits paid by the Plan on behalf of the Member resulting from the party's acts or omissions.

No judgment against any party will be conclusive between the Member and the Plan regarding the liability of the party or the amount of recovery to which the Plan is legally entitled unless the judgment results from an action of which the Plan has received notice and has had a full opportunity to participate.

Claims Submission & Appeals

The Plan reserves the right to determine whether a claim is an Eligible Benefit or to require verification of any claim for Eligible Benefits. In order to be considered for payment, expenses must be incurred while Member is eligible under the Plan. The date the medical service is received shall be the date the medical expenses are incurred. The Plan shall not be responsible for any expenses that are not Eligible Benefits.

The Plan may request Medical Records, operative reports, pathology reports, x-rays, photos, etc. of a Member. The Plan Benefits Review Committee may review the Medical Records or have the records reviewed by qualified healthcare Providers or other qualified entities to audit claims for eligibility, Preexisting Condition, Medical Necessity, and appropriateness of services with the Community Standard or usual patterns of care as determined by the Plan.

Benefits are adjudicated in conjunction with the Maximum Allowable Fee and code review systems implemented by the Plan. Claims may be returned for incomplete or improper coding. If, after a second request, necessary records are not received, the claim(s) will be denied for insufficient documentation.

Claims Submission

When a Contracted Provider is used, the Provider will submit the claims directly to the Plan. Payment will be made directly to the Contracted Provider. Claims and any other proof of loss must be received by the Plan within twelve (12) months or as soon as Member is reasonably able to provide such documentation. No action may be brought against the Plan until the earlier of:

- Sixty (60) days after proof of loss has been furnished as required under the Plan;

- Waiver by the Plan in writing of proof of loss;
- Or Denial of full payment.

These actions must commence within three (3) years after the date of the loss.

Required Information for Claims Submission

The CPT (Current Procedural Terminology); HCPCS (Health Care Financing Administration's Common Procedural Coding System); ICD9 (International Classification of Diseases) and ICD10 code(s) and NDC# (National Drug Code), if applicable, and the Provider's charge must be provided. Claims may be submitted electronically, or mailed to the Claims Administrator:

MOTIVHEALTH INSURANCE COMPANY
Claims Division
PO Box 709718
Sandy, UT. 84070-9718
EIN # 47-3906935
www.motivhealth.com
1-844-234-4472

Claims Appeal Process

If a Member disagrees with the Plan's decision regarding benefits, the Member may request a full and fair review by completing the Plan Appeal form located on each explanation of benefit statement, or available online at the Claim Administrator's website, and returning the form to the Plan within one hundred eighty (180) days after the Plan's initial determination. If the appeal form is not received by the Plan within 180 days, the appeal shall be denied. The Plan shall allow for expedited appeals only when required by federal law and at the request of the Member. The Member shall include with the appeal form all applicable information necessary to assist the Plan in making a determination on the appeal. Requests for a review of claims should be sent to the following address.

MotivHealth Insurance Company
Appeals and Policy Management Department
PO Box 709718
Sandy, UT. 84070-9718
Phone: 844-234-4472

The Plan shall review and investigate the appeal. If the Plan requires additional information to investigate the appeal, it shall inform the Member of what information is required, and the Member shall have forty-five (45) days to provide the information to the Plan. Unless an expedited appeal or unless the Plan requests additional information from the Member, the Plan shall decide the appeal and inform the Member of the decision within sixty (60) days from its receipt of the appeal form. In any case, no action for denied claims can be taken against the Plan before 60 days after the denial.

Agent for Service of Legal Process

Legal process may be served on the Plan through the Claims Administrator. If a legal summons is to be served on the Plan, it should be directed to:

MotivHealth Insurance Company
Legal Department
10421 South Jordan Gateway
Suite 300
South Jordan, Utah 84095

Employer/Plan Sponsor Contact Information

School District No. 1, City and County of Denver
1860 Lincoln Street
Denver, CO 80203
EIN # 84-6001099

General Exclusions from Coverage

The following are General Exclusions of the Plan:

1. Routine Services or Surgery that is dental in origin are excluded. This includes routine treatment not caused by an accident such as care of the teeth, gums, or alveolar process, extraction of teeth; dental implants and crowns or pontics over implants, reimplantation or splinting, endodontia, periodontia, and orthodontia, including anesthesia or supplies used in such care.
2. Medical services to treat or diagnose enuresis and/or encopresis as a physical organic illness. Inpatient treatment for behavior modification, enuresis, or encopresis or other treatment programs for enuresis or encopresis.
3. Services or items primarily for convenience, contentment, or other nontherapeutic purpose, such as guest trays, cots, telephone calls, shampoo, toothbrush, or other personal items.
4. Charges in excess of contract Limitations or Maximum Allowable Fee.
5. All charges for services received as a result of an Industrial Claim (on the job) injury or illness, any portion of which is payable under Worker's Compensation or Employer's liability laws.
6. This policy will only cover Eligible Benefits for which the Member is liable. Payment will not be made for any expense for which the Member is not legally bound. Any services the Member would not be liable for, in the absence of the Plan, are not covered. This includes but is not limited to the following:
    a. Co-insurance or copayment cards, such as pharmacy benefit cards, manufacturer rebates, etc.
    b. Anything that is paid for by some other entity other than the Plan.
7. Charges for educational material or literature.

8. Charges for nutritional counseling/analysis except for the benefits provided for diabetes education, anorexia, bulimia, or as allowed under the Affordable Care Act Preventive Services.
9. Charges for scholastic education, vocational training, learning disabilities, or behavior modification.
10. Occupational therapy for activities of daily living, academic learning, vocational or life skills, driver's evaluation or training, developmental delay and recreational therapy.
11. Charges for medical care rendered by an Immediate Family Member.
12. Charges prior to Coverage or after termination of Coverage even if illness or injury occurred while a Member.
13. Provider's telephone calls or travel time except in accordance with approved telemedicine services.
14. Overutilization of medical benefits as determined by the Plan.
15. Charges that are not medically necessary to treat the condition, as determined by the Plan, or charges for any service, supply or medication not reasonable or necessary for the medical care of the patient's illness or injury.
16. Charges for Unproven medical practices or care, treatment, Devices or drugs that are Experimental or Investigational in nature or generally considered Experimental or Investigational by the medical profession as determined solely by the Plan.
17. FDA approved medication for Experimental or Investigational indications.
18. Charges for services without adequate diagnosis or dates of service.
19. Charges for services, supplies or medications to the extent they are provided by any governmental plan or law under which the individual is, or could be covered.
20. Charges for services as a result of an auto related injury and covered under No-fault insurance or would have been covered if Coverage were in effect as required by law.
21. Services, treatments, or supplies furnished by a Hospital or facility owned or operated by the United States Government or any agency thereof.
22. Services or supplies received as a result of an act of war.
23. Any service or supply not specifically identified as a benefit.
24. Charges for commercial or private aviation services, meals, accommodations and car rental.
25. Charges for mileage reimbursement except for eligible ambulance service.
26. Charges by a Provider for case management.
27. Charges for independent medical evaluations and/or testing for the purpose of legal defenses or disputes.
28. Charges for submission of Medical Records necessary for claims review.
29. Delivery, shipping, handling, sales tax, or finance charges.
30. The Plan is not responsible to pay any benefits given verbally or assumed except as written in a Preauthorization, documented by Customer Service or Medical Case Management, or as described in the Plan.
31. Charges for remote medical evaluation and management, including prescriptive services provided by the Internet, telephone or catalog unless in conjunction with telemedicine services approved by the Plan.
32. Autopsy procedures.
33. Complications as a result of any non-covered service, procedure, or drug.

34. Services incurred in connection with injury or illness arising from the commission of
    a. A felony;
    b. An assault, riot or breach of peace;
    c. A Class A misdemeanor;
    d. Any criminal conduct involving the illegal use of firearm or other deadly weapon;
    e. Any other illegal acts of violence;
    f. This exclusion only applies when the covered member is a voluntary participant but does not apply to an insured or dependent who is under the age of eighteen (18).
35. Claims submitted past the timely filing limit allowed per the claims submission section of the Plan.
36. Charges for expenses in connection with appointments scheduled and not kept.
37. Charges for the treatment of sexual dysfunction, including Surgical treatment or drugs used for sexual dysfunction or enhancement.
38. Charges for services received as a result of medical tourism, or for traveling out of the United States to seek medical services or drugs.
39. Medical services, procedures, supplies or drugs used to treat secondary conditions or Complications due to any non-covered medical services, procedures, supplies or drugs are not covered. Such Complications include, but are not limited to.
    a. [Complications relating to services and supplies for or in connection with gastric bypass or intestinal bypass, gastric stapling, or other similar Surgical Procedure to facilitate weight loss, or for or in connection with reversal or revision of such procedures, or any direct Complications or consequences thereof.]
    b. Complications as a result of a Cosmetic Surgery or procedure, except in cases of Reconstructive Surgery
        i. When the service is incidental to or follows a Surgery resulting from trauma, infection or other diseases of the involved part; or
        ii. Related to a congenital disease or anomaly of a covered Dependent child that has resulted in functional defect;
    c. Complications relating to services, supplies or drugs which have not yet been approved by the FDA or which are used for purposes other than its FDA Approved purpose.
40. Maternity and related medical services for surrogate mothers.
41. Manipulation under anesthesia for any body part.
42. Mastectomy for gynecomastia.
43. Breast reduction.
44. Sclerotherapy of varicose veins.
45. Microphlebectomy (stab phlebectomy).
46. Assisted reproductive technologies invitro fertilization; gamete intra fallopian tube transfer; embryo transfer; zygote intra fallopian transfer; pre-embryo cryopreservation techniques; and/or any conception that occurs outside the woman's body. Any related services performed in conjunction with these procedures are also excluded.
47. Take-home medications/prescriptions.
48. Any over-the-counter product or medication is excluded with the following exceptions.
    a. Mastectomy bra including appropriate prosthetics for Mastectomy bras.

b. Breast Pump.

49. Shoe inserts or any foot orthotic expect an Orthopedic shoe is covered only if an integral part of a covered leg brace, including shoe inserts, heel/sole replacements, or shoe modification, when medically necessary for the proper functioning of the brace.
50. Tests and treatment for infertility.
51. Treatment of obesity by means of Surgery, medical services, or prescription drugs, regardless of associated medical, emotional, or psychological condition.

Specific Exclusions for Different Benefits

Exclusions from Coverage Relating to All Inpatient and Outpatient Hospital/Facility and Emergency Room Services

The following are Exclusions of the Plan:

1. Ineligible Surgical Procedures or related Complications.
2. Care, confinement or services in a nursing home, rest home or a transitional living facility, community reintegration program, vocational rehabilitation, services to retrain self-care, or activities of daily living.
3. Recreational therapy.
4. Autologous (self) blood storage for future use.
5. Organ or tissue donor charges, except when the recipient is an eligible Member covered under the Plan, and the transplant is eligible.
6. Custodial Care and/or maintenance therapy.
7. Any eligible Surgical Procedure when performed in conjunction with other ineligible Surgery. Those parts of the ineligible Surgical Procedure that cannot be split out will not be covered.

Exclusions from Coverage Relating to Surgery

The following are Exclusions of the Plan:

1. Breast Reconstructive Surgery, augmentation or implants solely for Cosmetic purposes.
2. Capsulotomy, replacement, removal or repair of breast implant originally placed for Cosmetic purposes or any other Complication(s) of Cosmetic or non-covered breast Surgery.
3. Any service or Surgery that is solely for Cosmetic purposes to improve or change appearance or to correct a deformity without restoring a physical bodily function, with the following exceptions.
    - Breast Reconstructive Surgery as allowed under WHCRA for Cosmetic purposes and
    - Reconstructive Surgery made necessary by an Accidental injury in the preceding five (5) years.
4. Rhinoplasty for Cosmetic reasons is excluded.
5. Surgical treatment for correction of refractive errors.

6. Expenses incurred for Surgery, preoperative testing, treatment, or Complications by an organ or tissue donor, where the recipient is not an eligible Member, covered by the Plan, or when the transplant for Member is not eligible.
7. Reversal of sterilization.
8. Rhytidectomy.
9. Complications as a result of non-covered or ineligible Surgery.
10. Injection of collagen, except as approved for urological procedures.
11. Lipectomy, abdominoplasty, panniculectomy.
12. Repair of diastasis recti.
13. Sperm banking system, storage, treatment, or other such services.
14. Hair transplants or other treatment for hair loss or restoration.
15. Chemical peels.
16. Treatment for spider or reticular veins.
17. Liposuction.
18. Orthodontic treatment or expansion appliance in conjunction with jaw Surgery.
19. Chin implant, genioplasty or horizontal symphyseal osteotomy.
20. Unbundling or fragmentation of surgical codes.
21. Any Surgery solely for snoring.
22. Otoplasty.
23. Abortions, except as in accordance with PPACA Sec. 1303 or other applicable law.
24. Subtalar implants.
25. Lasik, laser vision corrective surgery, or other refractive vision correction surgeries are excluded. A Pre-authorization will be required for other eye surgeries.
26. Orthognathic Surgery.
27. Any eligible Surgical Procedure when performed in conjunction with other ineligible Surgery. Those parts of the ineligible Surgical Procedure that cannot be split out will not be covered.
28. Obesity Surgery such as Lap Band, gastric bypass, stomach stapling, gastric balloons, etc., including any present or future complications.

Exclusions from Coverage Relating to Medical Visits

The following are Exclusions of the Plan:

1. Hospital visits the same day as Surgery or following a Surgical Procedure except for treatment of a diagnosis unrelated to the Surgery.
2. Hearing aids and examinations made in connection with a hearing aid.
3. Services for weight loss or in conjunction with weight loss programs regardless of the medical indications except as allowed under the Affordable Care Act Preventive Services.
4. Sublingual antigens.
5. Charges in conjunction with ineligible procedures, including pre or postoperative evaluations.
6. Epidemiological and predictive genetic screening except intrauterine genetic evaluations (amniocentesis or chorionic villi sampling) for high-risk pregnancy or as allowed under the Affordable Care Act Preventive Services.

7. Exclusions include any diagnostic testing or imaging used with the goal of identifying a cancer or disease in a Member who has a genetic predisposition or gene marker or single nucleopeptide (SNP) "defect" and who has no current signs or symptoms related to the disease process for which a predisposition may exist.
8. Acupuncture treatment.
9. Physical or occupational therapy primarily for maintenance care.
10. Functional or work capacity evaluations, sports evaluations for the purpose of playing sports, impairment ratings, work hardening programs or Back to School.
11. Hypnotherapy or biofeedback.
12. Hair transplants or other treatment for hair loss or restoration.
13. Vision therapy.
14. Testing and treatment therapies for developmental delay or child developmental programs. May be covered under rehabilitative or habilitative coverage and limitations.
15. Rolfing or massage therapy.
16. Training and testing in conjunction with Durable Medical Equipment or prosthetics.
17. Nutritional analysis or counseling, except in conjunction with diabetes education, anorexia, bulimia, or as allowed under the Affordable Care Act Preventive Services.
18. Reports, evaluations, examinations not required for health reasons, such as employment or insurance examinations, or for legal purposes such as custodial rights, paternity suits, etc.
19. Visits in conjunction with palliative care of metatarsalgia or bunions; corns, calluses or toenails, except removing nail roots and care prescribed by a licensed physician treating a metabolic or peripheral vascular disease. See applicable Outline of Coverage for Eligible Benefits.
20. Cardiac Rehabilitation, Phases 3 and 4.
21. Pulmonary Rehabilitation, Phase 3.
22. Chelation therapy.
23. Office visits in conjunction with allergy, contraception, hormone, or repetitive therapeutic injections when the only service rendered is the injection.
24. Fitness programs.
25. Charges for special medical equipment, machines, or Devices in the Provider's office used to enhance diagnostic or therapeutic services in a Provider's practice.
26. Childbirth education classes.
27. Topical hyperbaric oxygen treatment.
28. Home births.

Exclusions from Coverage Relating to Diagnostic Testing, Lab and X-Ray

The following are Exclusions of the Plan:

1. Charges in conjunction with ineligible procedures, including pre or post-operative evaluations.
2. Routine drug screening, except when ordered by a treating physician. Routine drug screening while in a substance abuse program is excluded regardless of whether ordered by a treating physician.

3. Sublingual or colorimetric allergy testing.
4. Charges in conjunction with weight loss programs regardless of Medical Necessity.
5. Exclusions include any diagnostic testing or imaging used with the goal of identifying a cancer or disease in a Member who has a genetic predisposition or gene marker or single nucleopeptide (SNP) "defect" and who has no current signs or symptoms related to the disease process for which a predisposition may exist.
6. Probability and predictive analysis and testing.
7. Unbundling of lab charges or panels.
8. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations.
9. Hair analysis, trace elements, or dental filling toxicity.
10. Molecular diagnostic (genetic testing) in the course of evaluating a Member for genetic or congenital disease.
11. Epidemiological and predictive genetic screening except intrauterine genetic evaluations (amniocentesis or chorionic villi sampling) for high-risk pregnancy or as allowed under the Affordable Care Act Preventive Services. Cell-free DNA analysis of maternal blood is excluded except for cases of high-risk pregnancy.

Exclusions from Coverage Relating to Mental Health

The following are Exclusions of the Plan:

1. Inpatient treatment for Mental Health without Preauthorization, as required by the Plan.
2. Milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, Stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances.
3. Mental or emotional conditions without manifest psychiatric disorder or nonspecific conditions.
4. Wilderness programs.
5. Psychological evaluations or testing for legal purposes such as custodial rights, etc., or for insurance or employment examinations.
6. Occupational or recreational therapy.
7. Hospital leave of absence charges.
8. Sodium amobarbital interviews.
9. Tobacco abuse.
10. Routine drug screening, except when ordered by a treating physician.

Exclusions from Coverage Relating to Anesthesia

The following are Exclusions of the Plan:

1. Anesthesia in conjunction with ineligible Surgery.
2. Anesthesia administered by the primary surgeon.
3. Monitored anesthesia care or on call time for consultant.
4. Additional charges for supplies, drugs, equipment, etc.

5. Anesthesia performed for any eligible Surgical Procedure when performed in conjunction with other ineligible Surgery.

Exclusions from Coverage Relating to Ambulance Benefits

The following are Exclusions of the Plan:

1. Charges for common or private aviation services.
2. Services for the convenience of the patient or family.
3. After-hours charges.
4. Charges for ambulance waiting time.

Exclusions from Coverage Relating to Home Health and Hospice Care

The following are Exclusions of the Plan:

1. Nursing or aide services which are requested by or for the convenience of the Member or family, which do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such services. This Exclusion applies even when services are recommended by a Provider.
2. Private duty nursing.
3. Home health aide.
4. Custodial Care.
5. Respite Care.
6. Travel or transportation expenses, escort services to Provider's offices or elsewhere, or food services.
7. Total Parenteral Nutrition through Hospice.
8. Home births

Exclusions from Coverage Relating to Adoption Benefits

The following are Exclusions of the Plan:

1. Transportation, travel expenses or accommodations, passport fees, translation fees, photos, postage etc.
2. Living expenses, food, and/or counseling for the birth mother.

Exclusions from Coverage Relating to Durable Medical Equipment/Supply Benefit

The following are some, but not necessarily all, items not covered as a benefit, regardless of the relief they may provide for a medical condition:

1. Training and testing in conjunction with Durable Medical Equipment or prosthetics.
2. More than one lens for each affected eye following surgery for corneal transplant.
3. Durable Medical Equipment that is inappropriate for the patient's medical condition.

4. Diabetic supplies, i.e., insulin, syringes, needles, etc. are a pharmacy benefit.
5. Equipment purchased from non-licensed Providers.
6. TENS Unit.
7. Neuromuscular Stimulator.
8. Hwave Electronic Device.
9. Sympathetic Therapy Stimulator (STS).
10. Support hose for phlebitis or other diagnosis.

The following are some, but not necessarily all of the items not covered as a benefit, regardless of the relief they may provide for a medical condition.

1. Bathroom lifts and/or toilet lifts.
2. Combination sit-to stand frame/table systems.
3. Electric, motorized, or powered standing devices.
4. Elevators.
5. Lifting, standing or positioning devices or other fixtures to real property such as ceiling lifts.
6. Platform lifts.
7. Stair gliders.
8. Stairway chair/stair lifts.
9. Vehicle modifications.

Exclusions from Coverage Relating to Prescription Drug Benefits

The following are Exclusions of the Plan:

1. A prescription that is not purchased from a designated pharmacy (if required) and/or exceeds any quantity levels or step therapy disclosed on the Plan's Preferred Drug List or website.
2. Vitamins, minerals, food supplements, homeopathic medicines and nutritional supplements (Prenatal vitamins and folic acid will be covered for pregnancy).
3. Dental rinses and fluoride preparations.
4. Hair growth and hair loss products.
5. Medications or nutritional supplements for weight loss or weight gain.
6. Medications needed to participate in any drug research or medication study.
7. Non-approved indications determined by the Plan's Pharmacy and Therapeutics Committee and the Plan.
8. Drugs for athletic and mental performance.
9. New medications released by the FDA until they are reviewed for efficacy, safety and cost effectiveness by the Plan.
10. Oral infant and medical formulas.
11. Therapeutic Devices or appliances unless listed in the Plan's Preferred Drug List.
12. Diagnostic agents.
13. Over-the-counter medications and products unless listed in the Plan's Preferred Drug List.
14. Biological serum, blood, or blood plasma.

15. Medications and injectables prescribed for Industrial Claims and Worker's Compensation.
16. Medications dispensed from an institution or substance abuse clinic when the Member does not use their pharmacy card at the Plan Contracted pharmacy are not payable as a pharmacy claim.
17. Compounding fees, powders, and non-covered medications used in compounded preparations.
18. Medications used for Cosmetic indications.
19. Replacement of lost, stolen or damaged medications.
20. Nasal immunizations unless listed in the Plan Preferred Drug List.
21. Medications for Elective abortions except in accordance with state and federal law.
22. Drugs for the treatment of nail fungus.
23. Oral and nasal antihistamines for allergies.
24. An additional medication that may be considered duplicate therapy defined by the FDA or the Plan.
25. Medications not listed on the Claims Administrator's website. For a complete list of covered drugs, refer to the Claims Administrator's website.
26. Drugs purchased from nonparticipating Providers over the Internet.

Exclusions from Coverage Relating to Maximum Out-of-Pocket Benefits

Amounts paid by the Member for the following services will not apply to the Member's out-of-pocket maximum:

1. Any service or amount established as ineligible under this Plan or considered inappropriate medical care.
2. Charges in excess of Maximum Allowable Fee or the Plan Limitations.
3. Penalties for failing to obtain Preauthorization or to complete Pre-notification.
4. Specific Exclusions are listed under the most commonly applicable Benefit category but are not necessarily limited to that category only.