

COLORADO SCHOOL OF MINES



STUDENT HEALTH BENEFITS PLAN (SHBP) 2010-11 PLAN DOCUMENT

Effective Date: August 24, 2010

For the most current information regarding the SHBP, refer to this CSM web site at: <http://healthcenter.mines.edu/SHBP>

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THIS INSTRUMENT, established by the Colorado School of Mines (hereinafter CSM), sets forth the Colorado School of Mines Student Health Benefits Plan (hereinafter SHBP).

A. Establishment of SHBP. CSM hereby sets forth its student group health plan under the following terms and conditions.

- (1) The SHBP is provided by CSM for the sole purpose of providing health care benefits to the *Students* covered by the program. The SHBP is operated in full compliance with the standards for student health insurance/benefit programs endorsed by the American College Health Association. The SHBP complies fully with Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, as all three laws were amended by the Civil Rights Restoration Act of 1987, and other applicable law. Pregnancy benefits are provided on the same basis as any other temporary disability.
- (2) Reserve funds for the SHBP are developed and maintained to fund adequate contingencies and such funds are encumbered for the sole benefit of SHBP-Covered Persons. In the event of discontinuation of the insurance program (either self-funded or fully insured) reserve funds would be used for health related purposes to benefit CSM *Students*. SHBP funds and SHBP reserve funds are not commingled with other CSM accounts, and they earn interest income.
- (3) The SHBP complies with all applicable mandated coverage for similarly situated fully insured programs that are otherwise regulated under the blanket and franchise sections of the Colorado Insurance Code.
- (4) Benefits are administered exclusively based on the provisions of this Plan Document. There are no unpublished Plan provisions. All documents pertaining to the program and/or directions to other applicable CSM policies are available at <http://healthcenter.mines.edu/SHBP>.
- (5) Extra-contractual benefits may only be provided to the extent that the Plan Administrator determines that such benefits are *Medically Necessary* and result in either (1) improved quality of care for the *Covered Person* with no substantive difference in the amount of benefit payments that would otherwise be provided by the SHBP, or (2) cost savings for the SHBP. Upon recommendation of the Claims Administrator, any extra-contractual benefits must be reviewed and approved by the Plan Administrator.

B. Effective. The SHBP as described herein is effective **August 24, 2010**.

C. General Provisions. The SHBP is subject to all of the conditions and provisions set forth in this document and subsequent amendments, which are made a part of this Plan Document.

IN WITNESS WHEREOF, the Colorado School of Mines has caused this SHBP to be executed by its duly-authorized representative.

Board of Trustees of the Colorado School of Mines

Date

By: _____

Authorized Signature

Title

Printed Name and Title

The Colorado School of Mines has prepared this document to help you understand your medical, dental, vision, and prescription drug benefits as a *Covered Person* in the Student Health Benefits Plan (SHBP). Please read it carefully. The Schedule of Benefits provides an overview of your coverage. Terms printed in capitalized letters and in italics are defined in Section XVII, Definitions.

For United States citizens and permanent residents, treatment or services rendered outside the United States of America or its territories are covered on the same basis as treatment or services rendered within the United States. For international *Students* and their covered dependents, such SHBP benefits are only provided to the extent they are not covered by any other insurance plan, insurance program, or system of socialized medicine.

Your benefits under the SHBP are affected by certain limitations and conditions designed to encourage you to be a wise consumer of health services and to use only those services you need. Also, benefits are not provided for certain kinds of treatments or services, even if your health care *Provider* recommends them.

If you have any questions about any of your coverage, please contact the SHBP's Claims Administrator: Klais & Company, Inc., at 800-331-1096. Refer to the Student Health Center web site for secure messaging options for communications with Klais & Company, Inc., and the CSM Student Health Insurance Coordinator.

Please make note of the following provisions.

(1) Preferred Provider Networks

The chosen Preferred Provider Network is a group of *Providers/Practitioners*, and *Hospitals* who have agreed to accept a negotiated fee for their services. Preferred Provider Networks may be used by *Covered Persons* to provide most of the Covered Medical Services described in Section VI of this Plan Document. As a *Covered Person* in the SHBP, you maintain the freedom to choose participating or non-participating *Providers/Practitioners*. Please visit www.UHCSR.com/CSM for a listing of participating *Providers/Practitioners*. CSM also directly contracts with a selected panel of mental health care *Providers*. A directory of these *Providers* is available at the CSM Counseling Center and at <http://counseling.mines.edu>.

When you choose a participating *Provider/Practitioner* or *Hospital*, this SHBP contains many advantages.

- (a) You usually pay less money out of your pocket for health care services.
- (b) You may change your *Provider(s)/Practitioner(s)* and/or *Hospital* at any time, because you are not required to designate a primary care *Provider/Practitioner*.

- (c) Your participating *Provider(s)/Practitioner(s)* and/or *Hospital* will file claims directly, so you do not have to wait for claim reimbursement.
- (d) You are not responsible for charges over the negotiated fees allowed by the applicable network for the Covered Medical Services described under Section VI of this Plan Document, but you are responsible for the applicable deductible, copayment, and/or coinsurance amounts.

(2) Outpatient surgery

If appropriate, consider having surgery performed in the outpatient department of the *Hospital*, a surgical care center, or a *Provider's/Practitioner's* office. This will eliminate the *Hospital* room and board charges as well as overnight stays.

(3) Generic Medications

A generic drug is a prescription drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. Whenever possible, request that your *Provider(s)/Practitioner(s)* prescribe a generic drug if it is the lowest cost option and it will provide an effective medication.

Please also refer to the important Preadmission/Precertification of care requirements, explained in Section VII.

Plan Name	Colorado School of Mines Student Health Benefits Plan (SHBP).
Type of Plan	Non- <i>ERISA</i> governed student health benefits plan providing medical, dental, and vision, prescription drug benefits on a partially self-funded basis.
Effective	Effective August 24, 2010
Plan Sponsor	The Board of Trustees of the Colorado School of Mines 1500 Illinois Street Golden, Colorado 80401
Group Number	SU100A
Plan Administrator	Director of Student Services Ben F. Parker Student Center, Suite 40 Colorado School of Mines 1600 Maple Street Golden, CO 80401 303-273-3297
Claims Administrator	Klais & Co., Inc. 1867 West Market St. Akron, OH 44313 800-331-1096 Web Site: http://www.klais.com Secure Messaging: CSM-SHBP@Klais.com at https://csm.wordsecure.com
In-Network Preferred Providers	www.UHCSR.com/CSM — CSM Counselor Referral Network: http://counseling.mines.edu
Pharmacy Provider Network	Medco Health Solutions, Inc. PO Box 14711 Lexington, KY 40512 Member Phone: 800-711-0917 Pharmacy Phone: 800-922-1557 Web Site: http://www.medco.com

Medical Evacuation and Repatriation Provider	Assist America, Inc. 202 Carnegie Center, Suite 302A Princeton, NJ 08540 - (800) 304-4585 / (609) 921-0868 www.assistamerica.com/student Web Site: www.assistamerica.com
Nurse-Line Services	877-643-5130
Agent for Service of Legal Process	Office of Legal Services Colorado School of Mines 1500 Illinois Street Golden, Colorado 80401
Termination and/or Modification of SHBP	The Plan Sponsor may terminate the SHBP at the end of any <i>Plan Year</i> , or change the provisions of the SHBP at any time by a written Plan Document amendment signed by a duly-authorized officer of the Plan Sponsor. The consent of any <i>Covered Person</i> is not required to terminate or change the SHBP.

The SHBP is not an employer-sponsored health plan. Accordingly, the rules and regulations of the Employee Retirement Income Security Act of 1974 (*ERISA*), the Consolidated Omnibus Budget Reconciliation Act of 1996 (COBRA), and other federal laws that apply exclusively to employer-sponsored health plans are not applicable to the SHBP. To the extent that the SHBP voluntarily adopts certain practices as described under *ERISA*, such adoption shall not be deemed to subject the SHBP to *ERISA*. Similarly, as a partially self-funded health plan, the SHBP is not regulated by the State of Colorado's Department of Insurance.

The federal laws and regulations that are applicable to the SHBP include, but are not limited to, the following.

- Title IX of the Education Amendments of 1972. The SHBP provides pregnancy benefits on the same basis as any other temporary disability.
- Section 504 of the Rehabilitation Act of 1973.
- Age Discrimination Act of 1975.
- Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- Regulations of the United States Information Agency applicable to visa recipients.

CSM Board of Trustees Non-Discrimination policy (pursuant to the authority conferred upon it by §23-41-104(1), C.R.S. (1998)), attendance and employment at CSM are based solely on merit and fairness. Discrimination on the basis of age, gender, race, ethnicity, religion, national origin, disability, sexual orientation, and military veteran status is prohibited.

A. Eligible Students

Students eligible for the SHBP are defined as:

- (1) All degree seeking *Students* who are United States Citizens or permanent residents enrolled at the Colorado School of Mines.
- (2) All international *Students*, regardless of degree-seeking status, enrolled at the Colorado School of Mines. This provision does not apply to visiting scholars who have an appointment letter through Academic Affairs.

Any *Student* who does not meet one of the classifications listed above is not eligible to enroll in the SHBP.

The maximum period for eligibility under the SHBP is nine (9) years while in a single degree program. Students may be required to establish that they are pursuing a degree and making normal progress toward degree completion.

Unless otherwise specified for *Students* who have an approved *Medical Withdrawal/Leave of Absence for Medical Purposes from CSM*, a *Student* must attend regularly scheduled classes and maintain eligibility for the SHBP for the first thirty-one (31) calendar days of the *Coverage Period* that he or she first enrolls in the SHBP each *Plan Year*. Students who do not meet this requirement are not eligible for participation in the SHBP.

Eligible *Students* may choose to participate in the SHBP during the *Annual Open Enrollment Period* with coverage commencing on the first day of the *Plan Year* or the first day of the *Coverage Period* (the *Effective Date*). The *Effective Date* will be earlier than the first day of the *Plan Year* if the *Student* is required by CSM to be on campus or participate in a CSM-sponsored activity or program. In no event will the *Effective Date* be more than 20 days earlier than the first day of the *Plan Year* or August 1st for *Students* participating in NCAA-Sanctioned Intercollegiate Sports.

The requirements for *Students* to have health insurance are established by CSM under policies published separately from this Plan Document in the annual Student Health Program brochure.

Eligible *Students* must enroll each *Plan Year* by the enrollment deadlines established by the Plan Administrator. *Students* who have other health insurance will be able to waive coverage under the SHBP if their insurance meets or exceeds the waiver criteria established and published by the Plan Administrator. All SHBP enrollment waiver requests must be received by the Plan Administrator by the due dates established and published by the Plan Administrator each *Plan Year*. Otherwise, eligible *Students* will be automatically enrolled in and charged for the SHBP.

Each *Student* who meets the eligibility requirements of the SHBP and who submits an enrollment application that has been approved by the Plan Administrator (or who is automatically enrolled per the terms of the SHBP) shall become a *Covered Student*.

A SHBP-Covered Student who withdraws from the Colorado School of Mines during any Coverage Period, after the date that no portion of his or her tuition/fee billing is refunded by CSM, will not lose eligibility for the SHBP. Coverage will remain in force, including coverage for any dependents covered by the SHBP, for the remainder of that coverage period.

Refunds for the cost of coverage under the SHBP are only provided for Students who enter into the Uniformed Services. A pro-rated refund will be returned to such person upon request. Students who withdraw from CSM for non-medical reasons prior to CSM's Census Date are not eligible for enrollment in the SHBP. Students who withdraw between Census Date and the first 31 days of each Coverage Period for non-medical reasons are also ineligible for enrollment in the SHBP. Students must notify the Registrar's Office of such withdrawal and the entire cost of coverage for that semester will be refunded, including dependent coverage. Such Students will not be entitled to any benefits and no claims will be honored. **No other refunds will be issued.**

B. Qualified Late Enrollees

Students may be approved to enroll in the SHBP after the Plan Year's enrollment deadline under the provision established in this Section. For example, Students who enroll at CSM in the spring semester, or Students who Involuntarily Lose eligibility under a group health insurance plan due to a loss of employment or an attainment of a maximum age to be covered under their parent's plan. Such Students will be Qualified Late Enrollees for the SHBP if they request enrollment from the Plan Administrator within 30 days of the Involuntary Loss of their group health insurance plan. Qualified Late Enrollees may also enroll their Eligible Dependents in the SHBP. Documentation of Involuntary Loss of coverage must be provided to the Plan Administrator. The cost of the SHBP is pro-rated for Qualified Late Enrollees on a monthly basis. The Effective Date will be the first of the month in which the Student Involuntarily Loses his or her health insurance.

Students who were not aware they had become uninsured will be allowed to enroll in the SHBP as a Qualified Late Enrollee if there is reasonable evidence, based solely upon a determination by the Plan Administrator, to support a finding that the Student was not aware of the loss of his or her health insurance. In this situation, the requirement for application for enrollment in the SHBP in the 30 days immediately following the Involuntary Loss of group health insurance coverage will be waived.

C. Unqualified Late Enrollees

Any eligible Student who is subject to the Colorado School of Mines's insurance requirement and is found to be uninsured (or does not have health insurance that meets CSM's insurance requirement) during the Plan Year (and is not a Qualified Late Enrollee) will be enrolled in the SHBP. Unqualified Late Enrollees cannot purchase dependent coverage under the SHBP until the next Annual Open Enrollment Period.

Unqualified Late Enrollees will be subject to a pre-existing condition limitation (as specified under Section IX (B), Pre-existing Condition Limitation) that includes a six-month look-back period for diagnosis or treatment and a six-month waiting pe-

riod for benefits for any pre-existing condition to begin. The cost of the SHBP is not pro-rated for Unqualified Late Enrollees.

D. Eligible Dependents

An *Eligible Dependent* is one of the persons defined in this Section. Except as specifically provided, dependents must be enrolled in the SHBP during *the Annual Open Enrollment Period* and reenroll each *Plan year*.

- (1) A person of the opposite gender who is the husband or wife of the *Covered Student* as recognized under the Federal Defense of Marriage Act (DOMA) is an *Eligible Dependent*. Such person may also be referred to as a spouse under the terms of the SHBP.
- (2) A child of the *Covered Student* who is unmarried and who has not attained the age of 19 as of the close of the calendar year in which the taxable year of the *Covered Student* begins and who meets the following requirements is an *Eligible Dependent*:
 - (a) has the same principal place of residence as the *Covered Student* for more than $\frac{1}{2}$ of the taxable year of the *Covered Student*; and
 - (b) has not provided over $\frac{1}{2}$ of his or her own support in that year.

For purposes of determining eligibility for *Eligible Dependent* coverage, the term child includes:

- a natural child;
- a stepchild by legal marriage;
- a child who has been legally adopted by the *Covered Student* or placed with the *Covered Student* for adoption by a court of competent jurisdiction; and
- a child for whom legal guardianship has been awarded, provided that the child legally resides with the *Covered Student* in a parent-child relationship for more than $\frac{1}{2}$ of the taxable year, must not have provided more than one-half of his or her own support in that year, or be the subject of a Qualified Medical Child Support Order (as described later in this section).

In addition to the foregoing, an unmarried child who is permanently and *Totally Disabled* (as defined in Internal Revenue Code Section 22(e)(B)) at any time during the calendar year in which the taxable year of the *Covered Student* begins shall be deemed to have met the age requirements stated above. The Plan Administrator may require, at reasonable intervals during the two years following the child's 19th birthday, subsequent proof of the child's incapacity and de-

pendency. After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator has the right to have such child examined by a *Provider/Practitioner* of the Plan Administrator's choice to determine the existence of such incapacity.

- (3) A same-sex domestic partner may be an *Eligible Dependent*. In order to obtain SHBP coverage for a same-sex domestic partner, the *Covered Student* must file an Affidavit of Domestic Partnership (Spousal Equivalency) with the Plan Administrator and declare and acknowledge that the *Covered Student* and his/her same-sex domestic partner meet the following criteria.
- (a) They are at least 18 years of age and mentally competent to consent to the contract.
 - (b) They are not related by blood to a degree of closeness which would prohibit legal marriage in the state in which they legally reside.
 - (c) They reside together in the same residence and intend to do so indefinitely.
 - (d) They are jointly responsible for each other's common welfare and financial obligations.
 - (e) Neither person is married to another person under the laws of the state in which they reside.
 - (f) The two parties are each other's sole same-sex domestic partner and intend to remain so indefinitely.

It is further understood, acknowledged and agreed to the following.

- The *Covered Student* shall provide the Plan Administrator with a valid copy of registration of domestic partnership (if any), that may be of record and filed with the partner's city, county, or other municipal registry.
- The *Covered Student* shall immediately notify the Plan Administrator of any changes in the status of his or her same-sex domestic partnership. The *Student* must file a Statement of Domestic Partner Termination with the Plan Administrator within 30 days of the earlier of: (1) the death of the domestic partner; or (2) the date of termination of the domestic partnership.
- The *Covered Student* will be financially liable for the reimbursement of any *Expenses Incurred* as a result of any false or misleading statements contained in the aforementioned Affidavit or accompanying written documentation.

- Any coverage afforded the same-sex domestic partner will be in consideration of said Affidavit and accompanying written documentation being true, complete, and accurate. The same-sex domestic partner shall not be considered for coverage until said Affidavit and accompanying written documentation is completed, returned, and found to be satisfactory to the Plan Administrator.
- The Affidavit and accompanying written documentation will be maintained by the Plan Administrator as a confidential personal document and shall not be disclosed in the absence of a written consent, except as necessary to provide benefits or as otherwise required by law.

(4) Unmarried children of a same-sex domestic partner are *Eligible Dependents*.

If husband and wife (or both same-sex domestic partners) are both *Covered Students*, each can be covered individually or as the *Eligible Dependent* of the other. Neither can be covered both as a *Covered Student* and as an *Eligible Dependent*. Only one of the two covered spouses/partners may cover *Eligible Dependents*.

Except as provided under Subsection B entitled Qualified Late Enrollees and Subsection C entitled Unqualified Late Enrollees of this Section IV, each *Eligible Dependent* will be eligible to participate in the SHBP beginning with the latest of the following dates, provided the Plan Administrator is notified in writing within thirty-one (31) days of such event and the *Covered Student* has agreed to pay any required contribution for such coverage:

- the date the *Covered Student's* coverage begins, provided the *Covered Student* enrolled all *Eligible Dependents* on or before the date on which such *Covered Student's* participation commenced hereunder;
- the date of enrollment, if the *Covered Student* enrolls all *Eligible Dependents* within thirty-one (31) days of the *Covered Student's* own eligibility date;
- the date the *Covered Student* enrolls the *Eligible Dependent*, if the enrollment is within thirty-one (31) days of the date any new *Eligible Dependent* is acquired and proof of *Eligible Dependent* status is furnished (A newborn *Eligible Dependent*, born to either a male or female *Covered Student*, is not considered to be acquired until the *Eligible Dependent's* birth.); or
- in the case of an adopted child, the date the child is placed with the *Covered Student* for adoption by a court of competent jurisdiction, as defined in Subsection E of this Section IV.

E. Adopted Child Provision

Eligible Dependent children placed for adoption with a *Covered Student* shall be eligible for coverage under the same terms and conditions as apply in the case of *Eligible Depen-*

dent children who are natural children of *Covered Students* under the SHBP, irrespective of whether or not the adoption has become final. Coverage under the SHBP shall not be restricted for any *Eligible Dependent* child adopted by the *Covered Student* or placed with a *Covered Student* for adoption, solely on the basis of a pre-existing condition of such child at the time that such child would otherwise become eligible for coverage under the SHBP, if the adoption or placement for adoption occurs while the *Covered Student* is eligible for coverage under the SHBP.

As used in this section only, the term child means: in connection with any adoption, or placement for adoption of a child, a child who has not attained age eighteen (18) as of the date of such adoption or placement for adoption. The terms placement or being placed for adoption in connection with any placement for adoption of a child with any person means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

The child's placement for adoption terminates upon the termination of such legal obligations, and in such an event, the child's coverage shall cease after the last day of the month the placement is terminated unless coverage must be continued pursuant to a Qualified Medical Child Support Order.

F. Coverage Pursuant to a Qualified Medical Child Support Order

Certain *Eligible Dependents* shall be provided benefits in accordance with applicable requirements of any Qualified Medical Child Support Order, provided that such order does not require the SHBP to provide any type or form of benefit, or any option under the SHBP, not otherwise provided under the SHBP, except to the extent necessary to meet the requirements of law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 4301 of the Omnibus Budget Reconciliation Act of 1993). A *Covered Student* may obtain a copy of the Qualified Medical Child Support Order procedures from the Plan Administrator.

An Alternate Recipient shall mean any child of a *Covered Student* who is recognized under a Medical Child Support Order as having a right to enroll under the SHBP with respect to such *Covered Person*.

Any payment of benefits made by the SHBP pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian. The terms Qualified Medical Child Support Order and Medical Child Support Order shall have the meanings given to them in Section 609 of *ERISA*.

PRESCRIPTION BENEFIT	IN-NETWORK MEDCO	OUT-OF-NETWORK
<p>Prescription medications are categorized within three tiers. Each tier is assigned a copay, which is an amount you pay when you fill a prescription at a participating retail pharmacy or refill your ongoing prescription through the network mail-order pharmacy service.</p> <p>Tier 4 prescriptions are for self-administered injectables only.</p> <p>Benefits are also available for smoking cessation Prescription Drugs when enrolled in an approved <i>Smoking Cessation Counseling Program</i> up to a \$250 per <i>Covered Person Per Plan Year</i> / \$500 Maximum Lifetime Benefit.</p>	<p>Up to a 30 days, 30 units, (or 90 days for mail order), whichever is greater, supply per prescription for</p> <p>Tier 1: \$15 copay per prescription.</p> <p>Tier 2: \$40 copay per prescription.</p> <p>Tier 3: \$60 copay per prescription.</p> <p>Tier 4: 30% copay per prescription not to exceed \$250 maximum copay per prescription.</p> <p>Mail order prescriptions are available from MEDCO up to a 90 day supply for two times the applicable copayment.</p>	<p>No Benefits</p>
<p>Outpatient prescription drug copayments/coinsurance do not count toward satisfaction of the Annual Out-of-Pocket Maximum Expense Limit.</p>		

CHARGES INCURRED AT COULTER STUDENT HEALTH CENTER	
<p>Explanation of benefit statements will not be issued for services or supplies provided by Coulter Student Health Center. Copayments and coinsurance for charges incurred at the Student Health Center do not count toward the lifetime maximum benefit or toward the annual maximum out-of-pocket expense limit.</p> <p>Except as specifically provided, this benefit does not include routine sexually transmitted disease testing, employment physicals, or other services or supplies for care not related to a <i>Covered Illness</i> or <i>Injury</i>.</p>	
<p>Laboratory Service, including reference laboratory services when the specimen is obtained at Coulter Student Health Center.</p> <p>This benefit includes pap smears and other laboratory services related to annual womens' health exams.</p>	<p>100% Coverage</p> <p>Charges for laboratory services and travel-related immunizations for Wellness Benefits for adults age 20 and are limited to 50% Coverage. The \$300 lifetime maximum benefit for Travel and Wellness benefits does not apply to these charges.</p>
<p>Dental Clinic Services</p>	<p>100% coverage for covered dental care services subject to the following copayments.</p>
<p><u>Examinations</u> Initial, with X-rays as needed Emergency exam with X-rays as needed</p>	<p>\$10 copayment \$0 copayment</p>
<p><u>Preventive/Diagnostic</u> Prophylaxis Recall exam Sealant per tooth Four bitewing X-rays Full Mouth X-rays Peri-Apical Films Vitality Testing Flouride Treatment</p>	<p>\$15 copayment \$15 copayment \$10 copayment \$10 copayment \$15 copayment \$0 copayment \$0 copayment \$5/\$10 copayment</p>

SCHEDULE OF BENEFITS

Section V

<u>Restorative</u>	
Amalgam -1 surface	\$20 copayment
Amalgam -2 surfaces	\$25 copayment
Amalgam -3 surfaces	\$30 copayment
Amalgam -4 surfaces	\$35 copayment
Resin-1 surface	\$20 copayment
Resin-2 surfaces	\$25 copayment
Resin-3 surfaces	\$30 copayment
Resin-4 surfaces	\$35 copayment
<u>Emergency</u>	
Pulpectomy/pulpotomy	\$20 copayment
Sedative filling/interim restoration	\$15 copayment
<u>Periodontics</u>	
Limited scaling/root cleaning	\$25 copayment
Perio scaling/root planing	\$35 copayment per hour
Perio maintenance	\$20 copayment
Limited Scaling	\$25 copayment
<u>Oral Surgery</u>	
Extraction (simple)	\$30 copayment
Incision and Drainage	\$15 copayment
Abscess	

Only the benefits stated in this Section apply to services covered by the SHBP for dental care received at the Coulter Student Health Center. No other benefits are provided

SCHEDULE OF BENEFITS

Section V

MEDICAL BENEFITS MAX = Maximum	IN-NETWORK PROVIDERS <i>PA = Preferred Allowance</i>	OUT-OF-NETWORK PROVIDERS <i>R&C = Reasonable and Customary Allowance</i>
Lifetime Maximum	\$2,000,000 combined for both <i>In-Network Preferred Providers</i> and <i>Out-of-Network Providers</i>	
Annual Plan Year Deductible	Not Applicable – <i>In-Network</i> benefits are generally subject to a copayment and coinsurance for each service provided.	Per <i>Covered Person</i> : \$1,000 Family: \$3,000 These annual <i>Plan Year</i> deductibles do not apply in addition to deductibles or copayments that are charged by specific benefit (e.g. hospitalization). Both annual <i>Plan Year</i> deductibles and deductibles for specific benefits do not count toward satisfaction of the Annual Out-of-Pocket Maximums.
Coinsurance	Following satisfaction of any required copayment, the SHBP reimburses <i>Covered Expenses</i> up to 90% of the fee schedule amount (unless otherwise stated) up to the Annual Out-of-Pocket Maximum Expense Limit. The SHBP provides 100% coverage, not including prescription drug copayments, once the annual out-of-pocket expense maximum is reached.	Following satisfaction of the annual <i>Plan Year</i> deductible, the SHBP reimburses <i>Covered Expenses</i> up to 70% of <i>Reasonable and Customary Charges</i> .* The SHBP provides 100% coverage of <i>Reasonable and Customary Charges</i> once your annual out-of-pocket expense maximum is reached.
Annual Out-of-Pocket Maximums Note: Eligible charges incurred for either <i>In-Network</i> or <i>Out-of-Network Providers/Practitioners</i> will be used to satisfy the Out-of-	\$1,500 per <i>Covered Person</i> , per <i>Plan Year</i> . \$3,000 per Family, per <i>Plan Year</i> .	\$3,000 per <i>Covered Person</i> , per <i>Plan Year</i> . \$9,000 per Family, per <i>Plan Year</i> . Per Service Deductibles and outpatient prescription drug

<p>Pocket Maximums simultaneously.</p>		<p>copayments/coinsurance do not count toward satisfaction of the Annual Out-of-Pocket Maximum Expense Limit.</p>
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*** Availability of special additional benefits for out-of network care**

The level of benefits payable under the SHBP depends upon whether a *Covered Person* chooses to obtain medical care from an *In-Network Provider* or an *Out-of-Network Provider*. The Plan encourages the selection of an *In-Network Provider* by paying higher benefits when a *Covered Person* obtains medical care from an *In-Network Provider*.

Certain facilities, medical centers, and medical *Providers* have been designated as *Network Providers* under the SHBP. Treatment obtained from any *In-Network Provider* is payable as specified in the Schedule of Benefits under *In-Network* benefits. All other medical providers and facilities are considered *Out-of-Network Providers*. Treatment obtained from any *Out-of-Network Provider* is payable as specified in the Schedule of Benefits under *Out-of-Network* benefits.

In-Network Provider benefits will be paid for *Out-of-Network Providers* in the following circumstances:

- (1) *In-Network Preferred Providers* are not available in the geographic area where the *Student* is residing for more than thirty (30) days; or
- (2) *Emergency* treatment is provided for an *Injury* or an *Acute Medical Condition*.

In-Network Provider benefits will be paid for certain *In-Network* facility-affiliated Physicians and medical *Providers* who are *Out-of-Network Providers*. This includes but is not limited to charges for anesthesiologists and emergency room Physicians and the professional component charges for pathology and radiology. Charges made by such an *In-Network* facility-affiliated *Physician* or medical provider must be Reasonable and Customary as determined by the SHBP.

Charges made by an *Out-of-Network Provider* may exceed the *Reasonable and Customary (R&C)* amount for such procedures and a *Covered Person* may be balance billed for the difference. A *Covered Person* will not be balance billed for procedures performed by an *In-Network Provider* in excess of the *In-Network Provider* fee schedule.

SCHEDULE OF BENEFITS

Section V

	IN-NETWORK PREFERRED PROVIDERS	OUT-OF-NETWORK PROVIDERS
STATE OF COLORADO REQUIRED BENEFITS		
<ul style="list-style-type: none"> • Prosthetic Devices • Telemedicine Services • Mammography • Diabetes • Cervical Cancer Vaccines • Medical Foods • Prostate Cancer Screening • Child Health Supervision Services • Therapies for Congenital Defects and Birth Abnormalities • Cleft Lip or Cleft Palate • Dental Procedures for Dependent Children • Colorectal Cancer Screening • Hearing Aids for Minor Children 	Refer to end of Section V for applicable coverage for each benefit.	Refer to end of Section V for applicable coverage for each benefit.
INPATIENT		
<p>Hospital Expense, daily semi-private room rate; general nursing care provided by the <i>Hospital</i>; <i>Hospital</i> Miscellaneous Expenses, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies.</p> <p>In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.</p>	90% of <i>PA</i> / \$250 copay per admission	70% of <i>R&C</i> / \$750 Deductible per admission
<p>Routine Newborn Care, while <i>Hospital</i> confined; and <i>Routine Nursery Care</i> provided immediately after birth. Four days <i>Hospital</i> confinement expense maximum.</p>	Paid as any other <i>Illness</i>	

SCHEDULE OF BENEFITS

Section V

<p>Surgeon's Fees, in accordance with data provided by Ingenix.</p> <p>If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.</p>	90% of <i>PA</i>	70% of <i>R&C</i>
Assistant Surgeon	90% of <i>PA</i>	70% of <i>R&C</i>
Anesthetist , professional services in connection with inpatient surgery.	90% of <i>PA</i>	70% of <i>R&C</i>
Registered Nurse's Services , private duty nursing care.	90% of <i>PA</i>	70% of <i>R&C</i>
Physician visits , benefits do not apply when related to surgery.	90% of <i>PA</i>	70% of <i>R&C</i>
Pre-Admission Testing , payable within three (3) working days prior to admission.	90% of <i>PA</i>	70% of <i>R&C</i>
<p>Psychotherapy</p> <p>Refer also to State of Colorado Required Benefits in this Section V.</p>	<p>Paid as any other <i>Illness</i> at a coinsurance rate of 50% for psychotherapy treatment subject to the following maximums:</p> <p>Inpatient care limited to 45 days or 90 partial hospitalization days in any 12 month period, maximum benefits are combined for <i>both In-Network Preferred Providers</i> and <i>Out-of-Network Providers</i>.</p>	<p>Subject to <i>R&C</i> allowances, paid as any other <i>Illness</i> at a coinsurance rate of 50% for psychotherapy treatment subject to the following maximums:</p> <p>Inpatient care limited to 45 days or 90 partial hospitalization days in any 12 month period, maximum benefits are combined for <i>both In-Network Preferred Providers</i> and <i>Out-of-Network Providers</i>.</p>
<p>Biologically Based Mental Illness and Defined Mental Disorders (including alcohol and drug treatment).</p> <p>Refer also to State of Colorado Required Benefits in this Section V.</p>	Paid as any other <i>Illness</i>	Paid as any other <i>Illness</i>

SCHEDULE OF BENEFITS

Section V

OUTPATIENT		
<p>Surgeon's Fees, in accordance with data provided by Ingenix.</p> <p>If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.</p>	90% of <i>PA</i>	70% of <i>R&C</i>
<p>Day Surgery Miscellaneous, related to scheduled surgery performed in a <i>Hospital</i>, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies.</p> <p><i>Reasonable and Customary and Charges</i> for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.</p>	90% of <i>PA</i> \$250 copayment	70% of <i>R&C</i> \$750 Deductible
Assistant Surgeon	90% of <i>PA</i>	70% of <i>R&C</i>
Anesthetist , professional services in connection with outpatient surgery.	90% of <i>PA</i>	70% of <i>R&C</i>
Physician visits , benefits do not apply when related to surgery.	100% of <i>PA</i> \$25 copay per visit	70% of <i>R&C</i> \$25 deductible per visit
<p>Physiotherapy, Benefits are limited to one visit per day (includes occupational and speech therapy. Forty (40) visits maximum Per <i>Plan Year</i>).</p> <p>For children up to age 5, benefits are limited to 40 therapy visits each per <i>Plan Year</i> each for physiotherapy, occupational, and speech therapy.</p>	90% of <i>PA</i> \$25 copay per visit for visits one through 20. The copayment increases to \$40 for visits 21 through 40.	70% of <i>R&C</i>

SCHEDULE OF BENEFITS

Section V

<p>Medical Emergency, attending Physician's charges and the use of the emergency room and supplies. Co-pay/Deductible waived if admitted.</p>	<p>90% of <i>PA</i> \$100 copay per visit (includes all ancillary charges)</p>	<p>70% of <i>R&C</i> \$100 deductible per visit (includes all ancillary charges)</p>
<p>Urgent Care</p>	<p>90% of <i>PA</i> \$35 copay per visit</p>	<p>70% of <i>R&C</i> \$35 deductible per visit</p>
<p>Laboratory and Radiology Services</p>	<p>90% of <i>PA</i></p>	<p>70% of <i>R&C</i></p>
<p>Radiation Therapy & Chemotherapy</p>	<p>90% of <i>PA</i></p>	<p>70% of <i>R&C</i></p>
<p>Tests and Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, X-Rays and Laboratory Procedures.</p>	<p>90% of <i>PA</i></p>	<p>70% of <i>R&C</i></p>
<p>Biologically Based Mental Illness and Defined Mental Disorders (including alcohol and drug treatment)</p>	<p>Paid as any other <i>Illness</i></p> <p>Benefits are increased to 100% of <i>R&C</i> and no copayment for first visit and \$10 copayment per visit thereafter when services are referred by CSM Counseling Center and <i>Covered Person</i> obtains services from <i>Providers</i> directly contracted to CSM. Reauthorization for benefits by the Counseling Center is required at visit nine (9) and again at visit (19).</p>	<p>Paid as any other <i>Illness</i></p>
<p>Psychotherapy</p> <p>Refer also to State of Colorado Required Benefits in this Section V for psychotherapy coverage.</p> <p>Maximum benefits of \$10,000 in any 12 month period, combined for <i>both In-Network Preferred Providers</i> and <i>Out-of-Network Providers</i>.</p>	<p>Paid as any other <i>Illness</i> at a coinsurance rate of 50%.</p> <p>Benefits are provided on the same schedule as <i>Biologically Based Mental Illness</i> and <i>Defined Mental Disorders</i> when care is received from <i>Providers</i> directly contracted by CSM and care is authorized, as specified, by the CSM Counseling Center (this provision only applies to the co-</p>	<p>Subject to <i>R&C</i> allowances, paid as any other <i>Illness</i> at a coinsurance rate of 50%.</p>

SCHEDULE OF BENEFITS

Section V

	payment benefit and the maximum benefit limit of \$10,000 in any 12 month period applies to this provision).	
OTHER		
Acupuncture (12 visits per <i>Plan Year</i>)	100% of <i>PA</i> \$25 copay per visit	70% of <i>R&C</i> \$25 deductible per visit
Ambulance Services (Co-payments/Deductibles are charged per trip)	100% of <i>PA</i> \$200 copayment	100% of <i>R&C</i> \$200 deductible
Air Ambulance	90% of <i>PA</i> \$5,000 maximum per trip	90% of <i>R&C</i> \$5,000 maximum per trip
Alcohol/Drug Abuse	Paid as any other <i>Illness</i> Refer to end of Section V, State of Colorado Required Benefits, for <i>Biologically Based Mental Illness</i> .	
Allergy Injections (If not billed with an office visit)	90% coverage.	70% of <i>Reasonable and Customary Charges</i> (after annual <i>Plan Year</i> deductible).
Annual Gynecological Exam (this benefit is not subject to the deductible requirement for out-of-network care)	100% of <i>PA</i> \$25 copay per visit	70% of <i>R&C</i>
Hemophilia Factors	90% of <i>PA</i> Lifetime maximum benefit of \$50,000	Not Covered
Coulter Student Health Center	Refer to Section V, Schedule of Benefits, for SHBP coverage of laboratory charges and dental care charges.	
Dental Care. Limited to <i>Injury</i> to sound natural teeth.	90% of <i>PA</i>	70% of <i>R&C</i>
Durable Medical Equipment , a written prescription must accompany the claim when submitted. Replacement equipment is not covered. Refer to end of Section V, Required State of Colorado Benefits, for exceptions for <i>Prosthetic Devices</i> .	90% of <i>PA</i> \$5,000 maximum per <i>Plan Year</i>	Not Covered

SCHEDULE OF BENEFITS

Section V

<p>Hospice Care, limited to 30 inpatient days maximum Per <i>Plan Year</i>/91 outpatient days maximum Per <i>Plan Year</i>. Visit maximums are in and out-of-network combined.</p>	90% of <i>PA</i>	70% of <i>R&C</i>
<p>Learning Disability Diagnosis and Treatment (including ADHD and ADD).</p> <p>This benefit requires referral from the CSM Counseling Center.</p>	Covered as any other service or supply up to a lifetime maximum benefit of \$600. This maximum does not apply to prescription drug coverage.	Not Covered
<p>NCAA Sanctioned Intercollegiate Sports Benefit, up to a maximum benefit of \$90,000 per <i>Injury</i>.</p>	Paid as any other <i>Injury</i> .	
<p>Organ Transplants</p>	90% of <i>PA</i> \$250 copay per hospital admission	Not Covered
<p>Pregnancy and Complication of Pregnancy. Voluntary termination of pregnancy is not covered.</p>	Paid as any other <i>Illness</i> .	
<p>Second and Third Surgical Opinion</p>	90% coverage.	70% of <i>Reasonable and Customary Charges</i> (after annual <i>Plan Year</i> deductible).
<p>Skilled Nursing Care, limited to 30 days Per <i>Plan Year</i> in and out-of-network combined. Co-payment waived if admitted directly to a <i>Skilled Nursing Facility</i> from an inpatient acute facility.</p>	90% of <i>PA</i> / \$250 copay per admission	70% of <i>R&C</i> /\$750 Deductible per admission
<p>Vision, provided at one exam per <i>Plan Year</i>.</p>	100% of <i>PA</i> \$25 copay per visit	70% of <i>R&C</i> \$25 deductible per visit
<p>Wellness and Travel Medicine Benefits</p> <p>Benefits are provided only for SHBP <i>Covered Students</i>.</p> <p>Medical expenses for travel-related immunizations and required diagnostic tests are covered under this benefit. Expenses for employment</p>	50% of <i>PA</i> up to a lifetime maximum benefit of \$300. Laboratory charges and immunization charges incurred at Coulter Student Health Center do not apply to this maximum benefit.	Not Covered

<p>physicals are not covered by this benefit.</p> <p>For Wellness, for all <i>SHBP-Covered Students</i> 20 years of age or older:</p> <ul style="list-style-type: none">a. Annual tests to determine blood hemoglobin, blood pressure, blood glucose level, amid blood cholesterol level; or, alternatively, low-density lipoprotein (LDL) level and blood high-density lipoprotein (HDL) level: andb. Annual consultation with a <i>Physician</i> to discuss lifestyle behaviors that promote health and well-being. <p>Laboratory, radiology, and other testing procedures are not covered except as specifically provided.</p>		
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State of Colorado Required Benefits

Some terms in this Section are included in the definitions but are not shown in italicized print as the definition may be used by Colorado statute or regulation and this definition may differ from the definition used for other purposes under the SHBP.

Benefits for Prosthetic Devices

Benefits will be paid for the *Reasonable and Customary Charges* for the purchase of *Prosthetic Devices*. Repairs and replacements of *Prosthetic Devices* are also covered unless necessitated by misuse or loss. Benefits shall be subject to all deductible, copayment, coinsurance, limitations, or any other provisions of the SHBP.

Benefits for Telemedicine Services

Benefits will be paid for *Covered Expenses* on the same basis as services provided through a face-to-face consultation for services provided through *Telemedicine* for an SHBP *Covered Person* residing in a county with one hundred fifty thousand or fewer residents. Nothing in this provision shall require the use of *Telemedicine* when in person care by a participating provider is available to an SHBP *Covered Person* within the provider network and within the SHBP *Covered Person's* geographic area. Benefits shall be subject to all deductible, copayment, coinsurance, limitations, or any other provisions of the SHBP.

Benefits for Mammography

Benefits will be paid for the actual expense incurred up to \$90.00 for *Low-Dose Screening Mammography* for the presence of occult breast cancer. Benefits will be provided according to the following guidelines:

1. A single baseline mammogram for women thirty-five to thirty-nine years of age.
2. A mammogram not less than once every two years for women forty years of age and under fifty years of age or more often for women with risk factors to breast cancer if recommended by her Physician.
3. A mammogram every year for women fifty to sixty-five years of age.

The deductible will not be applied to this benefit. Benefits shall be subject to all copayment, coinsurance, limitations or any other provisions of the SHBP.

Benefits for Diabetes

Benefits will be paid for the *Reasonable and Customary Charges* for all medically appropriate and necessary equipment, supplies, and outpatient diabetes self-management training and educational services including nutritional therapy if prescribed by a *Physician*. Diabetes outpatient self-management training and education shall be provided by a *Physician* with expertise in diabetes. Benefits shall be subject to all deductible, copayment, coinsurance, limitations, or any other provisions of the SHBP.

Benefits for Cervical Cancer Vaccines

Benefits are payable for the cost of cervical cancer vaccinations for all female *Covered Persons* under the age of 20 for whom a vaccination is recommended by the Advisory Committee on Immunization practices of the United States Department of Health and Human Services.

Benefits for Medical Foods

Benefits are payable for *Medical Foods* needed to treat inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids as specified below. Benefits for Prescription Drugs will be paid the same as any other *Illness* for *Medical Foods*, to the extent *Medically Necessary*, for home use for which a *Physician* has issued a written, oral or electronic prescription. Benefits will not be provided for alternative medicine. Coverage includes but is not limited to the following diagnosed conditions: phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic acidemia; and propionic acidemia. Benefits do not apply to cystic fibrosis patients or lactose- or soy-intolerant patients.

There is no age limit on the benefits provided for inherited enzymatic disorders except for phenylketonuria. The maximum age to receive benefits for phenylketonuria is twenty-one years of age; except that the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is thirty-five years of age.

Benefits shall be subject to all deductible, copayment, coinsurance, limitations, or any other provisions of the SHBP.

Benefits for Prostate Cancer Screening

Benefits will be paid for actual charges incurred up to \$65 for an annual screening by a *Physician* for the early detection of prostate cancer. Benefits will be payable for one screening per year for any male Insured 50 years of age or older. One screening per year shall be covered for any male Insured 40 to 50 years of age who is at risk of developing prostate cancer as determined by the Insured's Physician. The screening shall consist of the following tests:

- 1) a prostate-specific antigen (PSA) blood test; and
- 2) digital rectal examination.

The deductible will not be applied to this benefit and this benefit will not reduce any diagnostic benefits otherwise allowable under the SHBP. Benefits shall be subject to all copayment, coinsurance, limitations, or any other provisions of the SHBP.

Benefits for Biologically Based Mental Illness

Benefits will be paid the same as any other *Illness* for the treatment of *Biologically Based Mental Illness* and other defined *Mental Conditions*. The benefit provided will not duplicate any other benefits provided in the SHBP. Benefits shall be subject to all deductible, copayment, coinsurance, limitations, or any other provisions of the SHBP.

Benefits for Psychotherapy

Benefits will be paid the same as any other *Illness* at a coinsurance percentage of 50% for Psychotherapy treatment subject to the following provisions:

Inpatient or Partial Hospitalization Benefits:

Benefits are limited to 45 days for inpatient care or 90 days for partial hospitalization care in any 12-month period. For the purpose of computing the period for which benefits are payable, the following will apply:

- 1) Two days of partial hospitalization shall reduce by one day the 45 days for inpatient care. One day of inpatient care shall reduce by two days the 90 days available for partial hospitalization.
- 2) Each day of inpatient confinement under this benefit or each two days of partial hospitalization shall reduce by one day, the total days available for all *Illnesses* for any one 12-month period.

Partial Hospitalization, for the purposes of this benefit, means continuous treatment for at least three hours, but not more than 12 hours during a 24-hour period.

Outpatient Benefits:

Refer to the Schedule of Benefits for enhanced coverage for *Students* obtaining a referral from the CSM Counseling Center and obtaining services from a Provider under direct contract to CSM.

Treatment will be provided for outpatient services furnished by 1) a comprehensive health care service corporation; or 2) a hospital, a community mental health center; or 3) other mental health clinic approved by the Colorado Department of Human Services to provide such care; or 4) a registered professional nurse; or 5) a licensed clinical social worker, acting within the scope of license; or 6) furnished by or under the supervision of a licensed physician or psychologist. Except as stated below, all such services must be provided by or under the supervision of a licensed physician or licensed psychologist; and records must show that the licensed physician or psychologist saw the patient or had a written summary of consultations or a personal consultation with the therapist at least once each 90 days.

Covered services under this benefit, which can legally be furnished by a registered professional nurse or licensed clinical social worker, acting within the scope of his or her license, will not require the supervision of a physician or psychologist. Reimbursement may be made directly to such provider. Outpatient Benefits are limited to \$10,000 in any 12-month period. Benefits are subject to all deductible, copayment, coinsurance, limitations, or any other provisions of the SHBP.

Benefits for Child Health Supervision Services

Benefits will be paid for the *Reasonable and Customary and Charges* for Child Health Supervision Services from birth up to the age of 13. Benefits are payable on a per visit basis to one health care provider per visit. Child Health Supervision Services rendered during a periodic review are covered only to the extent such services are provided during the course of one visit by, or under the supervision of a single physician, physician's assistant or registered nurse. Child Health Supervision Services means the periodic review of a child's physical and emotional status by a physician or other provider as above.

A review shall include but not be limited to a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, preventative services, and laboratory tests in keeping with prevailing medical standards. Immunizations are based on the recommended childhood immunization schedule and the recommended immunization schedule for children who start late or who are more than 1 month behind published by the CDC. Recommended schedules are available from:

Advisory Committee on Immunization Practices, www.cdc.gov/nip/acip;
American Academy of Pediatrics, www.aap.org;
American Academy of Family Physicians, www.aafp.org.

The SHBP deductible and dollar limits will not be applied to this benefit. Benefits shall be subject to all copayment, coinsurance, limitations, or any other provisions of the SHBP.

Benefits for Therapies for Congenital Defects and Birth Abnormalities

Benefits will be paid the same as any other *Illness* for physical, occupational and speech therapy for congenital defects and birth abnormalities for covered Dependent children beginning after the first 31 days of life to five years of age. Benefits will be paid for the greater of the number of such visits provided under the SHBP or twenty visits per year for each therapy. Benefits will be provided without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity. Benefits shall be subject to all deductible, copayment, coinsurance, limitations, or any other provisions of the SHBP.

Benefits for Cleft Lip or Cleft Palate

Benefits will be paid the same as any other *Illness* for treatment of newborn children born with cleft lip or cleft palate or both. Benefits shall include the *Medically Necessary* care and treatment including oral and facial surgery; surgical management; the *Medically Necessary* care by a plastic or oral surgeon; prosthetic treatment such as obturators, speech appliances, feeding appliances; *Medically Necessary* orthodontic and prosthodontic treatment; habilitative speech therapy, otolaryngology treatment; and audiological assessments and treatment. Benefits shall be subject to all deductible, copayment, coinsurance, limitations, or any other provisions of the SHBP.

Benefits for Hospitalization and General Anesthesia for Dental Procedures for Dependent Children

Benefits will be paid the same as any other *Illness* for general anesthesia, when rendered in a *Hospital*, outpatient surgical facility, or other facility licensed pursuant to Colorado Statute Section 25-3-101, and for associated *Hospital* or facility charges for dental care provided to a Dependent child. Such Dependent child shall, in the treating Physician's opinion, meet one or more of the following criteria:

1. The child has a physical, mental, or medically compromising condition;
2. The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy;

3. The child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or
4. The child has sustained extensive orofacial and dental trauma.

Benefits shall be subject to all deductible, copayment, coinsurance, limitations, or any other provisions of the SHBP.

Benefits for Colorectal Cancer Screening

Benefits will be paid for the total costs of tests related to preventive health care services for the early detection of colorectal cancer and adenomatous polyps. Benefits will be provided for an average risk adult *Covered Person* who is asymptomatic and age 50 or older. Benefits will also be provided for an *Covered Person* who is at high risk for colorectal cancer and who has:

1. A family medical history of colorectal cancer;
2. A prior occurrence of cancer or precursor neoplastic polyps;
3. A prior occurrence of chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or
4. Other predisposing factors as determined by *Covered Person's* health care provider

The deductible will not be applied to this benefit. Benefits shall be subject to all copayment, coinsurance, limitations, or any other provisions of the SHBP.

Benefits for Hearing Aids for Minor Children

Benefits will be paid for *Covered Expenses* for *Hearing Aids* for a *Minor Child* who has a hearing loss that has been verified by a licensed physician and a licensed audiologist. The *Hearing Aid* shall be medically appropriate to meet the needs of the *Minor Child* according to accepted professional standards.

Benefits shall include the purchase of the following:

1. Initial *Hearing Aids* and replacement *Hearing Aids* not more frequently than every five years;
2. A new *Hearing Aid* when alterations to the existing *Hearing Aid* cannot adequately meet the needs of the *Minor Child*; and
3. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to professional standards.

Benefits shall be subject to all deductible, copayment, coinsurance, limitations, or any other provisions of the Plan Document.

A. Hospital Charges

Room and board and other professional services on an inpatient or outpatient basis:

- (1) charges made for *Preadmission Tests* on an outpatient basis for a scheduled *Hospital* admission or surgery provided the tests are done within seven (7) days of the planned admission, and the surgery and the tests are accepted by the *Hospital* in place of the same post-admission tests;
- (2) charges made by a *Hospital* for room and board in a semiprivate room, *Intensive Care Unit*, cardiac care unit, or burn care unit, but excluding charges for a private room (unless *Medically Necessary*) which are in excess of the *Hospital's* semiprivate room rate;
- (3) charges made for *Routine Nursery Care* (including circumcision and *Provider's/Practitioner's* visits) while confined, even though no *Illness* or *Injury* exists;
- (4) charges made by a *Hospital* for necessary medical supplies and services, including X-rays, laboratory, and anesthetics and the administration thereof;
- (5) charges made by a *Hospital* for drugs and medicines obtained through written prescription by a *Provider/Practitioner*;
- (6) outpatient surgical services performed at a *Provider's/Practitioner's* office, *Ambulatory Surgical Center*, the outpatient department of a *Hospital*, *Birthing Center* or *Freestanding Health Clinic*;
- (7) charges made by a *Birthing Center* or *Freestanding Health Clinic* (Payment will be limited to the amount that would have been paid if that person were in a *Hospital*.);
- (8) charges for radiation, chemotherapy, or hemodialysis (renal therapy) at a *Medicare*-approved dialysis center;
- (9) charges for administration of infusions and transfusions (This includes the cost of unreplaced blood and blood plasma or autologous blood and blood plasma. Expenses for storage of autologous blood or blood plasma will not be covered.);
- (10) charges for inpatient respiratory, physical, occupational, inhalation, speech, and cardiac rehabilitation therapy;
- (11) emergency room charges; and
- (12) outpatient department charges.

Day Treatment/inpatient confinement in a licensed general *Hospital*, in a mental *Hospital* under the direction and supervision of the Department of Mental Health, or in a private mental *Hospital* licensed by the Department of Mental Health, or confinement in

a public or private *Alcoholism/Substance Addiction/Abuse* facility, for the treatment of a *Mental or Nervous Disorder* or *Alcoholism/Substance Addiction/Abuse*.

Note: *Biologically-Based Mental Illnesses* will be paid as any other *Illness* and shall not be subject to the forty-five (45) day maximum per person or ninety (90) partial days per person, per *Plan Year*.

Day treatment/inpatient confinement in a public or private *Alcoholism/Substance Addiction/Abuse* facility for the treatment of *Alcoholism* and *Substance Addiction/Abuse* is payable as described in the Schedule of Benefits up to a combined maximum (with inpatient *Mental or Nervous Disorder* treatment) of forty-five (45) days per person or 90 partial days per person, per *Plan Year*.

Every day of inpatient treatment will reduce the number of remaining *Day Treatment* days by two days. Conversely, every two days of *Day Treatment* will reduce the number of remaining inpatient treatment days by one day.

B. Skilled Nursing/Extended Care Facilities

Inpatient confinement in a *Skilled Nursing/extended care* facility and/or in a rehabilitation facility/*Hospital* is provided if:

- (1) charges are incurred within fourteen (14) days following a *Hospital* confinement which lasted three (3) days; and
- (2) the attending *Provider/Practitioner* certifies that twenty-four (24) hour nursing care is *Medically Necessary* for recuperation from the *Illness* or *Injury* which required the *Hospital* confinement.

C. Ambulance Services

Ambulance services must be:

- (1) to the nearest *Hospital* or medical facility which is equipped to provide the service required;
- (2) when *Medically Necessary*, from a *Hospital*; and
- (3) for an air ambulance or rail transportation when:
 - (a) required because the life of the patient would be endangered through the use of any other form of transportation; and
 - (b) used to transport the patient to the nearest medical facility equipped to provide care.

D. Diagnostic X-ray and Laboratory Services

Charges incurred for X-rays, microscopic tests, laboratory tests, allergy testing, electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved and performed by *Providers/Practitioners* throughout the United States.

E. Diagnostic Imaging and Scans

Charges incurred for diagnostic imaging and general imaging, including but not limited to, ultrasounds, MRI/MRA, CT/CAT, PET, and nuclear medicine.

F. Emergency Facilities

Charges incurred for *Medically Necessary* care at an emergency treatment center, walk-in medical clinic or ambulatory clinic (including clinics located at a *Hospital*).

G. Provider/Practitioner Services

Charges made by legally-licensed *Providers/Practitioners* for medical care and/or treatment including office visits, home visits, diagnostic eye exam, *Hospital* inpatient care, *Hospital* outpatient visits/exams, and clinic care.

H. Adult Routine Physical Exams

As stated in Section V, State of Colorado Required Benefits, charges incurred for routine adult physical examinations including all related charges and tests billed at the time of visit, including but not limited to, X-rays, laboratory, and clinical tests as provided for in the Schedule of Benefits.

I. Annual Gynecological Exam

Charges incurred for routine OB-GYN exams up to a maximum of one (1) exam per person, per *Plan Year*.

J. Routine Well Child Care

As provided in Section V, State of Colorado Required Benefits, charges incurred for routine *Well Child Care* up to age 13, including all charges billed at the time of visit in accordance with the standards and frequencies endorsed by the American Academy of Pediatrics. This includes, but is not limited to, charges for physical examinations, history, sensory screening, neuropsychiatric evaluation, and appropriate immunizations.

K. Routine Physical Examination Testing

As provided in Section V, State of Colorado Required Benefits, charges for one (1) routine cytological screening (Pap smear) per person, per *Plan Year*; one (1) routine mammogram per person, per *Plan Year* at age 35 and older (or as recommended by the *Pro-*

vider(s)/Practitioner(s) when there is a family history of breast cancer); one (1) routine PSA test per person, per *Plan Year*; and one (1) routine colonoscopy per person, per *Plan Year* at age 50 and older (or as recommended by the *Provider(s)/Practitioner(s)* when there is a family history of colon cancer).

L. Family Planning Services

Charges for Family Planning Services, including:

- (1) consultations, exams, procedures, and medical services related to the use of all contraceptive methods to prevent pregnancy that have been approved by the U.S. Food and Drug Administration (FDA);
- (2) injection of birth control drugs, including prescription injectibles when supplied by the *Provider/Practitioner* during the visit;
- (3) insertion of a levonorgestrel implant system (Norplant[®]), including the implant system itself; and
- (4) IUDs, diaphragms, and other prescription contraceptive methods approved by the FDA when the items are supplied by the *Provider/Practitioner* during the visit.

M. Second and Third Surgical Opinions

Charges incurred for a second surgical opinion, and, in some instances, a third opinion, are as follows:

- (1) fees of a legally-qualified *Provider/Practitioner* for a second surgical consultation when non-*Emergency* or elective surgery is recommended by the *Covered Person's* attending *Provider/Practitioner* (The *Provider/Practitioner* rendering the second opinion regarding the *Medical Necessity* of such surgery must be qualified to render such a service, either through experience, specialization training, education, or similar criteria, and must not be affiliated in any way with the *Provider/Practitioner* who will be performing the actual surgery.); and
- (2) fees of a legally-qualified *Provider/Practitioner* for a third consultation, if the second opinion obtained does not concur with the first *Provider's/Practitioner's* recommendation (This third *Provider/Practitioner* must be qualified to render such a service and must not be affiliated in any way with the consulting *Provider/Practitioner* or with the *Provider/Practitioner* who will be performing the actual surgery.).

N. Anesthesia Services

Charges by a *Provider/Practitioner* incurred for a surgical operation and for the administration of anesthesia.

O. Multiple Surgical Procedures

If two or more surgical procedures are performed at one time through the same incision in the same operative field, the maximum allowable amount for the surgery will be either the fee schedule amount for the primary procedure and 50% of the fee schedule amount for the secondary or lesser procedure(s), or if not in the network, the *Reasonable and Customary Charge* for the major procedure and 50% of the *Reasonable and Customary Charge* for the secondary or lesser procedure(s). No additional benefit will be paid under the SHBP for incidental surgery done at the same time and under the same anesthetic as another surgery.

P. Assistant Surgeons

The SHBP will also pay for a surgical assistant when the nature of the procedure is such that the services of an assistant, who is a *Provider/Practitioner*, are *Medically Necessary*.

Q. Dental Injury Related Services

The following dental procedures, including related *Hospital* expenses (when deemed to be *Medically Necessary*), will be covered the same as any other *Illness*:

- (1) treatment of an *Injury* to a sound natural tooth, other than from eating or chewing, including replacement of teeth and any related X-rays; and
- (2) dental services for children under the age of six who have a dental condition of significant dental complexity, or for *Covered Persons* who have exceptional medical circumstances or developmental disabilities for which *Medically Necessary Hospital* or surgical day care facility services, including administration of general anesthesia, are required, except as defined under Medical Benefit Exclusions.

R. Cosmetic Surgery

Charges for cosmetic purposes or for cosmetic surgery are covered if:

- (1) due solely to an *Accidental* bodily *Injury*, providing that coverage is in effect at the time that the *Injury* and treatment occur;
- (2) due solely to a birth defect of a covered dependent child, provided coverage is in effect at the time that the child is born and at the time that treatment occurs; or

- (3) due solely to surgical removal of diseased tissue as a result of an *Illness*. *Covered Persons* electing breast reconstruction, following a mastectomy, are also covered for reconstruction of the other breast to produce symmetrical appearance, and coverage for prostheses and physical complications of all stages of a mastectomy (The reconstruction procedure will be performed in a manner determined between the *Providers/Practitioners* and patient.).

S. Miscellaneous Surgical Procedures

Charges for surgical procedures including circumcision. Amniocentesis is included if deemed *Medically Necessary*. No benefits will be payable if amniocentesis is performed only to determine the sex of an infant before birth and for women under age thirty-five (35) unless certified as *Medically Necessary* by a *Provider/Practitioner*.

T. Mental or Nervous Disorder, Chemical Dependency and Substance Addiction/Abuse

Charges for the treatment of *Mental or Nervous Disorders* on an outpatient basis, up to a combined maximum (with outpatient *Alcoholism/Substance Addiction/Abuse* treatment) of thirty (30) visits per person, per *Plan Year*.

Charges for the treatment of *Alcoholism* and *Substance Addiction/Abuse* on an outpatient basis, up to a combined maximum (with outpatient *Mental or Nervous Disorder* treatment) of thirty (30) visits per person, per *Plan Year*. Services must be furnished by:

- (1) a comprehensive health service organization;
- (2) a licensed or accredited *Hospital*;
- (3) a community mental health center, or other mental health clinic or day care center which furnishes mental health services, subject to the approval of the Department of Mental Health;
- (4) a licensed detoxification facility;
- (5) a licensed social worker; or
- (6) a psychiatrist.

Provider(s)/Practitioner(s) visits for medication management will be considered separately and will not accumulate toward the *Mental or Nervous Disorder* benefit annual or period of coverage maximums.

Note: *Biologically-Based Mental Illnesses* are covered the same as any other *Illness* and are not subject the outpatient *Plan Year* maximum of thirty (30) visits.

U. Chiropractic Care

Charges made by a licensed chiropractor, up to a maximum of 40 visits per *Plan Year* (to be combined with Physiotherapy services).

V. Podiatry Services

Charges incurred for *Medically Necessary* treatment of the feet, including treatment of metabolic or peripheral vascular disease.

W. Inpatient Nursing Services

Services by a private duty nurse are eligible expenses (24-hour private duty nursing care is not a *Covered Expense*) when furnished by a Registered Nurse (R.N.), or Licensed Practical Nurse (L.P.N.), for necessary nursing care as evidenced by a written statement from the attending *Provider/Practitioner*, providing that the nurse is not an immediate member of the *Covered Person's* family and does not reside in the *Covered Person's* home.

X. Diabetic Care

Charges incurred for ambulatory diabetic self-management training and education, including:

- (1) medical nutrition therapy, used to diagnose or treat insulin dependent diabetes, non-insulin dependent diabetes, or gestational diabetes;
- (2) blood sugar kits, insulin and insulin infusion pumps, diabetic supplies for testing blood and urine specimens at home, syringes, monitors, or test strips and lancets; or
- (3) approved self-management education training as well as professional instructions, excluding printed material.

Y. Home Health Care Services

Charges made by a *Home Health Care Agency* for care in accordance with a *Home Health Plan*, up to a maximum of 60 visits per person, per *Plan Year*. Such expenses include charges for:

- (1) part-time or intermittent nursing care rendered by a Registered Nurse (R.N.);
- (2) a Licensed Practical Nurse (L.P.N.), a vocational nurse, or a public health nurse who is under the direct supervision of a Registered Nurse;
- (3) *Home Health* aides; and

- (4) medical supplies, drugs, and medications prescribed by a *Provider/Practitioner* and laboratory services by or on behalf of a *Hospital* to the extent that such items would have been covered by this SHBP had the *Covered Person* remained in the *Hospital*.

Home Health care means a visit by a member of a *Home Health* care team. Each such visit that lasts for a period of four (4) hours or less is treated as one (1) visit. No benefits will be provided for services and supplies not included in the *Home Health Plan*, services of any social worker, transportation services, *Custodial Care* and housekeeping, or for services of a person who ordinarily resides in the home of the *Covered Person*, or is a close relative of the *Covered Person*.

Z. Outpatient Rehabilitation Services

Charges incurred for outpatient rehabilitative therapy services include the following expenses.

- (1) Charges incurred for the treatment or services rendered by a physical therapist under direct supervision of a *Provider/Practitioner* in a home setting or a facility or institution whose primary purpose is to provide medical care for an *Illness* or *Injury*, or at a freestanding duly-licensed outpatient therapy facility up to a maximum of 40 visits per person per *Plan Year* (to be combined with Chiropractic Care services).
- (2) Charges incurred for inhalation therapy under the direct supervision of a *Provider/Practitioner* in a home setting or a facility or institution whose primary purpose is to provide medical care for an *Illness* or *Injury*, or at a freestanding duly-licensed outpatient therapy facility.
- (3) Charges incurred for the treatment and services rendered by a registered occupational therapist to restore physical function and provided under the direct supervision of a physician in a home setting or a facility or institution whose primary purpose is to provide medical care for an *Illness* or *Injury*, or at a freestanding duly-licensed outpatient therapy facility.
- (4) Charges incurred for the services of a legally-qualified speech therapist under the direct supervision of a physician for restorative or rehabilitative speech therapy for speech loss or impairment, other than a functional nervous disorder, or due to surgery performed on account of an *Illness* or *Injury*. If speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to therapy.
- (5) Charges incurred for cardiac rehabilitation program (limited to Phase I and Phase II only), provided such treatment is recommended by the attending *Provider/Practitioner* up to a maximum of twelve (12) weeks per person, per cardiac event. Phase I consists of acute inpatient hospitalization, whether for heart attack or heart surgery, highly supervised with a tailored exercise program with continuous monitoring during exercise. Phase II consists of out-

patient supervised treatment for *Covered Persons* who have left the *Hospital* but still need a certain degree of supervised physical therapy and monitoring during exercise. Phase II services are usually tailored to meet the *Covered Person's* individual needs. Benefits are not payable for Phase III, which consists of outpatient services without supervision. The Phase III program is developed for patients who are well enough to continue exercising on their own, monitoring their own progress.

AA. Pregnancy Care

Expenses relating to pregnancy and birthing are covered according to the following schedule.

- (1) Prenatal care of the mother and/or fetus is treated as any other *Illness* or *Injury* covered under the SHBP.
- (2) Inpatient care for the mother and/or newborn child will be provided for a minimum of 48 hours following a vaginal delivery, or a minimum of 96 hours following a cesarean section. However, the mother's or newborn's attending health care *Provider/Practitioner*, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable).
- (3) No authorization from the SHBP need be sought by the attending *Provider/Practitioner* for prescribing a length of inpatient stay for the mother or newborn not in excess of 48 hours (or 96 hours, as applicable). In any case, the 48- or 96-hour limit may be exceeded with authorization of the Claim Administrator in cases of *Medical Necessity*.
- (4) Genetic counseling and testing is provided only when *Medically Necessary* for pregnancy related care.
- (5) Therapeutic abortions (i.e. abortion procedures when the pregnancy is considered a life threatening complication of a non-psychiatric, medical condition) including instances of rape or incest (as documented in medical records and/or police reports).

BB. Mastectomy Care

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner to be determined in consultation with the attending *Provider/Practitioner* and the patient, for:

- (1) all stages of reconstruction of the breast on which the mastectomy was or is to be performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;

- (3) prostheses; and
- (4) treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductible, coinsurance, and/or co-payments applicable to other medical and surgical benefits provided under this SHBP.

CC. Miscellaneous Medical Services and Supplies

- 1) Charges for expendable supplies including, but not limited to, prescription drugs, medicines, oral contraceptives, contraceptive devices and Depo Provera[®] injections, insulin, surgical bandages, syringes, dressings, surgical supports, head halters, colostomy bags, catheters, crutches, splints, casts, trusses, traction apparatus, and cervical collars.
- (2) Charges for oxygen and other gasses and their administration.
- (3) Charges for the rental or the purchase (whichever is less) of prosthetic appliances to aid impaired functions including, but not limited to, wheelchairs, standard *Hospital*-type beds, mechanical respirators, iron lungs, bed rails, equipment for the administration of oxygen, *Hospital*-type equipment for hemodialysis, kidney or renal dialysis (including training of a person to operate and maintain equipment), and other *Medically Necessary* durable medical or surgical equipment. Expenses related to necessary repairs and maintenance are also covered.
- (4) Charges for wigs and artificial hairpieces, only after chemotherapy or radiation therapy and not due to the normal aging process or premature baldness. The lifetime benefit maximum is \$500.
- (5) Charges for appliances, prostheses, and orthopedic braces such as artificial arms and legs including accessories; orthotics, orthopedic or corrective shoes, and other supportive appliances for the feet (when *Medically Necessary* due to an *Injury* or *Illness*); arm, back, and neck braces; surgical supports; head halters; larynx appliances; eye prostheses; and breast prostheses (when *Medically Necessary* for breast removal); and surgical brassieres (limited to two (2) per person, per *Plan Year*) when purchased following a mastectomy. Replacement, repair, or adjustment is covered only when necessary due to physiological changes, or the replacement is less expensive than the repair of existing equipment. The *Plan Year* maximum benefit for Durable Medical Equipment is \$5,000.
- (6) Charges for compression therapy garments (e.g., Jobst[®] garments) when *Medically Necessary* due to an *Injury* or *Illness*.
- (7) Charges for chemotherapy (antineoplastic) when drugs are taken by infusion, perfusion, intracavity, or parenteral means.

- (8) Charges for *Medically Necessary* routine patient care incurred as a result of a treatment being provided in accordance with a clinical trial, to the extent that such costs would be covered by non-investigative treatments, if the treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer, or the treatment is being provided for any other life-threatening condition. Coverage for Phase I or Phase II clinical trials shall be decided on a case-by-case basis. Coverage is provided if Covered Medical Services are first approved by the Claims Administrator, subject to:
 - (a) treatment is being provided by an approved clinical trial;
 - (b) standard treatment has been or would be ineffective, does not exist, or there is no superior non-*Investigational* treatment alternatives;
 - (c) facility and personnel providing the treatment are capable of doing so by virtue of their experience and education; and
 - (d) available clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-*Investigational* alternative.
- (9) Charges for services related only to diagnosis of temporomandibular joint (TMJ) disorders (treatment of TMJ disorders is not covered).
- (10) Charges for growth hormones when prescribed by a board-certified pediatric endocrinologist and a written treatment plan is submitted for approval to the Claims Administrator. The *Covered Person* must be seen by the attending *Provider/Practitioner* every six (6) months and a written response to the treatment must be verified by the *Provider/Practitioner*. The medication will be covered for a thirty (30) day supply at a time;
- (11) Charges for allergy testing and treatment, including preparation of serum and injections.
- (12) Charges for titer when *Medically Necessary* and not for routine testing.
- (13) Charges for applicable state surcharges on covered benefits paid under the SHBP for which the *Covered Person* is legally liable, to the extent required by law.
- (14) Charges for other *Medically Necessary* services and supplies as prescribed by the attending *Provider/Practitioner* and determined to be *Medically Necessary* by the Claims Administrator.

DD. Hospice Care Benefits

Hospice care benefits are provided to a terminally-ill *Covered Person* with a life expectancy of less than six (6) months; or to members of his or her immediate family. Benefits are limited to:

- (1) room and board for a confinement in an inpatient *Hospice* facility;
- (2) ancillary charges furnished by the *Hospice* while the patient is confined therein, including rental of durable medical equipment which is used solely for treating an *Injury* or *Illness*;
- (3) medical supplies, drugs, and medicines prescribed by the attending *Provider/Practitioner*, but only to the extent that such items are necessary for pain control and management of the terminal condition;
- (4) *Provider/Practitioner* services and/or nursing care by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or a Licensed Vocational Nurse (L.V.N.);
- (5) *Home Health* aide services;
- (6) charges for home care furnished by a *Hospital* or *Home Health Care Agency*, under the direction of a *Hospice*, including *Custodial Care* if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse, or a *Home Health* aide;
- (7) medical social services by licensed or trained social workers, psychologists, or counselors;
- (8) nutrition services provided by a licensed dietitian;
- (9) respite care; and
- (10) bereavement counseling.

Bereavement counseling is a support service provided by the *Hospice* team to *Covered Persons* in the deceased's immediate family after the death of such terminally-ill person. Such visits are to assist the *Covered Persons* in adjusting to the death. Benefits will be payable provided:

- (a) on the date immediately before his or her death, the terminally-ill person was in a *Hospice Plan of Care* program and was a *Covered Person* under the SHBP; and
- (b) charges for such services are incurred by the *Covered Person(s)* within six (6) months of the terminally-ill person's death.

The term immediate family means: parents, spouse (or same-sex domestic partner) and children of the terminally-ill *Covered Person*.

EE. Organ Transplant Benefits

Expenses for an organ and/or tissue transplant will be subject to the following requirements.

(1) Covered Organ Transplants

human heart	kidney
bone marrow	cornea
liver	pancreas
lung	

(2) Preauthorization Requirement for Organ Transplants

Inpatient *Hospital Expenses Incurred* in connection with any organ or tissue transplant will be subject to Preadmission/Precertification Requirement for Hospitalization as described in Section VII of this Plan Document entitled Preadmission/Precertification. All potential transplant cases will be assessed for their appropriateness for Large Case Management.

(3) Transplant Benefit Period

Covered transplant expenses will accumulate during a Transplant Benefit Period and will be charged toward the Transplant Benefit Period maximums, if any, shown in the Schedule of Benefits. The term Transplant Benefit Period means the period which begins on the date of the initial evaluation and ends on the date which is twelve (12) consecutive months following the date of the transplant. If the transplant is a bone marrow transplant, the date the marrow is reinfused is considered the date of the transplant.

(4) Covered Transplant Expenses

Covered Expenses, with respect to transplants, refers to the fee schedule amount of *In-Network Preferred Providers*, or if not in the network, the *Reasonable and Customary Charges* for services and supplies which are covered under this SHBP (or which are specifically identified as covered only under this provision) and which are *Medically Necessary* and appropriate to the transplant. Such *Covered Expenses* include:

- (a) charges incurred in the evaluation, screening, and candidacy determination process;
- (b) charges incurred for organ transplantation; and
- (c) charges for organ procurement, including donor expenses which are not covered under the donor’s plan of benefits, subject to the following:

- Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving, and transporting the organ.
- Coverage for organ procurement from a living donor will be provided for the costs involved in screening the potential donor, as well as for medical expenses employed with removal of the donated organ and the related medical services provided to the donor in the interim and for follow-up care.
- If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the *Covered Person's* bone marrow (autologous) or donated marrow (allogenic). Coverage will also be provided for search charges to identify an unrelated match, treatment and storage costs of the marrow, up to the time of reinfusion. The harvesting of the marrow need not be performed within the Transplant Benefit Period.
- Coverage will be provided for follow-up care, including immunosuppressant therapy.
- Coverage will be provided for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual or in the event that the recipient or the donor is a minor, two other individuals. In addition, all reasonable and necessary lodging and meal *Expenses Incurred* during the Transplant Benefit Period will be covered.

(5) Re-Transplantation

Up to two re-transplants, for a total of three transplants, will be covered per person, per lifetime. Each transplant and re-transplant will have a new Transplant Benefit Period and a new maximum benefit.

(6) Accumulation of Expenses

Expenses Incurred during any one Transplant Benefit Period for the recipient and for the donor will accumulate towards the recipient's benefit and will be included in the SHBP's overall per person Maximum Lifetime Benefit.

(7) Donor Expenses

If the recipient is not covered under the SHBP, but the donor is, neither the donor nor the recipient is eligible for coverage; however,

- (a) if both the donor and recipient are covered under the SHBP, eligible charges incurred by both patients will be covered; or

- (b) if the recipient is covered under the SHBP, but the donor is not, the SHBP will provide coverage for eligible charges to both the recipient and donor as long as similar benefits are not available to the donor from other coverage sources.

FF. Wellness and Travel Medicine Benefits

In addition to State of Colorado Required Benefits, as specified in Section V, and other benefits provided by the SHBP, a general wellness and travel medicine benefit (including necessary travel immunizations) is provided for *SHBP-Covered Students* up to a combined lifetime maximum benefit of \$300. This maximum benefit does not apply to laboratory charges incurred at Coulter Student Health Center. Refer to the Schedule of Benefits for covered wellness services for adults age 20 and older.

The SHBP does not include any requirements for preadmission or precertification of services.

A. Covered Drugs

When all of the provisions of the SHBP are satisfied, the SHBP will provide benefits as specified in the Schedule of Benefits for the following *Medically Necessary* covered drugs, devices, and supplies:

- (1) Federal Legend Drugs and State-Restricted Drugs;
- (2) compounded medications of which at least one ingredient is a Legend Drug;
- (3) insulin;
- (4) oral, transdermal, intervaginal contraceptives (including devices and implants), or contraceptive injections;
- (5) blood factors up to a *Plan Year* maximum of \$50,000;
- (6) Legend smoking deterrents up to a lifetime maximum of \$500
- (7) Legend Vitamin B12 (all dosage forms); and
- (8) self-injectable prescription medications.

B. Dispensing Limits

The amount of any drug which may be dispensed per prescription or refill (regardless of the dosage form) is limited to a 30 day supply or 30 units, or 90 day supply for mail order, whichever is greater. Other dispensing limits may be imposed as required by federal or state regulation or for other reasons

C. Excluded Drugs

Some items which are excluded under the Prescription Benefits and Exclusions may also be Covered Medical Services as provided in Section VI of this Plan Document. Expenses for the following are not covered by the SHBP unless specifically listed as a covered benefit:

- (1) drugs not classified as Federal Legend Drugs (i.e., over-the-counter drugs and products);
- (2) non-systemic contraceptives;
- (3) fertility and impotency drugs;
- (4) Legend vitamins;
- (5) cosmetic drugs and drugs used to promote or stimulate hair growth;

- (6) biologicals, immunization agents, or vaccine (refer to Covered Medical Expenses for Wellness and Travel Medicine benefits and coverage under State of Colorado Required Benefits, as specified in Section V);
- (7) drugs labeled “Caution – limited by federal law to *Investigational* use,” or “*Experimental* drugs,” even though a charge is made to the individual;
- (8) any prescription refilled in excess of the number of refills specified by the ordering *Provider/Practitioner*, or any refill dispensed one year after the original order (As determined by the Plan Administrator, this provision may not apply, in whole or in part, to prescription benefits at CSM Health Services.);
- (9) medication dispensed in excess of the dispensing limits;
- (10) medication for which the cost is recoverable under any workers’ compensation or occupational disease law or any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made by the pharmacy or *Provider/Practitioner*;
- (11) services or products that are determined by the SHBP as not being *Medically Necessary*;
- (12) medications provided to an international *Student* in his or her home country;
- (13) any medication that would be excluded under Medical Benefit Exclusions, except as otherwise provided, stated in Section IX;
- (14) insulin needles/syringes;
- (15) Over-the-counter diabetic supplies;
- (16) allergy serums;
- (17) Anti-obesity medications; and
- (18) growth hormones.

D. Review of Prescription Drugs for Medical Necessity

All prescription drug charges are subject to review for *Medically Necessary* and for eligibility under the Prescription Benefits and Exclusions of the SHBP. This review process may require the *SHBP-Covered Person* to complete a claim form and submit it to the Claims Administrator.

A. Excluded Expenses

No benefits will be paid for loss or expense caused by, contributed to, or resulting from; or treatment, services or supplies for, at, or related to:

- (1) Any treatment that is not related to a covered *Injury* or *Illness*, or any service or supply that is not specifically listed in the Schedule of Benefits, Covered Medical Services, and/or Prescription Benefits and Exclusions sections of this Plan Document.
- (2) Charges incurred prior to the *Effective Date* of coverage under the SHBP, or after SHBP coverage is terminated, even if the *Illness* or *Injury* started while SHBP coverage was in force.
- (3) Charges for services or supplies that are submitted more than 12 months after the date of service.
- (4) Charges which exceed the fee schedule amount for *In-Network Preferred Providers* and which exceed the *Reasonable and Customary Charge* for *Out-of-Network Providers*.
- (5) Charges for services or supplies which are not *Medically Necessary* as defined in the section of this Plan Document entitled Definitions, whether or not prescribed and recommended by a *Provider(s)/Practitioner(s)*.
- (6) Except for benefits specifically stated as covered under the SHBP, charges for permanent dental restoration, dentures, oral surgery, including extraction of bone-impacted teeth, treatment of teeth and gum tissues, or dental X-rays. Charges are also excluded for treatment of Temporomandibular Joint Disorders (TMJ) and for orthognathic surgery
- (7) Except for benefits specifically provided as covered under the SHBP, charges for routine physical examinations, vaccinations, inoculations, or immunizations.
- (8) Except for benefits specifically provided as covered under the SHBP, charges for cosmetic or reconstructive surgery. Except as otherwise stated for newborn children, no benefits are provided under the SHBP for *Congenital* Conditions.
- (9) Charges for services and supplies furnished by or for the United States government or any other government, unless payment is legally required. Charges are also excluded for which there is no legal obligation to pay, such as that portion of any charge which would not have been made if the patient did not have SHBP coverage, or any charge for services or supplies which are normally furnished without charge.
- (10) Charges incurred in connection with an *Injury* arising out of, or in the course of, any employment for wage or profit, or disease covered with respect to such employment, by any Worker's Compensation Law, Occupational Disease Law or

similar legislation, with the exception of when a *Covered Person* is not covered by Worker's Compensation Law and lawfully chose not to be covered by such law. Charges are also excluded for services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered family member in the armed forces of a government.

- (11) Charges for any condition, disability, or expense sustained as a result of being engaged in:
 - (a) an illegal occupation;
 - (b) the commission or attempted commission of an assault or other illegal act;
 - (c) an intentional or accidental atomic explosion or other release of nuclear energy, whether in peacetime or wartime; or
 - (d) participation in a civil revolution, war, or act of war (whether declared or undeclared).
- (12) Charges for preparing medical reports, itemized bills, or claim forms. Charges are also excluded for mailing, shipping, and/or handling expenses, sales tax, broken appointments, or telephone calls.
- (13) Except as specifically provided, charges for travel expenses of a *Covered Person* other than local ambulance service to nearest medical facility equipped to treat the *Illness* or *Injury*.
- (14) Charges for services, supplies, or treatment not recognized by the American Medical Association as generally accepted and *Medically Necessary* for the diagnosis and/or treatment of an *Illness* or *Injury*, or for charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value.
- (15) Charges for drugs, devices, medical treatments, or procedures which are *Experimental* or *Investigational* as defined in Section XVII of this Plan Document entitled Definitions.
- (16) Except as specifically provided, charges for drugs, medicines, services, or supplies prescribed by a *Provider/Practitioner* when such prescription is made only on the basis of an online or telephonic consultation not preceded by an in-person medical examination with that *Provider/Practitioner*.
- (17) Charges for fluoride and vitamins, food supplements (except for benefits described in the Covered Medical Services and/or Prescription Benefits and Exclusions sections of this Plan Document), and any over-the-counter drugs or services or supplies which can be purchased without a prescription, or when no *Injury* or *Illness* is involved.

- (18) Except as specifically provided, charges for any service, care, procedure or program for weight or appetite control, weight loss, weight management, nutritional or dietary counseling (except as described herein), or for control of obesity even if the weight or obesity aggravates another condition, including but not limited to, gastric bypass, gastric stapling, balloon catheterization, liposuction, or reconstructive surgery.
- (19) Charges for any *Expenses Incurred* for communication, transportation, time spent traveling, or for expenses connected to traveling that may be incurred by a *Provider/Practitioner* or *Covered Person* in the course of rendering services.
- (20) Charges for personal comfort items (e.g., hot pads or hot water bottles), hygiene or convenience items such as televisions, telephones, radios, air conditioners, air purifiers, humidifiers, dehumidifiers, physical fitness equipment, or whirlpool baths, even if recommended or prescribed by a *Provider/Practitioner*. Any equipment, clothing, service, or supply that could also be used in the absence of treatment for *Illness* or *Injury* is not covered.
- (21) Charges for any expenses incurred for services and supplies related to sexual dysfunctions or inadequacies regardless of the cause, sex therapy, or for transsexual surgery and related preoperative and postoperative procedures or complications, which, as their objective, change the person's sex. Charges are also excluded for services and supplies related to penile prosthetic implants.
- (22) Charges for the diagnosis or treatment for the correction of *Infertility* (surgical or non-surgical), and any surgical impregnation procedures including, but not limited to,
 - (a) artificial insemination,
 - (b) reverse sterilization,
 - (c) in vitro fertilization (IVF),
 - (d) gamete intrafallopian transfer (GIFT), or
 - (e) *Infertility* medications.

Charges for services and supplies related to achieving pregnancy through a surrogate (gestational carrier).
- (23) Charges for reproductive sterilization (tubal ligation and vasectomy) and reversal of any reproductive sterilization procedure.
- (24) Charges for non-therapeutic abortions.
- (25) Charges for services related to adoption.

- (26) Except as provided for pregnancy, charges for genetic counseling, testing, or related services.
- (27) Charges for a residential treatment facility. Charges for *Custodial Care* which is designed essentially to assist the *Covered Person*, whether disabled or not, in meeting the activities of daily living, including services which constitute personal care, such as help in walking and getting in or out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision over medication which can normally be self-administered. Such services and supplies are deemed to be *Custodial Care* whenever and wherever furnished, without respect to the *Providers/Practitioners* by whom or by which they are prescribed, recommended, or performed. This exclusion does not apply to *Custodial Care* described under Section VI of this Plan Document entitled Covered Medical Services, Subsection DD entitled Hospice Care.
- (28) Charges for Friday, Saturday, and Sunday admissions, unless for *Emergency Care*. A Sunday admission will be allowed as long as a *Covered Person* is admitted less than twenty-four (24) hours prior to a *Covered Person's* surgery.
- (29) Charges for refractive eye surgery or procedures designed to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea, including but not limited to, LASIK, radial keratotomy, and keratomileusis surgery. Charges are also excluded for orthoptics and visual therapy for the correction of vision. Except as specifically provided, charges are also excluded for eye examinations for diagnosis or treatment of a refractive error, including the fitting of eyeglasses or contact lenses. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery.
- (30) Except as specifically provided, charges for services in connection with hearing examinations, *Hearing Aids* or such similar devices, or for the fitting of *Hearing Aids*.
- (31) Charges for educational, vocational, or training services and supplies. This exclusion does not apply to the treatment of diabetes.
- (32) Charges for expenses incurred for pastoral counseling, marriage counseling/therapy, music or art therapy (unless part of an inpatient program), assertiveness training, dream therapy, recreational therapy, stress management, or other supportive therapies.
- (33) Charges for hypnosis, massage therapy, rolfing, or biofeedback, unless biofeedback is approved by the CSM Counseling Center.
- (34) Charges for growth hormones.
- (35) Charges for services or supplies rendered by a homeopathic *Provider/Practitioner* or other health care *Provider/Practitioner* not specifically listed in the definition of *Provider(s)/Practitioner(s)*.

- (36) Charges for services incurred outside the United States if the *Covered Person* traveled to such location for the primary purpose of obtaining medical services, drugs, or supplies. Charges are also excluded for services incurred by an international *Student* for medical services in his or her home country.
- (37) Except as specifically provided, charges for services incurred for or related to smoking cessation programs and/or related program supplies.

B. Pre-existing Condition Limitation for Unqualified Late Enrollees

Unqualified Late Enrollees (as defined under Section IV, Subsection C, of this Plan Document entitled SHBP Eligibility) are subject to the following limitations.

(1) Pre-existing Condition

- (a) A Pre-existing Condition is any medical condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended by or received from a *Provider/Practitioner* in the six (6) month period immediately preceding the *Covered Person's Effective Date* under this SHBP. However, pregnancy does not constitute a Pre-existing Condition for the purpose of this Section IX (B).
- (b) A condition will cease to be a Pre-existing Condition when a *Covered Person* has been enrolled, beginning with his/her *Effective Date* under the SHBP, for a period of six (6) consecutive months, subject to Paragraph (e) below.
- (c) Notwithstanding any other provision in this SHBP, the restriction in Paragraph (b) above shall not apply to a newborn child, an adopted child under age 18, or a child under age 18 who has been placed for adoption with a *Covered Person* if that child becomes covered under this SHBP; any other group health plan; or any other *Creditable Coverage* within 30 days of birth, adoption, or placement for adoption, unless the child has a *Significant Break in Coverage*.
- (d) The exclusion of benefits for a Pre-existing Condition described in Paragraph (a) above shall not apply to a *Covered Person* who has resumed active participation in the SHBP immediately following a period of duty in the *Uniformed Service*, except with respect to a condition incurred by the *Covered Person*, or a condition that was aggravated, while the *Covered Person* was absent on duty in the *Uniformed Service*.
- (e) Notwithstanding any other provision in this SHBP, any period during which benefits for a Pre-existing Condition described in Paragraph (a) above otherwise would be excluded shall be reduced by the length of a *Covered Person's Creditable Coverage*, which is calculated by deter-

mining all days during which the *Covered Person* had one or more types of *Creditable Coverage*, without regard to specific benefits included in the coverage. However, the days of *Creditable Coverage* that occurred before a *Significant Break in Coverage* shall not be counted for the purpose of reducing any period of exclusion.

(2) Proof of Creditable Coverage

A *Covered Person* may prove *Creditable Coverage* by either of two methods.

(a) First, by presenting a written *Certificate of Coverage* from the source or entity that provided the coverage showing:

- the date the *Certificate* was issued;
- the name of the group health plan that provided the coverage;
- the name of the *Covered Person* to whom the *Certificate* applies;
- the name, address, and telephone number of the plan administrator or issuer providing the *Certificate*;
- a telephone number for further information (if different);
- either (1) a statement that the *Covered Person* has at least six (6) months of *Creditable Coverage*, not counting days of coverage before a *Significant Break in Coverage*, or (2) the date any waiting period (and affiliation period, if applicable) began and the date *Creditable Coverage* began; and
- the date *Creditable Coverage* ended, unless the *Certificate* indicates that coverage is continuing as of the date of the *Certificate*.

(b) Second, if the *Covered Person* for any reason is unable to obtain a *Certificate* from another plan, he/she may demonstrate *Creditable Coverage* by other evidence, including but not limited to, documents, records, third-party statements, or telephone calls by the SHBP to a third-party provider of medical services.

(3) Notice of Pre-existing Condition Exclusion

(a) If, within a reasonable time after receiving the information about *Creditable Coverage* described in Paragraph (2) above, this SHBP determines that an exclusion for Pre-existing Conditions applies, it will notify the *Covered Person* of that conclusion and will specify the source of any information on which it relied in reaching the determination. Such notification also will explain the SHBP's appeals procedures and give the *Covered Person* a reasonable opportunity to present additional evidence.

(b) If the SHBP later determines that a *Covered Person* did not have the claimed *Creditable Coverage*, the SHBP may modify its initial deter-

mination to the contrary. In that case, the *Covered Person* will be notified of the reconsideration; however, until a final determination is reached, the SHBP will act in accordance with its initial determination in favor of the *Covered Person* for the purpose of approving medical services.

- (c) The SHBP will assist in obtaining a *Certificate* from any prior plan or issuer, if necessary.

A. Maximum Benefits under All Plans

If any *Covered Person* covered under the SHBP is also covered under one or more Other Plan(s), and the sum of the benefits payable under all the plans exceeds the *Covered Person's* eligible charges during any claim determination period, then the benefits payable under all the plans involved will not exceed the eligible charges for such period as determined under the SHBP. Benefits payable under another plan are included, whether or not a claim has been made. For these purposes,

- (1) claim determination period means a calendar year; and
- (2) eligible charge means any necessary, reasonable, and customary item of which at least a portion is covered under the SHBP, but does not include charges specifically excluded from benefits under the SHBP that may also be eligible under any Other Plans covering the *Covered Person* for whom the claim is made.

B. Other Plan

Other Plan means the following plans providing benefits or services for medical and dental care or treatment:

- (1) group insurance or any other arrangement for coverage for *Covered Persons* in a group, whether on an insured or uninsured basis;
- (2) Blue Cross, Blue Shield, or any other prepayment coverage, including health maintenance organizations (HMOs), *Medicare*, or Medicaid; or
- (3) no-fault automobile insurance. (For purposes of the SHBP, in states with compulsory no-fault automobile insurance laws, each *Covered Person* will be deemed to have full no-fault coverage to the maximum available in that state. The SHBP will coordinate benefits with no-fault coverage as defined in the state of residence, whether or not the *Covered Person* is in compliance with the law, or whether or not the maximum coverage is carried.)

C. Determining Order of Payment

For the purpose of coordination of benefits for injuries incurred during the practice or play of NCAA-Sanctioned Intercollegiate Sports, the SHBP provides benefits on an always secondary payor basis in coordination of benefits with other group or individual health insurance plans. For all other expenses, if a *Covered Person* is covered under two or more plans, the order in which benefits will be determined is as follows.

- (1) The plan covering the *Covered Person* as a subscriber pays benefits first. The plan covering the *Covered Person* as an *Eligible Dependent* pays benefits second.

- (2) If no plan is determined to have primary benefit payment responsibility under (1) above, then the plan that has covered the *Covered Person* for the longest period has the primary responsibility.
- (3) A plan that has no Coordination of Benefits provision will be deemed to have primary benefit payment responsibility.
- (4) The plan covering the parent of the *Eligible Dependent* child pays first if the parent's birthday (month and day of birth, not year) falls earlier in the calendar year. The plan covering the parent of an *Eligible Dependent* child pays second if the parent's birthday falls later in the calendar year.
- (5) In the event that the parents of the *Eligible Dependent* child are divorced or separated, the following order of benefit determination applies:
 - (a) the plan covering the parent with custody pays benefits first;
 - (b) if the parent with custody has not remarried, then the plan covering the parent without custody pays benefits second;
 - (c) if the parent with custody has remarried, then the plan covering the step-parent pays benefits second, and the plan covering the parent without custody pays benefits third; and
 - (d) if a divorce decree or other order of a court of competent jurisdiction places the financial responsibility for the child's health care expenses on one of the parents, then the plan covering that parent pays benefits first.

D. Facilitation of Coordination

For the purpose of Coordination of Benefits, the Claims Administrator:

- (1) may release to, or obtain from, any other insurance company or other organization or individual any claim information, and any *Covered Person* claiming benefits under the SHBP must furnish any information that the Plan Administrator may require;
- (2) may recover on behalf of the SHBP any benefit overpayment from any other individual, insurance company, or organization; and
- (3) has the right to pay to any other organization an amount it will determine to be warranted, if payments that should have been made by the SHBP have been made by such organization.

A. Allocation of Authority

The Plan Administrator will control and manage the operation and administration of the SHBP. The Plan Administrator shall have the sole and exclusive right and discretion:

- (1) to interpret the SHBP, the Plan Document, and any other writings affecting the establishment or operation of the SHBP, both as to legal import and as to the application of the provisions of any such documents to the facts of a particular claim for benefits, and to decide all matters arising under the SHBP, including the right to remedy possible ambiguities, inconsistencies, or omissions; and
- (2) to make factual findings and decide conclusively all questions regarding any claim for benefits made under the SHBP.

All determinations of the Plan Administrator with respect to any matter relating to the administration of the SHBP will be conclusive and binding on all persons.

B. Powers and Duties of Plan Administrator

The Plan Administrator will have the following powers and duties:

- (1) to require any person to furnish such reasonable information as the Plan Administrator may request for the proper administration of the SHBP as a condition to receiving any benefits under the SHBP;
- (2) to make and enforce such rules and regulations and prescribe the use of such forms as the Plan Administrator will deem necessary for the efficient administration of the SHBP;
- (3) to decide on questions concerning the SHBP, or the eligibility of any person to participate in the SHBP, in accordance with the provisions of the SHBP;
- (4) to determine the amount of benefits that will be payable to any person in accordance with the provisions of the SHBP;
- (5) to inform *Covered Person(s)*, as appropriate, of the amount of such benefits payable in accordance with the provisions of the SHBP;
- (6) to provide a full and fair review to any *Covered Person* whose claim for benefits under the SHBP has been denied in whole or in part;
- (7) to designate other persons to carry out any duty or power that would otherwise be a fiduciary or clerical responsibility of the Plan Administrator under the terms of the SHBP;

- (8) to retain such actuaries, accountants, consultants, third-party administration services, legal counsel, or other specialists, as the Plan Administrator may deem appropriate and necessary for the SHBP's effective administration; and
- (9) to perform any other functions or actions that would commonly be within the purview of a similarly situated administrator for a student health insurance/benefits plan.

C. Delegation by the Plan Administrator

The Plan Administrator may employ the services of such persons (including an insurance company or third party administrator) as it may deem necessary or desirable in connection with the administration of claims or other operations of the SHBP.

The Plan Administrator also will have the power and duty to retain the services of one or more health care professionals, for the purpose of reviewing benefit claims that are under appeal for reasons based on medical judgment, such as *Medical Necessity* or *Experimental* treatments.

The Plan Administrator (and any person to whom any duty or power in connection with the operation of the SHBP is delegated) may rely upon all tables, valuations, certificates, reports, and opinions furnished by any duly-appointed actuary, accountant, consultant, third-party administration service, legal counsel, or other specialist, and the Plan Administrator or such delegate will be fully protected in respect to any action taken or permitted in good faith in reliance upon such table, valuations, certificates, etc.

D. Payment of Administrative Expenses

All reasonable costs incurred in the administration of the SHBP including, but not limited to, administrative fees and expenses owed to any third-party administrative service, actuary, consultant, accountant, specialist, or other person or organization that may be employed by the Plan Administrator in connection with the administration thereof, will be paid by the Plan Sponsor unless the Plan Administrator directs the SHBP to pay such expenses and such payment by the SHBP is permitted by law.

E. Fiduciary Liability

To the extent permitted by law, neither the Plan Administrator nor any other person will incur any liability for any acts or failure to act.

A. Termination Events

The coverage of any *Covered Person* shall automatically cease immediately upon the earliest day indicated below:

- (1) on the day in which the *Covered Person* ceases to be in a class of eligible *Students* or *Eligible Dependents* (except in the case of a *Student* who is withdraws from the Colorado School of Mines after the date in a coverage period when no portion of the *Student's* tuition/fee billing is refunded by the University – see Section VI A);
- (2) on the day in which the Plan Administrator terminates the *Covered Person's* coverage;
- (3) on the day the SHBP terminates;
- (4) on the day in which the *Covered Person* dies;
- (5) on the day in which the *Covered Person* enters service in the *Uniformed Services* on an active-duty basis; or
- (6) at the end of the *Plan Year* for a spouse who is divorced from a *Covered Student* during the *Plan Year*.

The coverage of an *Eligible Dependent* who has attained the maximum age limit shall not terminate if such *Eligible Dependent* is permanently and *Totally Disabled* (as defined in Internal Revenue Code section 22(e) (B) and in Section XVII of this Plan Document, entitled Definitions), at any time during the calendar year in which the taxable year of the *Covered Student* begins. Written proof of such *Eligible Dependent's* permanent and *Total Disability* must be submitted on an annual basis to the Plan Administrator, and the Plan Administrator reserves the right to require, at its expense, an independent medical, psychiatric, or psychological evaluation or examination in connection with any such annual review of such *Eligible Dependent's* disability status.

B. Certificate of Creditable Coverage

As mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the SHBP will provide a *Certificate of Coverage* to any *Covered Person* after the *Covered Student* loses coverage under the SHBP. In addition, a *Certificate* will be provided upon request, if the request is made within twenty-four (24) months after the *Covered Student* loses coverage under the SHBP. In that case, the *Certificate* will be provided at the earliest time that the SHBP, acting in a reasonable and prompt fashion, can furnish said *Certificate*.

The SHBP will make reasonable efforts to locate and provide *Certificates of Coverage* with respect to *Eligible Dependents*. However, although the SHBP will make reasonable efforts to collect information applicable to any *Eligible Dependents* of the *Covered*

Student and to include that information on the *Certificate*, the SHBP will not issue an automatic *Certificate* for *Eligible Dependents* until the SHBP has reason to know that an *Eligible Dependent* has lost coverage under the SHBP.

C. Medical Leave of Absence

Any full-time *Student* enrolled in the SHBP who, as a result of an *Injury* or *Illness*, is *Totally Disabled*, will be eligible to continue coverage under the SHBP for himself/herself (and for his/her *Eligible Dependents* who are enrolled in the SHBP at the time the *Medical Leave of Absence* commences) subject to the payment of the necessary contributions required under the SHBP. Certification of the *Medical Leave of Absence* must be made by the *Student's Provider/Practitioner* and such certification must be presented to and approved by the Plan Administrator. The *Medical Leave of Absence* cannot extend beyond a period of twelve (12) months for the purposes of eligibility under the SHBP.

For the purpose of this *Medical Leave of Absence* provision, full-time *Student* status is defined by the Registrar for the Colorado School of Mines for each class of *Students*.

D. Continuation of Coverage

Except as provided in Section C, Medical Leave of Absence, the SHBP does not offer Continuation of Coverage in the event a *Covered Person* loses coverage under the SHBP. The SHBP is not subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) affords protection to patients from unwarranted disclosure of private medical information by specifying those situations in which, and those persons to whom, personal information may be disclosed.

A. Permitted Disclosures

There are three circumstances under which the SHBP may disclose an individual's protected health information to the Plan Sponsor.

- (1) The SHBP may inform the Plan Sponsor whether an individual is enrolled in the SHBP.
- (2) The SHBP may disclose summary health information to the Plan Sponsor. The Plan Sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the SHBP. Summary health information is information that summarizes claims history, claims expenses, and/or types of claims without identifying the individual.
- (3) The SHBP may disclose an individual's protected health information to the Plan Sponsor for SHBP administrative purposes. This is because the Plan Sponsor performs many of the administrative functions necessary for the management and operation of the SHBP. The Plan Sponsor has certified to the SHBP that the SHBP's terms have been amended to incorporate the terms of this summary. The Plan Sponsor has agreed to abide by the terms of this summary. The SHBP's privacy notice also permits the SHBP to disclose an individual's protected health information to the Plan Sponsor as described in this summary.

B. Restrictions on Use and Disclosure

The restrictions that apply to the Plan Sponsor's use and disclosure of an individual's protected health information are as follows.

- (1) The Plan Sponsor will only use or disclose an individual's protected health information for SHBP administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the SHBP's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- (2) If the Plan Sponsor discloses any of an individual's protected health information to any of its agents or subcontractors, the Plan Sponsor will require the agent or subcontractor to keep an individual's protected health information confidential as required by the HIPAA regulations.
- (3) The Plan Sponsor will not use or disclose an individual's protected health information for CSM admissions-related or employment-related actions or de-

cisions or in connection with any other benefit or benefit plan of the Plan Sponsor unless permitted under HIPAA.

- (4) The Plan Sponsor will promptly report to the SHBP any use or disclosure of an individual's protected health information that is inconsistent with the uses or disclosures allowed in this summary.
- (5) The Plan Sponsor will allow an individual or the SHBP to inspect and copy any protected health information about that individual who is in the Plan Sponsor's custody and control. The HIPAA Regulations set forth the rules that an individual and the SHBP must follow in this regard. There are some exceptions to this provision allowed under federal regulations.
- (6) The Plan Sponsor will amend, or allow the SHBP to amend, any portion of an individual's protected health information to the extent permitted or required under the HIPAA Regulations.
- (7) With respect to some types of disclosures, the Plan Sponsor will keep a disclosure log for a period of not less than six (6) years. An individual has a right to see the disclosure log. The Plan Sponsor does not have to maintain the log if disclosures are for certain SHBP-related purposes, such as payment of benefits or health care operations.
- (8) The Plan Sponsor will make its internal practices, books, and records relating to its use and disclosure of an individual's protected health information available to the SHBP and to the U.S. Department of Health and Human Services.
- (9) The Plan Sponsor will, if feasible, return or destroy all of an individual's protected health information in the Plan Sponsor's custody or control that the Plan Sponsor has received from the SHBP or from any business partner, agent, or subcontractor when the Plan Sponsor no longer needs an individual's protected health information to administer the SHBP. If it is not feasible for the Plan Sponsor to return or destroy an individual's protected health information, the Plan Sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information not feasible.

C. Authorized Recipients of Protected Health Information

The following classes of individuals or other workforce members under the control of the Plan Sponsor may be given access to an individual's protected health information on a need-to-know basis, solely for the purposes set forth above:

- (1) Director of Finance and Administration, Health Services, CSM;

- (2) Chair of the Student Health Insurance Advisory Committee;
- (3) Executive Director for Health Services, CSM; or
- (4) Professional staff and/or clinicians or counselors of CSM Health Services and Counseling Center.

This list includes every class of individuals or other workforce members under the control of the Plan Sponsor who may receive an individual's protected health information. If any of these individuals or workforce members use or disclose an individual's protected health information in violation of the rules that are set out in this summary, the responsible individual(s) or workforce member(s) will be subject to disciplinary action and sanctions. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to the SHBP and will cooperate with the SHBP to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to the individual.

D. Security Provisions

The Plan Sponsor will receive or generate electronic protected health information. The information may be identified to the individual in some cases. In relation to such electronic protected health information, the Plan Sponsor certifies to the SHBP that it agrees:

- (1) to take appropriate and reasonable safeguards (administrative, physical, and technical) to protect the confidentiality, integrity, and availability of the information it creates, receives, maintains, or transmits;
- (2) to require that any agent or subcontractor of the Plan Sponsor agrees to the same requirements that apply to the Plan Sponsor under this provision;
- (3) to report to the SHBP any security incident of which the Plan Sponsor becomes aware; and
- (4) to apply reasonable and appropriate security measures to maintain adequate separation between the SHBP and Plan Sponsor.

A. Payment Condition

- (1) The SHBP may elect, but is not required, to conditionally advance payment of medical benefits in those situations where an *Injury, Illness*, disease, or disability is caused, in whole or in part, by, or results from, the acts or omissions of a third party, or the acts or omissions of a *Covered Person* (“SHBP Beneficiary”) where any insurance coverage, no-fault, uninsured motorist, underinsured motorist, medical payment provision, or other insurance policies or funds (“Coverage”) is available.
- (2) A SHBP Beneficiary, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees, by acceptance of the SHBP’s payment of medical benefits, to maintain one hundred percent (100%) of the SHBP’s payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust and without dissipation except for reimbursement to the SHBP or its assignee. By accepting benefits under the SHBP, the SHBP Beneficiary recognizes the property right or equitable interest of the SHBP in any cause of action the SHBP Beneficiary may have and the proceeds thereof.
- (3) In the event a SHBP Beneficiary settles, recovers, or is reimbursed by any third party or Coverage, the SHBP Beneficiary agrees to reimburse the SHBP for all benefits paid or that will be paid. The SHBP Beneficiary acknowledges that the SHBP has the first priority right of recovery and a first lien to the extent of benefits provided by the SHBP. If the SHBP Beneficiary fails to reimburse the SHBP for all benefits paid or to be paid out of any judgment or settlement received, the SHBP Beneficiary will be responsible for any and all expenses (fees and costs) employed with the SHBP’s attempt to recover such money from the SHBP Beneficiary.

B. Subrogation

- (1) As a condition to participating in and receiving benefits under this SHBP, the SHBP Beneficiary agrees to subrogate the SHBP to any and all claims, causes of action or rights that may arise against any person, corporation, and/or entity, and to any Coverage for which the SHBP Beneficiary claims an entitlement, regardless of how classified or characterized. The SHBP Beneficiary agrees to reimburse the SHBP for any such benefits paid when judgment or settlement is made.
- (2) If the SHBP Beneficiary decides to pursue a third party or any Coverage available as a result of the said *Injury* or condition, the SHBP Beneficiary agrees to include the SHBP’s subrogation claim in that action. If there is a failure to do so, the SHBP will be legally presumed to be included in such action.
- (3) The SHBP may, in its own name or in the name of the SHBP Beneficiary or their personal representative, commence a proceeding or pursue a claim against such other third party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or payments advanced by the SHBP.

- (4) The SHBP Beneficiary then authorizes the SHBP to pursue, sue, compromise, or settle any such claims in their name and agrees to cooperate fully with the SHBP in the prosecution of any such claims.* This includes the failure of the SHBP Beneficiary to file a claim or pursue damages against:
- (a) the responsible party, their insurer, or any other source on behalf of that party;
 - (b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, or uninsured or underinsured motorist coverage;
 - (c) any policy of insurance from any insurance company or guarantor of a third party;
 - (d) any worker's compensation or other liability insurance company; or
 - (e) any other source, including but not limited to, crime victim restitution funds, any medical, disability, or other benefit payments, and school insurance coverage.

* The SHBP Beneficiary, his or her guardian, or the estate of a SHBP Beneficiary, assigns all rights to the SHBP or its assignee to pursue a claim and the recovery of all expenses from any sources listed above.

C. Right of Reimbursement

- (1) The SHBP shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs, or application of the common fund doctrine, the make whole doctrine, the Rimes Doctrine, or any other similar legal theory, and without regard to whether the SHBP Beneficiary is fully compensated by his/her net recovery from all sources. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the SHBP Beneficiary's recovery is less than the benefits paid, then the SHBP is entitled to be paid all of the recovery achieved.
- (2) The SHBP will not be responsible for any expenses, attorney fees, costs, or other monies incurred by the attorney for the SHBP Beneficiary or his/her beneficiaries, commonly known as the common fund doctrine. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of a litigious nature may be deducted from the SHBP's recovery without the prior, expressed written consent of the SHBP.

- (3) Furthermore, it is prohibited for the SHBP Beneficiary to settle a claim against a third party or any available coverage for certain elements of damages, but eliminating damages relating to medical *Expenses Incurred*.
- (4) The SHBP's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the SHBP Beneficiary, whether under the doctrines of causation, comparative fault, or contributory negligence, or any other similar doctrine in law. Accordingly, any so-called "lien reduction statutes" which attempt to apply such laws and reduce a subrogating SHBP's recovery for any reason, will not be applicable to the SHBP and will not reduce the SHBP's subrogation recovery.
- (5) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the SHBP and signed by the SHBP Beneficiary.
- (6) This provision shall not limit any other remedies of the SHBP provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable *Illness, Injury*, disease, or disability.

D. Excess Insurance

If at the time of *Injury, Illness*, disease, or disability there is available, or potentially available, based on information known or provided to the SHBP or to the SHBP Beneficiary any other Coverage including, but not limited to, judgment at law or settlements, the benefits under this SHBP shall apply only as excess insurance over such other sources of indemnification. The SHBP's benefits shall be excess to:

- (1) the responsible party, their insurer, or any other source on behalf of that party;
- (2) any first party insurance through medical payment coverage, personal injury protection, no-fault insurance, or uninsured or underinsured motorist coverage;
- (3) any policy of insurance from any insurance company or guarantor of a third party;
- (4) any worker's compensation or other liability insurance company; and
- (5) any other source including, but not limited to, crime victim restitution funds, any medical, disability, or other benefit payments, and school insurance coverage.

E. Wrongful Death Claims

In the event that the SHBP Beneficiary dies as a result of his or her *Injuries* and a wrongful death or survivor claim is asserted against a third party or any Coverage under the laws of any state, the SHBP's subrogation and reimbursement rights still apply.

F. Obligations

- (1) It is the SHBP Beneficiary's obligation:
 - (a) to cooperate with the SHBP, or any representatives of the SHBP, in protecting its rights of subrogation and reimbursement, including completing discovery, attending depositions, and/or attending or cooperating in a trial in order to preserve the SHBP's subrogation rights;
 - (b) to provide the SHBP with pertinent information regarding the *Injury*, including accident reports, settlement information, and any other requested additional information;
 - (c) to take such action and execute such documents as the SHBP may require to facilitate enforcement of its subrogation and reimbursement rights;
 - (d) to do nothing to prejudice the SHBP's rights of subrogation and reimbursement;
 - (e) to promptly reimburse the SHBP when a recovery through settlement, judgment, award, or other payment is received;
 - (f) to not settle, without the prior consent of the SHBP, any claim that the SHBP Beneficiary may have against any legally-responsible party or insurance carrier; and
 - (g) to refrain from releasing any party, person, corporation, entity, insurance company, or insurance policies or funds, that may be responsible for or obligated to the SHBP Beneficiary for the *Injury* or condition without obtaining the SHBP's written approval.
- (2) Failure to comply with any of these requirements by the SHBP Beneficiary, his or her attorney or guardian may, at the SHBP's discretion, result in a forfeiture of payment by the SHBP of medical benefits, and any funds or payments due under this SHBP may be withheld to satisfy the SHBP Beneficiary's obligation. If the SHBP Beneficiary fails to reimburse the SHBP for all benefits paid or to be paid, as a result of said *Injury* or condition, out of any judgment or settlement received, the SHBP Beneficiary will be responsible for any and all expenses (whether fees or costs) incurred with the SHBP's attempt to recover such money from the SHBP Beneficiary.

G. Minor Status

- (1) In the event the SHBP Beneficiary is a minor, as that term is defined by applicable law, the minor's parent(s) or court-appointed guardian shall cooperate in any and all actions requested by the SHBP to seek and obtain any requisite court approval in order to bind the minor and his or her estate insofar as the subrogation and reimbursement provisions are concerned.
- (2) If the minor's parent(s) or court-appointed guardian fail or refuse to take such action, the SHBP shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees incurred with obtaining such approval shall be paid by the minor's parent(s) or court-appointed guardian.

H. Language Interpretation

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

I. Severability

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

A. Amendment

The Plan Administrator has the right to amend this SHBP in any and all respects at any time, and from time to time, without prior notice. Any such amendment will be by a written instrument signed by a duly-authorized Officer of the Plan Sponsor. The Plan Administrator will notify all *Covered Persons* of any amendment modifying the material terms of the SHBP as soon as is administratively feasible after its adoption.

B. Termination of SHBP

Regardless of any other provision of the SHBP, the Plan Sponsor reserves the right to terminate the SHBP at any time without prior notice. Such termination will be evidenced by a written resolution of the Plan Sponsor. The Plan Administrator will provide notice of the SHBP's termination as soon as is administratively feasible.

A. Plan Funding

All benefits paid under the SHBP shall be paid in cash from the designated SHBP fund established and maintained by the Plan Sponsor. No person shall have any right, title, or interest whatever in or to any investment reserves, accounts, or funds that CSM may purchase, establish, or accumulate to aid in providing benefits under the SHBP. No person shall acquire any interest greater than that of an unsecured creditor.

B. In General

Any and all rights provided to any *Covered Person* under the SHBP shall be subject to the terms and conditions of the SHBP. This Plan Document shall not constitute a contract between the Plan Sponsor and any *Covered Person* nor shall it be consideration or an inducement for the initial or continued enrollment of any *Student* in the Colorado School of Mines. Likewise, maintenance of this SHBP shall not be construed to give any *Covered Person* the right to be retained as a *Covered Person* by the Plan Sponsor or the right to any benefits not specifically provided by the SHBP.

C. Waiver and Estoppel

No term, condition, or provision of the SHBP shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the SHBP, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and it shall operate only with regard to the specific term or condition waived, and it shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No *Covered Person* or eligible beneficiary other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

D. Non-Vested Benefits

Nothing in the SHBP shall be construed as creating any vested rights to benefits in favor of any *Covered Person*.

E. Interests Not Transferable

The interests of the *Covered Student* and their *Eligible Dependents* under the SHBP are not subject to the claim of their creditors and may not be voluntarily or involuntarily transferred, alienated, or encumbered without the written consent of the Plan Administrator.

F. Severability

If any provision of the SHBP shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the SHBP, but the SHBP shall be construed and enforced as if the invalid or illegal provision had never been inserted.

The Plan Sponsor shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the SHBP.

G. Headings

All section headings in this Plan Document have been inserted for convenience only and shall not determine the meaning of the content thereof.

The following words and phrases will have the following meanings when used in the within this Plan Document, unless a different meaning is plainly required by the context.

Accident/Accidental – means a sudden or unforeseen event which:

- (1) causes *Injury* to the physical structure of the body;
- (2) results from an external agent of trauma;
- (3) is definite as to time and place; and
- (4) may happen involuntarily and entail unforeseen consequences or may be the result of an intentional self-inflicted *Injury* and entail foreseeable consequences.

An *Accident* does not include harm resulting from a disease or *Illness* and will be determined by the Claims Administrator.

Alcoholism – means an alcohol-induced disorder which produces a state of psychological and/or physical dependence.

Ambulatory Surgical Center – means a specialized facility:

- (1) where coverage of services performed at such a facility is mandated by law, and such facility has been licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located; or
- (2) where coverage of services performed at such a facility is not mandated by law and meets all of the following requirements.
 - (a) It is established, equipped, and operated in accordance with the applicable laws in the jurisdiction in which it is located primarily for the purpose of performing surgical procedures.
 - (b) It is operated under the supervision of a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is devoting full-time to such supervision and permits a surgical procedure to be performed only by a duly-qualified *Provider/Practitioner* who, at the time the procedure is performed, is privileged to perform such procedure in at least one *Hospital* (as defined) in the area.
 - (c) It requires in all cases (other than those requiring only local infiltration anesthetics) that a licensed anesthesiologist or licensed *Practitioner/Provider* qualified to administer anesthesia, administers the anesthetics and remains present throughout the surgical procedure.
 - (d) It provides at least two operating rooms and at least one post-anesthesia recovery room; is equipped to perform diagnostic X-ray and laboratory examinations; and has trained personnel and necessary equipment and supplies available to handle

foreseeable emergencies, such equipment and supplies including but not limited to, a defibrillator, a tracheotomy set, and a blood bank or other blood supply.

- (e) It provides the full-time services of one or more Registered Nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room.
- (f) It maintains a written agreement with at least one *Hospital* in the area for immediate acceptance of patients who develop complications or require post-operative or post-treatment confinement.
- (g) It maintains an adequate medical record for each patient, such record to contain an admitting diagnosis, including, for all patients except those undergoing a procedure under local anesthesia, a pre-operative examination report, medical history, laboratory tests and/or X-rays, an operative report, and a discharge summary.

Annual Open Enrollment Period – means the period of time at the beginning of each *Plan Year* under policies determined and published by the Plan Administrator, during which *Students* may elect to enroll in the SHBP (including his or her dependents). *Students* first enrolling at CSM at periods other than the beginning of a *Plan Year* may also enroll in the SHBP under policies determined and published by the Plan Administrator. *Students* who waive enrollment in the SHBP cannot change their election for waiving SHBP coverage until the next *Annual Open Enrollment Period*. *Students* who attain other health insurance that would qualify for waiving SHBP coverage may apply to withdraw from the SHBP at the end of any semester *Coverage Period*.

Biologically-Based Mental Illness – means a schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Refer also to *Mental Disorder*.

Birthing Center – means a facility operated primarily for the purpose of providing treatment for obstetrical care for which it was duly incorporated as a *Birthing Center* and registered as a *Birthing Center* with the existing state. The *Birthing Center* must also be licensed, if required by law.

Certificate/Certificate of Coverage – means a written certification provided by any source that offers medical coverage, including the SHBP, for purposes of confirming the duration and type of a *Covered Person's Creditable Coverage*.

Congenital Condition(s) – means a condition existing since birth, regardless of whether the condition is diagnosed or treated and whether the condition is inherited or caused by environmental factors.

Coverage Period – means the various periods during which benefits provided under this Plan are available to a *Covered Person*.

Covered Expense(s) – means the fee schedule amount for *In-Network Provider(s)/Practitioner(s)* or the *Reasonable and Customary Charge* for *Out-of-Network Provider(s)*.

er(s)/Practitioner(s) for services or supplies provided for *Medically Necessary* treatment of an *Illness* or *Injury*. *Covered Expenses* may be subject to copayments, the annual *Plan Year* deductible, and/or coinsurance as are stated in Section V of this Plan Document entitled Schedule of Benefits.

Covered Person – means a *Student* or *Eligible Dependent* enrolled in this SHBP.

Covered Student – means any *Student* who enrolls in the SHBP and signs the enrollment application form on behalf of himself or herself, and on behalf of any *Eligible Dependents*, and pays the necessary contributions under the SHBP. *Covered Student* also means those *Students* who are automatically enrolled in the SHBP and pay the necessary contributions under the SHBP.

Creditable Coverage – means coverage a *Covered Person* had under any of the following sources: A group health plan, health insurance coverage, *Medicare*, Medicaid, medical and dental care for members and former members of the *Uniformed Services*, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Subscribers Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act.

Custodial Care – means care which is designed essentially to assist the *Covered Person*, whether disabled or not, in meeting the activities of daily living, including services which constitute personal care such as help in walking and getting in or out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision over medication which can normally be self-administered. Such services and supplies are deemed to be *Custodial Care* whenever and wherever furnished, without respect to the *Provider/Practitioner* by whom or by which they are prescribed, recommended, or performed.

Day Treatment – means mental health or *Substance Addiction/Abuse* care on an individual or group basis for more than two (2) hours but less than twenty-four (24) hours per day in either a licensed *Hospital*, rural health center, community mental health center or *Substance Addiction/Abuse* treatment facility. This type of care is also referred to as partial hospitalization.

Effective Date – means either the first day of the *Plan Year* or the first date of any *Coverage Period*. The *Effective Date* may be earlier than the first day of the *Plan Year* under certain circumstances established by CSM and published in this Plan Document or subsequent amendment. For Qualified Late Enrollees and newly acquired dependents, the *Effective Date* will be the first date of the month for SHBP coverage, unless otherwise specified in this Plan Document.

Effective Treatment of Alcoholism/Substance Addiction/Abuse – is a program of *Alcoholism/ Substance Addiction/Abuse* therapy that meets all of the following requirements.

- (1) It is prescribed and supervised by a qualified *Provider/Practitioner*.

- (2) The *Provider/Practitioner* certifies that a follow-up program has been established which includes therapy by a *Provider/Practitioner*, or group therapy under a *Provider's/Practitioner's* direction at least once per month.
- (3) It includes attendance at least twice a month at meetings of organizations devoted to the therapeutic treatment of *Alcoholism/Substance Addiction/Abuse*.

Treatment for maintenance care is not considered *Effective Treatment*. Maintenance care consists of the providing of an environment without access to alcohol or drugs.

Eligible Dependent(s) – means person(s) eligible for coverage under the SHBP as a dependent of a *Covered Student* as defined in Section IV of this Plan Document, entitled SHBP Eligibility.

Emergency/Emergency Care – means treatment in a *Hospital*, clinic, or *Provider's/Practitioner's* office for any *Injury* or *Illness* that requires immediate medical intervention to prevent death or serious impairment of health. Examples of *Emergency Care* situations include, but are not limited to, symptoms of heart attack and stroke, poisoning, loss of consciousness, loss of breath, shock, severe bleeding, or convulsions. Emergency care does not include ambulance service to the facility where treatment is received (see Ambulance Services in Section V entitled Schedule of Benefits). In addition, see Section VII entitled Preadmission/Precertification.

ERISA – means the Employee Retirement Income Security Act of 1974, as amended from time to time.

Expenses Incurred – means an *Expense Incurred* at the time the service or supply to which it relates is provided.

Experimental/Investigational – means a drug, device, medical treatment, new technology, procedure, or supply, which is not recognized as a *Covered Expense* as follows.

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

- (4) Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, new technology, procedure, or supply is that further studies or clinical trials are necessary to determine maximum tolerated dose, toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, new technology, procedure, or supply; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, new technology, procedure, or supply.

Freestanding Health Clinic – means a private facility other than a private office of a *Provider/Practitioner*, which is operated primarily for the purpose of providing the treatment of *Illness* or minor *Injuries* of patients who are treated with or without an appointment for which it is duly licensed.

Hearing Aid – means amplification technology that optimizes audibility and listening skills in the environments commonly experienced by the patient, including a wearable instrument or device designed to aid or compensate for impaired human hearing. “Hearing Aid” shall include any parts or ear molds.

Home Health/Hospice – means care provided by a *Home Health Care/Hospice Care Agency* under an approved *Home Health Plan/Hospice Plan of Care*. *Home Health/Hospice* also means a licensed *Home Health Care/Hospice Care Agency* or *Inpatient Hospice Facility* that meets all of the requirements specified in this Plan Document.

Home Health Care/Hospice Care Agency – means an agency or organization which fully meets each of the following requirements.

- (1) It is primarily engaged in and is duly licensed, if such licensing is required, by the appropriate licensing authority to provide *Skilled Nursing* services and other therapeutic services.
- (2) It has policies established by a professional group employed with the agency or organization. The professional group must include at least one *Provider/ Practitioner* and at least one Registered Nurse (R.N.) to govern the services provided and it must provide for full-time supervision of such services by a *Provider/Practitioner* or Registered Nurse.
- (3) It maintains a complete medical record on each patient.
- (4) It has an administrator.

Home Health Plan/Hospice Plan of Care – means a prearranged, written outline of care that will be provided for the palliation and management of a person’s terminal *Illness* or *Home Health* care services.

Hospital – means any institution which meets in full all of the following requirements.

- (1) It must furnish day and night lodging.
- (2) It must be primarily engaged in providing, for compensation from its patients on an in-patient basis, diagnostic and therapeutic facilities for surgical and medical diagnosis, and treatment and care of injured and sick persons by or under the supervision of physicians who are legally licensed to practice medicine.
- (3) It must regularly and continuously provide day and night nursing service by or under the supervision of a *Provider/Practitioner*.
- (4) It must not be, other than incidentally, a place for the aged or a nursing or convalescent home.
- (5) It must be operated in accordance with the laws of the jurisdiction in which it is located pertaining to institutions identified as *Hospitals*.

The term *Hospital* includes an institution specializing in the care and treatment for rehabilitation and mental or emotional *Illness*, disorder, or disturbance, which would qualify under this definition as a *Hospital*. The term *Hospital* also includes a residential treatment facility specializing in the care and treatment of *Alcoholism*, drug addiction, or chemical dependency, provided such facility is duly licensed, if licensing is required by law in the jurisdiction where it is located, or otherwise lawfully operated if such licensing is not required.

The term *Hospital* also includes a rehabilitation facility/*Hospital* which is licensed by the State, accredited by the Joint Commission on Accreditation of Health Care Organizations, and accredited by the Commission of Accreditation of Rehabilitation Facilities.

Illness(es) – means an *Illness*, bodily disorder, disease, or *Mental or Nervous Disorder*. An *Illness* due to causes which are the same as or related to causes of a prior *Illness*, from which there has not been complete recovery will be considered a continuation of such prior *Illness*. The term *Illness* as used in this SHBP will include pregnancy, childbirth, miscarriage, termination of pregnancy, and any complications of pregnancy and related medical conditions.

Incurred Date – means the date the service was performed or the supply was provided.

Infertility – means the condition of a presumably healthy individual who is unable to conceive or produce conception during a one-year period.

Injury(ies) – means an *Accidental* bodily harm, damage, or trauma, which results independently of an *Illness*, and which will include all *Injuries* resulting from an *Accident* and all complications arising from such *Injuries* or *Accidents*.

In-Network Provider(s)/Practitioner(s) – means an individual *Provider/Practitioner*, an organization of *Provider(s)/Practitioner(s)*, *Hospitals* and other health care *Provider(s)/Practitioner(s)* that have agreed to participate in the Preferred Provider Networks offered under the SHBP. The level of coverage for benefits within the network is generally greater than the level of coverage for benefits outside the network.

Inpatient Hospice Facility – means an establishment which may or may not be part of a *Hospital* and which meets all of these requirements.

- (1) It complies with licensing and other legal requirements in the jurisdiction where it is located.
- (2) It is mainly engaged in providing inpatient palliative care for the terminally-ill on a 24-hour basis under the supervision of a *Provider/Practitioner* or by a Registered Nurse if the care is not supervised by a *Provider/Practitioner* available on a prearranged basis.
- (3) It provides pre-death and bereavement counseling.
- (4) It maintains clinical records on all terminally-ill persons.
- (5) It is not mainly a place for the aged or a nursing or convalescent home.

Inpatient Hospice Facility also will include a hospice facility approved for a payment of *Medicare* hospice benefits.

Intensive Care Unit – means an accommodation of part of a *Hospital*, other than a post-operative recovery room, which, in addition to providing room and board:

- (1) is established by the *Hospital* for a formal intensive care program;
- (2) is exclusively reserved for critically-ill patients requiring constant audio-visual observation prescribed by a *Provider/Practitioner* and performed by a *Provider/Practitioner* or by a specially-trained Registered Nurse; and
- (3) provides all necessary life-saving equipment, drugs, and supplies in the immediate vicinity on a standby basis.

Involuntarily Lose/Loss – means, as this term is used for the purposes of administering the provisions for Qualified Late Enrollees) the *Involuntary Loss* of a group health insurance program for any reasons other than (a) non-payment of premium or (b) loss of health insurance because of withdrawal from the Colorado School of Mines and with corresponding loss of eligibility status used to qualify for a parent's group health insurance plan. The University reserves the right to exclude from this definition losses of group health insurance coverage which the *Student* could have reasonably been expected to avoid.

Low-Dose Screening Mammography – means the X-ray examination of the breast, using equipment dedicated specifically for mammography including but not limited to the X-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

Medical Necessity/Medically Necessary – means a service or supply only when it meets all of the following requirements.

- (1) It must be legal.
- (2) It must be ordered by a *Provider/Practitioner*.
- (3) It must be safe and effective in treating the condition for which it is ordered.
- (4) It must be part of a course of treatment which is generally accepted by the American medical community. That community includes all of the branches, professional societies, and governmental agencies therein.
- (5) It must be of the proper quantity, frequency, and duration for treatment of the condition for which it is ordered.
- (6) It must not be redundant when it is combined with other services and supplies that are used to treat the condition for which it is ordered.
- (7) It must not be *Experimental* or *Investigational*.
- (8) Its purpose must be to restore health and extend life.

This determination may include the consideration of the findings and assessments of the following entities:

- the Office of Medical Application of Research of the National Institute of Health, the Office of Technology Assessment of the United States Congress or any similar entities;
- national medical associations, societies, and organizations;
- the Federal Drug Administration; and/or
- the Plan Administrator's own medical and legal counsel and advisors.

Medical Foods – means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy that are specifically designed and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients and are to be consumed or administered enterally either via tube or oral route

under the direction of a Physician.

Medical Withdrawal/Leave of Absence for Medical Purposes from CSM – for the purposes of the SHBP, for undergraduate *Students* means a *Medical Withdrawal* from CSM granted by the Associate Dean of Students. For the purposes of the SHBP, for graduate *Students* a *Leave of Absence for Medical Purposes* is granted by the Dean of Graduate Studies.

Medicare – means Title XVIII of the Social Security Act of 1965, as amended. Part A means *Medicare's* hospital plan and Part B means the supplementary medical plan.

Mental Disorder – means posttraumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, and general anxiety disorder. *Mental Disorder* also includes anorexia nervosa and bulimia nervosa to the extent those diagnoses are treated on an out-patient, *Day Treatment*, and in-patient basis, exclusive of residential treatment. Refer also to *Biologically Based Mental Illness*.

Minor Child – means, for the purposes of administering benefits for *Hearing Aids* for children, a *Covered Person* under the age of eighteen

Morbid Obesity – means a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age, and mobility as the *Covered Person*.

Out-Of-Network Provider(s)/Practitioner(s) – means an individual *Provider/Practitioner*, an organization of *Provider(s)/Practitioner(s)*, and other health care *Providers/Practitioners* that do not participate in the Preferred Provider Networks offered under the SHBP. The level of coverage for benefits outside of the network is generally less than the level of coverage for benefits within the network.

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Preadmission Tests/Testing – means tests performed in a *Hospital* prior to confinement as an inpatient resident, provided:

- (1) such tests are related to the performance of a scheduled surgery or a scheduled admission;
- (2) such tests have been ordered by a duly-qualified *Provider/Practitioner* after a condition requiring such surgery or treatment has been diagnosed and *Hospital* admission for such surgery or treatment has been requested by the *Provider/Practitioner* and confirmed by the *Hospital*; and
- (3) the patient is subsequently admitted to the *Hospital*, or the confinement is canceled or postponed because there is a change in the condition, which precludes the surgery or the treatment.

Preferred Allowance (PA) – means the agreed upon fee schedule that *In-Network Provider(s)/Practitioner(s)* have agreed to for services and supplies that are *Covered Expenses* under the SHBP.

Prosthetic Device – means an artificial device to replace, in whole or in part, an arm or leg. Benefits are limited to the most appropriate model that adequately meets the medical needs of the Insured as determined by a Physician.

Provider(s)/Practitioner(s) – means an appropriately-licensed (including Licensed Professional Counselors for the State of Colorado) Doctor of Medicine (M.D.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Licensed Anesthesiologist, Doctor of Podiatry Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Certified Nurse Midwife (C.N.M.), Certified Registered Nurse Anesthetist (C.R.N.A.), Registered Physical Therapist (R.P.T.), Psychologist/Counselor (Ph.D., Ed.D., Psy.D., MA), Registered Nurse (R.N.), Licensed Clinical Social Worker (L.C.S.W.), Master of Social Work (M.S.W.), Family Therapist (Ph.D. or MA), Occupational Therapist, *Provider's/Practitioner's* Assistant, Registered Respiratory Therapist, Nutritionist, Nurse *Practitioner* (A.R.N.P.), or Naturopath (N.D.).

Reasonable and Customary Charge(s) (R&C) – means both of the following relating to the determination of benefits for *Out-of-Network Providers/Practitioners*.

- (1) ***Reasonable*** – the amount which is determined to be *Reasonable* based on the complexity of treatment of a particular case and the prevailing fee for such treatment in the geographic area where the service is provided (In unusual circumstances or cases with medical complications requiring additional time, skill, and experience in connection with a particular service or procedure, moderate variations from the prevailing fee may be permitted.); and
- (2) ***Customary*** – the amount which falls within the range of usual charges for a given service charged by most *Provider(s)/Practitioner(s)* with similar training and experience in a geographic area as determined by the Plan Administrator.

Routine Nursery Care – means routine room and board or nursery charges, *Provider's/Practitioner's* or surgeon's charges, and any other related charges (including charges for circumcision) incurred while a newborn child is an inpatient in a *Hospital*, but coverage under this provision will not be provided beyond the date the newborn child is first discharged from the *Hospital*.

Significant Break in Coverage – means a period of sixty-three (63) consecutive days during all of which a *Covered Person* did not have any *Creditable Coverage*, but does not include waiting periods or affiliation periods.

Skilled Nursing/Skilled Nursing Facility – means an institution or part thereof constituted and operated pursuant to law which:

- (1) provides, for compensation, room and board and 24-hour *Skilled Nursing* service under the full-time supervision of a *Provider/Practitioner* or a Registered Nurse. Full-time supervision means a *Provider/Practitioner* or Registered Nurse is regularly on the premises at least 40 hours per week;
- (2) maintains a daily medical record for each patient;
- (3) has a written agreement of arrangement with a *Provider/Practitioner* to provide *Emergency Care* for its patients;
- (4) qualifies as an extended care facility under *Medicare*, as amended; and
- (5) has a written agreement with one or more *Hospitals* providing for the transfer of patients and medical information between the *Hospital* and the skilled or convalescent nursing facility.

In no event, however, will a convalescent or *Skilled Nursing Facility* be deemed to include an institution which is, other than incidentally, a place for rest, for the aged, for treatment of chemical dependency, for the blind or deaf, for the mentally ill, or for the mentally handicapped.

Smoking Cessation Counseling Program – means an educational program provided by a health care facility or *Provider/Provider* that is qualified to submit medical expense billing to the SHBP.

Student(s) – means persons who are *Students* at CSM and are eligible for coverage under the SHBP as defined in Section IV of this Plan Document, entitled SHBP Eligibility.

Substance Addiction/Abuse – means a substance-induced disorder, which produces a state of psychological and/or physical dependence.

Telemedicine – means the use of interactive audio, video, or other electronic media to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data and medical education. The term does not include services performed using a telephone or facsimile machine.

Total Disability or Totally Disabled – means the status of a *Covered Student* who, during any period when, as a result of *Injury* or *Illness*, is unable to attend class or complete other required school work. A covered spouse will be considered *Totally Disabled* during any period when, as a result of an *Injury* or *Illness*, he or she is unable to engage in the typical activities of a person of same age and sex. A covered unmarried child will be considered *Totally Disabled* if he or she meets the requirements for *Total Disability* as defined in Internal Revenue Code Section 22(e)(B).

Uniformed Service – means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time Na-

tional Guard duty; the commissioned corps of the Public Health Service; and any other category of persons designated by the President in the time of war or emergency.

Urgent Care Services – means care that is provided when an individual’s health is not in serious danger, but that individual needs immediate medical attention for an unforeseen *Illness* or *Injury*. Examples of *Illnesses* or *Injuries* in which *Urgent Care* might be needed are a broken or dislocated toe, a cut that needs stitches but is not actively bleeding, or symptoms of a urinary tract infection.

Well Child Care – means treatment that is in accordance with the standards and frequencies endorsed by the American Academy of Pediatrics. Covered Medical Services include, but are not limited to, physical examinations, history, sensory screening, developmental screening, and appropriate immunizations.

A. Claims Procedures

How a *Covered Person* files a claim for benefits depends on the type of claim. There are several categories of benefits.

- (1) **Concurrent Care Claim** – A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously-approved benefit claim. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought.
- (2) **Pre-Service Care Claim** – A pre-service care claim is a claim for a benefit under the SHBP with respect to which the terms of the SHBP require approval (usually referred to as *Precertification*) of the benefit in advance of obtaining medical care.
- (3) **Post-Service Care Claim** – A post-service care claim is a claim for a benefit under the SHBP that is not a pre-service claim.
- (4) **Urgent Care Claim** – An urgent care claim is a claim for medical care or treatment where a delay in deciding the claim:
 - (a) could seriously jeopardize the life or health of the *Covered Person* or the ability of the *Covered Person* to regain maximum function; or
 - (b) in the opinion of a *Provider/Practitioner* with knowledge of the *Covered Person's* medical condition, would subject the *Covered Person* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

A *Covered Person* may file any claim for benefits, including ones for concurrent care, pre-service care, or post-service care, by himself or herself, by his or her authorized representative, or by his or her health care service *Provider/Practitioner*. Any of these types of claims must be filed using a written form supplied by the Claims Administrator and must be submitted via the U.S. Postal Service or commercial mail/parcel service (such as, but not limited to, UPS or FedEx), by hand delivery, electronically, or by facsimile.

If a *Covered Person's* claim involves urgent care, a *Covered Person* may initiate a claim for urgent care benefits himself or herself if he or she is able, or his or her treating *Provider/Practitioner* may file the claim for him or her. The claim must be submitted via the U.S. Postal Service or commercial mail/parcel service (such as, but not limited to, UPS or FedEx), by hand delivery, electronically, or by facsimile.

A *Covered Person* may file any claim himself or herself, or he or she may designate another person as his or her authorized representative by notifying the Claims Administrator in writing of his or her designation. In that case, all subsequent notices will be provided to the *Covered Person* through his or her authorized representative and deci-

sions concerning that claim will be provided through his or her authorized representative.

The Claims Administrator provides forms for filing those claims and authorized representative designations under the Plan that must be filed in writing. **A Covered Person must submit a claim for benefits within 12 months after the date of service.** The completed form (and all invoices pertaining to services received if applicable) must be sent to the Claims Administrator/Prescription Benefit Manager at the following address:

Klais & Co., Inc.
1867 West Market St.
Akron, OH 44313

If an *Out-of-Network Provider/Practitioner* submits a claim on a *Covered Person's* behalf, the *Covered Person* will be responsible for the timeliness of the submission. If the *Covered Person* does not provide this information to the Claims Administrator within **12 months** of the date of service, benefits for that health service will be denied or reduced, at the Plan Administrator's discretion. This time limit does not apply if the *Covered Person* is legally incapacitated. If a *Covered Person's* claim relates to an inpatient stay, the date of service is the date the *Covered Person's* inpatient stay ends. If a *Covered Person* provides written authorization to allow direct payment to *Provider(s)/Practitioner(s)*, all or a portion of any *Covered Expenses* due to a *Provider/Practitioner* may be paid directly to the *Provider/Practitioner* instead of being paid to the *Covered Person*. The SHBP will not reimburse third parties who have purchased or been assigned benefits by *Provider(s)/Practitioner(s)*.

The Plan Administrator has final authority to determine the amount of benefits that will be paid on any particular benefit claim. The Plan Administrator has delegated the administration of claims processing under the SHBP to the Claims Administrator. In making benefit determinations, the Plan Administrator has the complete discretion and authority to make factual findings regarding a claim and to interpret the terms of the SHBP as they apply to the claims. In any case, a *Covered Person* will receive only those benefits under the SHBP that the Plan Administrator, in its sole discretion, determines he or she is entitled to receive.

If the *Covered Person's* claim involves urgent care, the *Covered Person* or his or her authorized representative will be notified of the SHBP's initial decision on the claim, whether adverse or not, as soon as is feasible, but in no event more than 72 hours after receiving the claim. If the claim does not include sufficient information for the Claims Administrator to make an intelligent decision, a *Covered Person* or his or her representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. A *Covered Person* will have at least 48 hours to respond to this request. The Claims Administrator then must inform him or her of its decision within 48 hours of receiving the additional information.

If a *Covered Person's* claim is one involving concurrent care, the Claims Administrator will notify the *Covered Person* of its decision, whether adverse or not, within 24 hours

after receiving the claim. The *Covered Person* will be given time to provide any additional information required to reach a decision.

If the *Covered Person's* claim is for a pre-service authorization, the Claims Administrator will notify him or her of its initial determination, whether adverse or not, as soon as possible, but not more than 15 days from the date it receives the claim. This 15-day period may be extended by the Claims Administrator for an additional 15 days if the extension is required due to matters beyond the Claims Administrator's control. A *Covered Person* will have at least 45 days to provide any additional information requested of the *Covered Person* by the Claims Administrator.

If the *Covered Person* has filed a post-service claim for reimbursement of medical care services that already have been rendered, the *Covered Person* will be notified of the Claims Administrator's decision on the *Covered Person's* claim only if it is denied in whole or in part. This notification will be issued no more than 30 days after the Claims Administrator receives the claim. The Claims Administrator may extend this 30-day period once for up to 15 days if the extension is required due to matters beyond the Claims Administrator's control. A *Covered Person* will have at least 45 days to provide any additional information requested of the *Covered Person* by the Claims Administrator, if the need for the extension is due to the Claim Administrator's need for additional information from the *Covered Person* or his or her health care *Providers*.

B. Claims Appeals

The *Covered Person* has 180 days after the receipt of a denial notice to request an appeal. His or her appeal must be in writing unless his or her claim involves urgent care, in which case the request may be made orally. His or her written appeal must contain the following information (where applicable):

- (1) the patient's name;
- (2) the patient's member identification number (provided on their SHBP identification card);
- (3) sufficient information to reasonably identify the claim(s) being appealed, such as the date(s) of service, *Provider's/Practitioner's* name(s), procedure(s) (if known), and claim number(s) (if available); and
- (4) a statement that the individual is filing an appeal. The statement must include an explanation of the *Covered Person's* rationale as to why the denial was inappropriate.

The appeal must be sent to:

Health Plans, Inc.
PO Box 747
Westborough, MA 01581-0747
www.healthplansinc.com

In connection with his or her right to appeal the Claim Administrator's initial determination regarding his or her claim, the *Covered Person* also:

- (1) may review pertinent documents and submit issues and comments in writing;
- (2) will be given the opportunity to submit written comments, documents, records, or any other matter relevant to his or her appeal;
- (3) will, at the *Covered Person's* request and free of charge, have reasonable access to, and copies of, all documents, records, and other information relevant to his or her appeal;
- (4) will be given a review that takes into account all comments, documents, records, and other information submitted by the *Covered Person* relating to the appeal regardless of whether such information was submitted or considered in the initial benefit determination; and
- (5) is entitled to have his or her appeal reviewed by a health care professional retained by the SHBP, if the denial was based on a medical judgment. This person may not have participated in the initial denial.

The Claims Administrator must issue a review decision on the *Covered Person's* appeal according to the following timetable:

- (1) urgent care claims – not later than 72 hours after receiving his or her request for an appeal;
- (2) pre-service claims – not later than 30 days after receiving his or her request for an appeal; or
- (3) post-service claims – not later than 60 days after receiving his or her request for an appeal.