HMO HEALTH PLANS, INC.

d/b/a

SAN LUIS VALLEY HMO, INC.

STATE OF COLORADO

LARGE GROUP
BENEFIT SCHEDULE
AND
MEDICAL AND HOSPITAL SERVICE AGREEMENT

HMO Health Plans, Inc. d/b/a San Luis Valley HMO, Inc.
HEALTH MAINTENANCE ORGANIZATION (HMO)
STATE OF COLORADO LARGE GROUP
BENEFIT SCHEDULE

ARTICLE I. GENERAL TERMS UNDER WHICH BENEFITS ARE PROVIDED

Subject to all terms, conditions and definitions in the Medical and Hospital Service Agreement and the Exclusions and Limitations in this Benefit Schedule, Members are entitled to receive benefits set forth in this Benefit Schedule upon payment of any applicable copayments. These services and benefits are available only in the Service Area and only if and to the extent that they are Medically Necessary services provided, prescribed, referred, or directed by the Participating Primary Care Physician (except for Emergency Medical Care or upon prior authorized Written Referral in accordance with the policies and procedures of SLVHMO.

The fact that a Physician may provide, prescribe, order, recommend, approve, refer or direct a service or supply does not, in and of itself, make the service or supply a covered benefit. To qualify as covered benefits, all services and supplies must be expressly set forth as benefits in this Benefit Schedule and must be performed by the Primary Care Physician or by another provider under a Written Referral, which requires prior authorization signed and approved by the Medical Director, except for: visits to a Participating Physician or Participating Certified Nurse Midwife for an annual gynecological examination; visits to a Physician covering in the absence of a Primary Care Physician; Emergency Medical Care; Urgent Care; and routine laboratory or x-ray tests performed by a Participating provider.

A service or supply not expressly included in this Benefit Schedule is not a covered benefit, even if it is not specifically listed as an exclusion in Article 8.

ARTICLE 2. PHYSICIAN SERVICES

Medically Necessary Physician services are covered as follows:

2.1 Preventive and Health Maintenance Services.

A. Newborn and Pediatric Care - Except as provided in Article 5, routine newborn care and treatment of illness or injury of the newborn are covered for the first 31 days from the moment of birth. The child must be enrolled within 31 days after the date of birth for such coverage to continue beyond the first 31 days. Pediatric care, as determined by the Primary Care Physician, including routine medical attention, immunizations, injections care and treatment of cleft lip or cleft palate treatment of cleft lip or cleft palate (as outlined below), necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, including medically necessary physical, speech and occupational therapy for covered children up to 5 years of age with a maximum of 20 therapy visits per year. Sick child care is covered as any other medical condition regardless of age.

Care and treatment of a newborn child born with a cleft lip or cleft palate or both, shall include as medically necessary the following: oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons; prosthetic treatment such as obturators, speech appliances, and feeding appliances; medically necessary orthodontic treatment; medically necessary

prosthodontic treatment; habilitative speech therapy; otolaryngology treatment and audiological assessments and treatments. There are no age limits regarding the above coverage of cleft lip or cleft palate for newborn children.

B. Well Child Visits to a Primary Care Physician including age appropriate physical exams, history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling.

Age Appropriate Health Maintenance Visits including age appropriate physical exams, history, anticipatory guidance and education (e.g., examine family functioning and dynamics, discuss dietary issues, review health promotion activities of the patient, etc.), exercise and nutrition counseling (including folate counseling for women of child bearing age), CBC, history and physical, UA, chemical profile, fasting lipid panel, and stool hemocult, are covered.

1. Well Child Visits are covered according to the following schedule:

Age 0-12 months	5 Well Child Visits 1 PKU 1 Home Visit for newborns released less than 48 hrs. after birth
Age 13-35 months	2 Well Child Visits
Age 3-6	3 Well Child Visits
Age 7-12	3 Well Child Visits
Age 13-18	1 Age Appropriate Health Maintenance Visit per Year; 1 dT; 1 Hepatitis B vaccination if not given previously

2. Adult Age Groups:

19-39 - One exam every 36 months (3 years)
1 fasting lipid panel
40-50 - One exam every 24 months (2 years);
1 fasting lipid panel every
Over 50 - One exam every 12 months (1 year)
including two colorectal visualizations
between ages 50 and 70
Over 65 - One age appropriate health maintenance visit
every year;

Scheduled Physical Examinations do not include stress test, EKG, chest x-ray or sigmoidoscopy unless Medically Necessary or as otherwise stated in the foregoing schedule.

More frequent examinations are covered only in support of diagnosis, as determined by the Primary Care Physician. Any first physical examination at

the request of member and not in support of a specific diagnosis as determined by the Primary Care Physician, will be considered a "Physical Examination" as described more fully above.

C. Men: When provided by a Participating Physician, screening for the early detection of prostate cancer is covered according to the following schedule:

1. one screening per year shall be covered for any man fifty years of age or older; and

2. One screening per year shall be covered for any man from forty to fifty years of age who is at increased risk of developing prostate cancer as determined by a Participating Physician.

The prostate screening shall consist of the following tests:

(a) a prostate-specific antigen ("PSA") blood test; and

(b) digital rectal examination.

D. Women: When provided by a Participating Physician or Participating Certified Nurse Midwife, yearly breast and pelvic exam, PAP test, and at the Physician's discretion, hematocrit and urinalysis, are covered. Screening and diagnostic mammography are covered when recommended by a Participating Physician according to the following schedule:

1. Single baseline mammogram and clinical breast exam for women thirty-five years of age and under forty years of age (once during 35 to 39 year period);

2. One mammogram and clinical breast exam once every two years for women forty years of age and under fifty years of age but at least once a year for women with risk factors to breast cancer as determined by her Primary Care Physician; and

3. One mammogram and clinical breast exam annually for women over fifty years of age.

E. Vision and Hearing Services are covered as follows:

1. Eye Exams - Eye examinations provided by a Primary Care Physician to determine the need for vision correction are covered. Eye examinations for the purpose of determining the need for corrective lenses are not covered. All types of vision hardware and corrective appliances are excluded.

2. Hearing Exams - Upon Written Referral, hearing tests in support of a diagnosis and medically covered condition are covered. Screening audiometry and tympanograms not in support of a diagnosis, hearing aids and other corrective appliances are excluded.

F. Family Planning - Counseling and assessment for birth control as provided by a Participating Physician are covered.

G. Infertility Services - Coverage is provided as Medically Necessary for *diagnostic services only* subject to applicable copayments, except as provided in Article 8, Paragraph 21 according to the following schedule:

Women - Maximum Visits - 6
Men - Maximum Visits - 4

Treatment of infertility, including treatment medications, is not covered.

H. Immunizations and injections are covered as follows:

1. Pediatric - in accordance with the guidelines of the American Academy of Pediatrics, as follows:

Abbreviations:

DTP - diphtheria-tetanus-pertussis vaccine
OPV - oral polio vaccine
IPV - injected polio vaccine
MMR - measles-mumps-rubella vaccine
DTaP - diphtheria-tetanus-acellular pertussis vaccine
Td - diptheria-tetanus vaccine

RECOMMENDED AGE	IMMUNIZATION	COMMENTS
Birth	Hepatitis B	For infants born to mothers who are HBsAg-positive. Initial dose must be given within 12 hrs of birth. Also HBIG within 12 hrs.
1 month	Hepatitis B	To be given to children of HBsAg-positive mothers.
2 months	DTP-HIB or DTP and HIB Polio**(IPV or OPV) Hepatitis B	Must check for immuno-suppression prior to oral polio administration - see special HIB schedule. May Initiate Hepatitis B in HBsAg-negative family
4 months	DTP-HIB or DTP and HIB Polio (IPV or OPV) Hepatitis B	May give all immunizations if given in different locations. 6-8 week minimum interval for oral polio.
6 months	DTP-HIB or DPT and HIB Polio (IPV or OPV) Hepatitis B	Note change -total of polio remains the same. Third OPV given at 6 months instead of 15-18 months.
12-18 months	Varicella (chicken pox)	It is unknown whether at this chicken pox vaccine boosters will be needed and how often. Parents may choose instead to Allow their children to catch natural disease which provides lifelong immunity.

RECOMMENDED AGE	IMMUNIZATION	COMMENTS
12-15 months	MMR	Since 92% of children immunized against measles at 12-14 months of age are protected, routine administration of measles vaccine is recommended from 12-15 months. Tuberculin testing may be done During this visit. MMR is Recommended over single virus Vaccines.
15 months	HIB	Any HIB may be used.
15-18 months	DTP, Polio DTaP May be used	May be given at 15 month or 18 month visit.
4-6 years	DTP, Polio DTaP may be used	At or before school entry
11-12 years	Hepatitis B Varicella (if not received earlier)	Adolescents who have not previously received 3 doses of Hepatitis B vaccine should initiate complete series at this time.
4-20 years	MMR	A second dose should be given upon entry to elementary school or at any opportunity including entry to college.
12 years	Varicella (chicken pox)	For those children who have not had chicken pox by this age.
16 years	Td	Repeat every ten years throughout life.

*Sources: This table is based on the recommendations of the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians.

**The ACIP and AAP recommend that the first two polio vaccinations be IPVs and the second two be OPVs. Schedules with all OPVs or IPVs are also safe and effective

2. Adult age 19 and over - One dT every ten years.

3. Age 65 and older - One influenza immunization per calendar year. One pneumococcal vaccine at or after age 65.

4. Immunizations and injections which are Medically Necessary and provided by a Primary Care Physician and those which become necessary due to a specific local threat of disease and provided by a Primary Care Physician are covered.

5. Administration of allergy treatment compounds, solutions, and medications is covered subject to the applicable copayment.

2.2 Diagnostic Services Diagnostic services, including radiology (X-ray), pathology, laboratory tests, and other imaging and diagnostic services are covered. Magnetic resonance imaging (MRI) and computerized tomography (CT) require a Written Referral.

2.3 Routine Office Visits with Primary Care Physician A Member's routine office visits to a Primary Care Physician are covered.

2.4 Chemical Dependency Treatment Diagnosis, and medical treatment for the abuse of or addiction to alcohol and drugs shall include acute detoxification for alcoholism or drug abuse on either an outpatient or inpatient basis, whichever is medically appropriate and Medically Necessary as determined by the Medical Director or his/her designee, in addition to services covered by the Basic Benefit Schedule for the treatment of other medical conditions. Court-ordered substance abuse will be covered as required by State law.

2.5 Smoking Cessation One smoking cessation education program benefit per lifetime, not to exceed a $150.00 maximum payment by HMO Health Plans, Inc. d/b/a San Luis Valley HMO, Inc.. Smoking cessation programs will only be covered when provided by a participating SLVHMO provider, and pre-approved by Written Referral. Nicotine patches are part of the smoking cessation benefit, and contribute toward the $150.00 lifetime maximum.

2.6 Physician Services While Hospitalized The services of Physicians while a Member is hospitalized, including services of Primary Care Physicians, specialist surgeons, assistant surgeons, anesthesiologists, and other appropriate medical personnel are covered.

2.7 Home Visits Medically Necessary visits by a Primary Care Physician to a Member's home are covered within the Service Area.

2.8 Specialty Physician Services Services of specialty Physicians are covered in accordance with the Written Referral requirements described in Article 1.

2.9 Outpatient Surgery Upon Written Referral, outpatient surgical procedures are covered.

ARTICLE 3. HOSPITAL INPATIENT SERVICES

Medically Necessary Hospital Inpatient Services are covered as followed:

3.1 Hospital Inpatient Services Are covered as Medically Necessary, when admitted to a SLVHMO authorized participating hospital with a Written Referral by the Primary Care Physician and prior approval by the SLVHMO Medical Director in accordance with the policies and procedures of SLVHMO or for an unforeseen illness, injury or condition requiring immediate, Medically Necessary services to be obtained through a Non-participating Provider because of the unavailability of a Participating Provider.

3.2 Maternity Hospitalization Refer to Article 6 on Maternity Benefits.

3.3 Hospital Room and Board An average two-bed accommodation, general nursing care, meals, special diets when Medically Necessary, use of operating room and related facilities, intensive care unit and services, x-ray, laboratory, and other diagnostic tests, drugs, medications, biologicals, anesthesia and oxygen services, physical therapy, radiation therapy, chemotherapy inhalation therapy, administration of whole blood, blood plasma,

prosthetic devices approved by the Food and Drug Administration and implanted during a surgery performed pursuant to a Written Referral (such as pacemakers and hip joints) and special duty nurses as Medically Necessary, are covered.

3.4 Private Room Covered only when Medically Necessary.

3.5 Chemical Dependency Treatment Refer to Article 2, Paragraph 4 on Chemical Dependency.

3.6 Inpatient Mental Health Limited to 45 full inpatient days or 90 half days of partial hospitalization (defined as ½ an inpatient day) with a combination of both not exceeding the 45 day inpatient limit each contract year, when provided by a Participating Physician or under an authorized referral in a participating hospital. Each two days of partial hospitalization care shall reduce by one day the 45 days available for inpaitent care, and each day of inpatient hospitalization care shall reduce by two days the 90 days available for partial hospitalization care. For the purpose of this section partial hospitalization means continuous treatment for at least three hours but not more than twelve hours in any twenty-four hour period. Coverage for biologically based mental illness shall be no less extensive than the coverage provided for any other physical illness. "Biologically based mental illness" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

3.7 Reconstructive Breast Surgery Following a mastectomy which resulted from disease, illness or injury is covered. If needed, all stages of one reconstructive breast reduction on the nondiseased breast to make it equal in size with the diseased breast after definitive reconstructive surgery on the diseased breast has been performed is also covered.

ARTICLE 4. EMERGENCY ROOM/ OUTPATIENT SERVICES

4.1 Emergency Room Treatment Provided only for medical emergency conditions requiring immediate medical attention, involving the sudden, unexpected onset of an acute illness or injury, which if not immediately diagnosed and treated, could lead to further disability or death. The illness or injury must be of such gravity that it is not feasible to schedule an appointment with the Participating Primary Care Physician's office. The SLVHMO office should be notified within 48 hours of any medical emergency requiring treatment. Claims for Emergency Medical Care shall be limited to the Usual, Customary and Reasonable reates in the geographic area in which the Medical services are provided.

A. Emergency Room copayments are waived when the Member is admitted through the hospital emergency room and no treatment is provided in the emergency room. If the admission is to a nonparticipating Hospital, the Member will be transferred to a Participating Provider as soon as medically feasible. All Medical Services provided after a Member has refused a medically feasible transfer are excluded.

4.2 Medical Emergency Ambulance Transport Medical emergency ambulance service is covered as Medically Necessary when authorized by the SLVHMO Medical Director or under medical emergency. Air Transport benefit will be subject to $15,000 per each flight.

A. Members shall have the option of calling the local prehospital emergency medical service system by dialing the emergency telephone access number 9-1-1 or its local equivalent whenever a Member is confronted with a life or limb threatening emergency. For the purposes of this section, a "life or limb threatening emergency" means any event which the Member believes threatens his or her life or to prevent death or serious impairment of health .

4.3 Diagnostic X-Ray and Laboratory Procedures Covered as Medically Necessary when ordered by the Participating Primary Care Physician or physician to whom Member has an authorized Written Referral, or when unforeseen, Medically Necessary services require immediate treatment from a Nonparticipating Provider because of the unavailability of a Participating Provider. Diagnostic laboratory and diagnostic and therapeutic radiological services in support of basic health services are covered. All outpatient procedures performed in a hospital, and magnetic resonance imaging (MRI) and computerized tomography (CT) performed in any setting required a Written Referral. Routine procedures performed at participating facilities outside a hospital require only verbal referral from the Primary Care Physician.

4.4 Radiation Therapy and Chemotherapy When Medically Necessary is covered with a Written Referral by the Primary Care Physician and prior approval by the SLVHMO Medical Director in accord with the policies and procedures of SLVHMO. Chemotherapy administered orally and high dose chemotherapy which requires the support of a *non-covered* bone marrow transplant or autologous stem cell rescue procedure, are not covered

4.5 Outpatient Surgery Only in authorized facilities with a prior approved SLVHMO Written Referral, or when unforeseen, Medically Necessary services require immediate treatment from a Nonparticipating Provider because of the unavailability of a Participating Provider. Diagnostic laboratory and diagnostic and therapeutic radiological services in support of basic health services are covered.

4 .6 Outpatient Services Shall include diagnostic services, treatment services and x-ray services, for patients who are ambulatory and may be provided in a non-hospital based health care facility or at a hospital.

4.7 Outpatient Mental Health 20 outpatient mental health visits per member per contract year, as may be Medically Necessary and appropriate as determined by the SLVHMO Medical Director, or his/her designee.

4.8 Urgent Care Urgent Care in the Service Area is covered only when obtained from a participating urgent care center. The Member must be able to establish the Medical Necessity and urgent nature of the care.

ARTICLE 5. MEDICAL CARE OUTSIDE THE SERVICE AREA

Medically Necessary Urgent Care and Emergency Medical Care provided outside the Service Area are covered at Usual, Customary and Reasonable rates as follows:

5.1 Physician Direction Urgent Care and Emergency Medical Care must be provided under the order and direction of a Physician.

5.2 Urgent Care Urgent Care received outside the Service Area is covered when obtained from a provider other than a hospital or emergency room.

A. Notice to SLVHMO When a Member receives Urgent Care, a claim must be submitted to SLVHMO within 60 days from the date the care was rendered. The claim must contain an itemized statement, physician and nurses notes, records, etc. and any other sufficient information to establish the Medically Necessary and urgent nature of the care.

5.3 Emergency Medical Care. Covered worldwide. Emergency benefits out of the area are limited to reasonable and customary charges, less the applicable copayments. A medical

emergency continues as long as the transfer of the Member to an appropriate SLVHMO provider of services or alternative designated by SLVHMO is precluded because of grave risk to the Member's health or when SLVHMO has determined that the distance and the nature of illness involved would make such a transfer unreasonable.

A. Notice to SLVHMO When a Member is admitted to a nonparticipating hospital for emergency inpatient care, notice of the admission sufficient to establish the Member's identity and the institution to which he or she was admitted must be provided to SLVHMO the first business day after admission or as soon as medically possible.

B. SLVHMO Approval of Services SLVHMO must approve in advance any expenses incurred after the patient is stabilized, and transfer to a Participating Provider is medically feasible.

C. Follow-up and Continued Care To be covered, all follow-up care must be provided in the Service Area by a Participating Provider in accordance with the terms and conditions of the Group Medical and Hospital Service Agreement and this Benefit Schedule. A hospitalized Member requiring continuous care shall be transferred by SLVHMO to a Participating Provider as soon as medically feasible. All Medical Services provided outside the Service Area to a Member who has refused a medically feasible transfer are excluded.

5.4 Medical Emergency Ambulance Transport Ambulance or other medical transportation services are covered upon Written Referral or in the event of a Medical Emergency. Medical transportation is not for the convenience of the Member and is covered only when determined to be Medically Necessary by the Medical Director in the context of the medical episode. See the plan copayment schedule for ground medical transportation and licensed air ambulance copayments.

ARTICLE 6. MATERNITY BENEFITS

Medically Necessary maternity care is covered as follows:

6.1 Availability Maternity benefits are available for Members.

6.2 Prenatal and Postnatal Care Prenatal and postnatal care are covered.

6.3 Hospital Room and Board Hospital room and board is covered as for any covered illness or injury. Certified length of stay for routine vaginal delivery and caesarean section is covered as Medically Necessary. Coverage shall be in compliance with C.R.S. 10-160104(1)(b)(I) which states that coverage for a hospital stay for a newborn following a normal vaginal delivery shall no be limited to less than forty-eight hours. If forty-eight hours following delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning. Coverage for a hospital stay for a newborn following a caesarean section shall not be limited to less than ninety-six hours. If ninety-six hours following the caesarean section falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.

6.4 Delivery and Nursing Care Delivery services and facilities and nursing care are covered in a Hospital only.

6.5 Physicians' Services Physician obstetrical services are covered.

6.6 Prenatal Diagnosis Prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures during the pregnancy are covered as Medically Necessary.

6.7 Complications Medically Necessary care for complications including miscarriages, caesarian sections, ectopic pregnancies, is covered.

6.8 Maternity Medical Services Outside the Service Area For maternity care and complications for a pregnant Subscriber or Subscriber's spouse and, in the event of delivery, the newborn, are provided only as follows:

A. High Risk For a Member determined by her Physician to be at high risk of complications, who has been notified of that determination, Medical Services necessitated by or relating to her pregnancy will not be covered when provided outside the Service Area, unless a Member was required to leave the Service Area due to a family emergency. If a Member determined by her Physician to be at high risk of complications delivers outside the Service Area, all Medical Services for the newborn necessitated by or related to the birth, including neonatal care for premature birth, are covered for 31 days from date of birth.

B. Normal Risk For all other Members, Medical Services necessitated by or relating to pregnancy provided outside the Service Area during the 31 day period prior to the expected date of delivery will not be covered, unless a Member was required to leave the Service Area due to a family emergency. If a Member delivers outside the Service Area within such 31 day period, Medical Services for the newborn necessitated by or relating to the birth, including neonatal care for premature birth, are covered for 31 days from date of birth.

ARTICLE 7. OTHER SERVICES

7.1 Diabetes Coverage includes equipment, supplies, outpatient self-management training and education, including medical nutrition therapy if prescribed by a Participating Physician and authorized by SLVHMO. Equipment such as a glucometer is covered and billed as Durable Medical Equipment. Supplies such as test strips and lancets are covered 80% with a pre-authorized Written Referral.

7.2 Home Health Care Covered as Medically Necessary when prescribed and directed by a Participating Member Physician, and care is through a participating and certified home health agency with prior approval of SLVHMO, including skilled nursing services and other therapeutic services in the home or place of residence. Limited to 60 days per benefit year.

A. Services will be covered only if hopsitalization or confinement of the Member in a skilled nursing facility would be required if such home health services and benefits were not provided.

B. Services shall include visits to the Member by the Participating Providers of services specified below for the usual and customary time required to perform that particular service.

C. Only the following services will be covered: i) professional services of a registered or licensed vocational nurse; and, ii) short term physical therapy, as described below in Article 7, Paragraph 6and subject to the limitation therein.

D. Personal comfort and convenience items and Custodial Care are not covered.

E. Daily coverage is limited to what SLVHMO would pay a participating Skilled Nursing Facility for 24-hour Skilled Nursing Service.

7.3 Hospice Palliative, supportive and interdisciplinary team services providing physical, psychological, spiritual and bereavement care for terminally ill individuals and their families within a continuum of inpatient and home care available 24 hours, 7 days a week. Whether provided in the home, in a licensed hospice, and/or other licensed health facility. Services include, but shall not necessarily be limited to the following: nursing, physician, certified nurse aide, nursing services delegated to other assistants, homemaker, physical therapy, pastoral, counseling, trained volunteer and social services.

A. All hospice services shall be provided under active management through a hospice which is responsible for coordinating all hospice care services, regardless of the location or facility in which such services are furnished.

B. Allowed only for individuals who are terminally ill and have a life expectancy of 6 months or less.

C. Subject to referral by Primary Care Physician and review of care at periodic intervals by Primary Care Physician.

D. Bereavement support services for the family of the deceased will be covered for up to 3 months following death.

E. Short term acute patient care or continuous home care which may be required during a period of crisis, for pain control or symptom management is provided. Prior authorization is required by the hospice interdisciplinary team.

F. Other covered benefits for hospice care include:

1. Medical supplies;
2. Drugs and biologicals;
3. Prosthesis and orthopedic appliances
4. Oxygen and respiratory supplies
5. Diagnostic testing;
6. Rental or purchase of durable medical equipment
7. Transportation
8. Physician services

7.4 Skilled Nursing Facility Covered as Medically Necessary, with a Written Referral by the Primary Care Physician and prior approval by the SLVHMO Medical Director in accordance with the policies and procedures of SLVHMO. Limited to 100 days per benefit year.

7.5 Skilled Nursing Care Medically Necessary Skilled Nursing Services due to an injury or sickness that resulted in hospital confinement, are covered in a participating Skilled Nursing Facility upon Written Referral. Limited to 100 days per benefit year.

7.6 Rehabilitative Services Upon Written Referral, services of licensed therapists for short term rehabilitative services, including physical, occupational and speech therapy, are covered for up to 60 consecutive days inpatient and 20 visits outpatient services, per acute condition, providing that such services can be expected to result in the significant improvement of the Member's condition within the allowed period. The 60 day period shall begin with the first visit of a therapist. These benefits will not exceed 60 days inpatient or 20 visits outpatient per acute condition and shall not cover chronic or recurring conditions which are not subject

to sustained significant improvement within the 60 day inpatinet or 20 visit outpatient time limit.

7.7 Continuing Care After a period of hospitalization, a Member shall have the right to return to the location from which he/she initially entered the hospital regardless of whether the facility was contracted with SLVHMO, provided that the preferred facility is able to provide the needed services to the Member and is willing to accept payment on the same terms as a provider within SLVHMO's network.

7.8 Health Education Services Instruction in the appropriate use of health services and the contribution each Member can make to the maintenance of his own health is covered when provided by the Participating Primary Care Physician or with a Written Referral by the Primary Care Physician and prior approval by the SLVHMO Medical Director. This shall include:

A. Instruction in personal health care measures, and

B. Information about services including recommendations on generally accepted medical standards for use and frequency of such service.

C. Diabetic education classes for insulin dependent diabetes and pregnancy induced diabetes are covered.

7.9 Oral Surgery/Dental Anesthesia Services The following oral surgery services are covered upon Written Referral:

A. Care for the treatment of acute facial fractures;

B. Treatment of neoplasms (tumors) of the face, facial bones, or mouth;

C. Congenital defects causing significant respiratory or ingestive dysfunction and cleft lip, cleft palate, or any condition or illness which is related to or developed as a result of the cleft lip or cleft palate, shall be considered to be compensable for coverage;

D. Treatment of disorders related to temporomandibular joint syndrome causing significant respiratory or ingestive dysfunction; and

E. Treatment for accidental injury to sound natural teeth, limited to treatment of traumatized teeth and surrounding tissue provided within 24 hours after injury. No other oral surgery services are covered with the exception of Colorado mandatory coverage:

Hospitalization and general anesthesia for dental procedures for dependent children:

(I) The child has a physical, mental, or medically compromising q condition; or
(II) The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or
(III) 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
(IV) The child has sustained extensive orofacial and dental trauma.

7.10 Organ and Tissue Transplants Covered transplants include: heart, l ung, heart/lung, except when necessitated by disease primarily attributable to a Member's

smoking; liver, except when necessitated by disease primarily attributable to a Member's use of alcohol; kidney; pancreas for uremic insulin-dependent diabetics concurrently receiving a kidney transplant; cornea; bone marrow for treatment of neuroblastoma and Hodgkins or non-Hodgkins lymphoma; autologous or allogeneic bone marrow transplants, and stem cell rescue or hematopoietic support only for malignant tumors when necessary to support high dose chemotherapy, (and in that event the high dose chemotherapy is covered); and autologous or allogeneic bone marrow transplants and/or stem cell rescue only for aplastic anemia, leukemia, hereditary severe combined immunodeficiency disease, Wiskott-Aldrich Syndrome, and High Risk Stage II and III breast cancer.

The maximum lifetime coverage for all covered transplant services is $250,000. Any charges beyond the benefit limit are the Member's responsibility.

Services, supplies and pharmaceuticals required in connection with a covered transplant procedure are covered, including

A. Evaluation of a Member as a transplant candidate, b) tissue typing, c) a covered transplant procedure, d) scheduled follow-up care, e) anti-rejection drugs, and transportation and living expenses when SLVHMO requires the member to receive care from a Specialty Care Center outside the service area if the same services are not available from a Participating Provider within the service area. Organ or bone marrow search, selection, transportation and storage costs are not covered.

B. When the recipient of a covered transplant is a Member, donor costs directly relating to the acceptablility of an organ and the costs of services directly related to surgical removal of the organ for the donor, as well as the costs of treating complications directly resulting from the surgery, will also be paid under the limits of this benefit, provided that the donor is not eligible for coverage under any other health care plan or government funding program.

C. All services must be provided upon Written Referral. Coverage of all transplants is conditioned upon acceptance of the Member into the tranplant program at one of SLVHMO's participating Specialty Care Centers. Coverage may also be subject to approval by an appropriate evaluation committee designated by SLVHMO. The committee shall have complete discretion in determining whether or not a transplant will be covered and will consider factors such as the treatment's effectiveness in improving the length and quality of life; the mortatlity and morbidity associated with the treatment; alternative treatment methods; the current medical and scientific literature; the positions of governmental agencies regarding the treatment; community standards of care; and the patient's physical and mental condition.

D. SLVHMO reserves the right to direct care contracted to Specialty Care Centers which are more costs effective and provide high quality of care for the patient. Specialty Care Centers may be located anywhere in the United States, so the Member may be required to travel outside the Service Area for care.

7.11 Durable Medical Equipment Except for prosthetic arms and legs as described in 7.12 below, benefit is limited to $3,000 per contract year and must be determined as Medically Necessary by SLVHMO's Medical Director and a Plan Physician, but only if provided or distributed through a Participating Hospital or other Participating Provider upon a Written Referral. Coverage includes fitting; rental; purchase; maintenance or repair of Durable Equipment, when necessitated by accidental irreparable damage or due to changes in the condition or size of the patient; home administered oxygen, corrective appliances and artificial aids and braces; prosthetic and orthotic appliances, and/or fittings for such

devices; and prescription lenses following a cataract operation or to replace organic lenses missing because of congenital absence, and diabetic equipment (i.e. glucometer).

7.12 Prosthetic Arms and Legs Prosthetic arms and/or legs are covered at the federal benefit level with prior authorization. Covered benefits are limited to the most appropriate model that adequately meets the medical needs of the patient and prosthetic arm and/or leg or service is provided by a participating vendor. Repairs and replacements of prosthetic arms and/or legs are covered subject to applicable copayments. Repairs and replacements of prosthetic limbs are not covered when necessitated by misuse or loss.

7.13 Prescription Drugs See applicable benefit description.

ARTICLE 8. - EXCLUSIONS AND LIMITATIONS

All benefits, accommodations, care, services, equipment, medication or supplies furnished for the following are expressly excluded from coverage:

8.1 Any care deemed not Medically Necessary by the Medical Director or not in accordance with accepted medical standards, and any hospital or medical care services not specifically provided for in the Medical and Hospital Service Agreement or this Basic Benefit Schedule.

8.2 All services or supplies that exceed any maximum cost or time (days or visits) limitation imposed herein.

8.3 All services or supplies rendered for any illness, injury, or condition to the extent that benefits are either (i) available to the Member as an insured under the terms of any insurance (except group or individual health insurance) policy that is in force or (ii) would be available to the Member under a policy that is required to be in force under applicable law, but for the fact that the Member does not carry such policy contrary to such law

8.4 Medical, surgical or other health care procedures, treatments, devices, products or services that are Experimental or Investigative.

8.5 Services or supplies for any illness, condition or injury caused in whole or in part by or related to: (i) use of a motor vehicle by the Member when the Member has 0.08 percent or more by weight of alcohol in his or her blood; (ii) use of illicit drugs; or (iii) the Member's engaging in any activity which constitutes a felony.

8.6 Services by a Nonparticipating Provider, except upon Written Referral or for the provision of Emergency Medical Care or Urgent Care. Coverage for services of a Nonparticipating Provider for Emergency Medical Care or Urgent Care is limited to a Usual, Customary and Reasonable fee, less the applicable Copayment.

8.7 Expenses for any condition or complication directly caused by any non-covered procedure, treatment, service, drug, device, product or supply are excluded from coverage.

8.8 A private room or services of private or special duty nurses other than as Medically Necessary when a Member is an inpatient in a Hospital.

8.9 Services of any provider other than a Physician, a provider acting under the supervision of a Physician or certified nurse midwife, or a provider whose services must be covered by health maintenance organizations under the laws of this State. Examples of providers whose services are not covered include but are not limited to chiropractors, physiologists, homeopaths, naturopaths, rolfers, religious practitioners, and hypnotherapists.

8.10 Acupuncture, and acupressure whether or not provided by a Physician.

8.11 Services performed in connection with treatment to teeth or gums, upper or lower jaw augmentation or reduction or cosmetic reconstruction, or orthognathic surgery including treatment for disorders of the temporomandibular joint, regardless of the cause of the disorder, except those specifically described as covered herein. All dental services. Treatment of disease or pain related to temporomandibular joint dysfunction, except those services specifically described as covered herein. General anesthesia for dental procedures except as provided under mandatory coverage as outlined in Article 7, Paragraph 9.

8.12 Nursing homes and custodial care.

8.13 Eye refractions or examinations except as provided in Section 2.1E., eye glasses and all other types of vision hardware or vision corrective appliances including contact lenses, eye exercises, visual analysis, therapy or training, radial keratoplasty, photo refractive keratotomy and clear lensectomy; Please refer to the Supplemental Vision Plan for coverage of eyeglasses and related services. Hearing screening exams except as provided in Article 2, Paragraph 1E, hearing aids, masking devices or other hearing devices or the fitting thereof.

8.14 Deluxe Durable Medical Equipment or Prosthetic or Orthotic Appliances, *except when such deluxe features are determined to be Medically Necessary by the SLVHMO Medical Director.* Durable Medical Equipment, Prosthetic and Orthotic Appliances and cataract lenses ordered prior to the effective date of coverage, even if delivered after the effective date of coverage. Repair or replacement of any Durable Medical Equipment, Prosthetic or Orthotic Appliance resulting from misuse. Batteries, physician equipment such as sphygmomanometers, stethoscopes, etc.. All disposable, non-prescription, or over-the-counter supplies such as ace bandages and splints; exercise and hygiene equipment; corrective shoes and arch supports; support garments; devices not exclusively medical in nature, including but not limited to, sauna baths, spas, elevators, air conditioners or filters, humidifiers or dehumidifiers; equipment that can be used after the medical need is over such as orthopedic chairs and motorized scooters; or modifications to the home or motorized vehicles.

8.15 Surgery or other health care services or supplies to correct or restore or enhance body parts not likely to result in significant improvement in bodily function, including, but not limited to, breast implants. The Medical Director shall have sole discretion to determine whether the services are likely to result in significant improvement in function. Cosmetic products, health and beauty aids, services and medications related to the diagnosis and treatment of, or to reverse or retard the effects of, aging of the skin.

8.16 Preparation and presentation of medical or psychological reports or physical examinations required primarily for the protection and convenience of the Member or third parties, including, but not limited to, examinations or reports for school events, camp, employment, marriage, trials or hearings, licensing and insurance are expressly excluded, unless performed as a Scheduled Physical Examination as described in Article 2, Paragraph 1.

8.17 Immunizations required for the purpose of travel outside of the continental United States

8.18 All military service connected conditions.

8.19 Payment for care for conditions that state or local law requires be treated in a public facility.

8.20 Reversal of voluntary, surgically induced infertility (sterilization). Procedures, services and supplies related to sex transformation, transsexualism or paraphilias (sexual deviations).

Artificial insemination, invitro fertilization and gamete interfallopian transfer procedures. Complications caused by treatment of infertility. Elective abortions.

8.21 Diagnosis, treatment and rehabilitation services for obesity, non-covered services related to obesity, educational services, diet supplements, weight loss surgery or complications caused by weight loss surgery.

8.22 All organ and tissue transplants or autologous stem cell rescue *not explicitly listed as covered.* Services for an organ donor or prospective organ donor when the transplant recipient is not a Member. Organ and bone marrow search, selection, transportation and storage costs. Permanent or temporary implantation of artificial, non-human or mechanical organs and devises and related implantation services to replace or assist human organ function, except for dialysis to maintain a kidney, until the time of organ transplant. High dose chemotherapy which requires the support of a *non-covered* bone marrow transplant or autologous stem cell rescue. Transplants disapproved by the appropriate evaluation committee. Liver transplants necessitated by disease primarily attibuted to the Member's use of alcohol and heart, lung, and heart/lung transplants necessitated by disease primarily attributed to the Member's smoking. Bone marrow transplantation for human gene therapy (enzyme deficiencies, severe hemoglobinopathies, primary lysosomal storage disorders. All organ and tissue transplants or autologous stem cell rescue for Members who have not been continuously covered under this schedule since birth or for at least the previous twelve consecutive months without lapse in coverage.

8.23 Personal comfort items, such as television, telephone, lotions, shampoos, meals in the home, guest meals in inpatient facilities, housekeeping services, etc.

8.24 Diagnosis and treatment for mental retardation, learning or behavioral disorders, psychosocial problems, speech delay, conceptual handicap and developmental disability or delay or, dyslexia. Testing for ability, developmental status, intelligence, aptitude or interest and sleep therapy for insomnia.

8.25 Long term rehabilitative services.

8.26 Surgical treatment or hospitalization for treatment of impotency, prosthetics or aids.

8.27 Genetic counseling or engineering, except prenatal diagnosis of congenital disorders to the extent specifically described as covered herein.

8.28 Recreational or educational therapy, non-medical self-help training or therapy and sleep therapy.

8.29 Bone and eye bank charges.

8.30 Counseling or training in connection with family, sexual, marital, or occupational issues, cardiac rehabilitation classes or programs, diabetes classes for situations other than newly diagnosed insulin dependent diabetes and pregnancy induced diabetes.

8.31 Orthoptics, pleoptics, visual analysis, visual therapy and/or training.

8.32 Services for which the Member would not be liable in the absence of SLVHMO coverage. Services rendered by a person who resides in the Member's home or by an immediate relative of the Member.

8.33 For treatment of any Injury or Illness that arises out of, or as the result of, any work for wage or profit; except that, this exclusion will not apply to:

A the sole proprietor, if the employer is a proprietorship;

B a partner of the employer, if the employer is a partnership;

C. an executive officer of the employer, if the employer is a corporation; for any treatment that results from injury or illness that arises out of or as a result of any work for the employer and then only if he or she is not required to have coverage under any Workers' Compensation Act or similar law and does not have such coverage.

8.34 Court-ordered care, unless determined to be Medically Necessary and pre-authorized by SLVHMO and as required by Colorado law.

8.35 Prescriptions relating to an inpatient/outpatient confinement filled at a hospital pharmacy prior to discharge (take-home medications). All smoking cessation aids and medications (except as covered by the smoking cessation benefit). Contraceptives or contraceptive devices (except legend oral contraceptives). Non-legend drugs other than insulin. Injectables obtained through a pharmacy (other than insulin). Legend drugs which have an over-the-counter equivalent (e.g., Monistat 7, Disobrom, etc.). Anorectics and diet formulations used for the purpose of weight loss. Nystatin oral powder, progesterone suppositories and oral suspension, and growth hormones. All forms of Benzoyl Peroxide. Medications with no approved indications. Immunization agents, biological sera, antigen, blood and blood plasma. Prescriptions filled by non-participating pharmacies. Prescriptions which an eligible person is entitled to receive without charge from any Worker's Compensation Law or automobile accident liability insurance. Drugs that are labeled "Caution - limited by Federal law to investigational use", or experimental drugs even though a charge may be made to the recipient. Refilling of a prescription in excess of the number specified or any refill dispensed after one year from the original order.

8.36 Psychiatric therapy as a condition of parole, probation, or court order.

8.37 Treatment at pain clinics and chronic pain centers.

8.38 Hair analysis.

8.39 Routine foot care (including treatment for corns, calluses, and cutting of nails), foot care in connection with flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.

8.40 Post-partum exercises.

8.41 Medical Services provided outside the Service Area for maternity care and complications for a pregnant Member and, in the event of delivery, the newborn, during the 31-day period prior to the expected date of delivery or at any time after the Member has been notified that she is at high risk of complications, unless the Member was required to leave the Service Area due to a family emergency.

8.42 Services for conditions arising from the Member's refusal to accept treatment recommended by a Participating Physician may be denied.

8.43 All forms of birth control (except legend oral contraceptives and Depo-Provera dispensed through the Primary Care Physician and pre-authorized by Written Referral) are excluded.

8.44 Any Medical Services for injuries sustained while committing a state or federal crime.

8.45 Except as described in Article 7, Paragraph 9, dental benefits are optional and are covered only under a Dental Benefit Plan.

8.46 Any ambulance services which are not Medically Necessary. Medically Necessary ambulance service is provided if authorized prior to transport by the Participating Primary Care Physician or approved after transport as Medically Necessary by the Medical Director. SLVHMO does not provide ambulance transportation due to the absence of other transportation on the part of the Member. An ambulance ordered by a neighbor, relative, school officer, employer, etc. may be denied for coverage if the service is not determined to be Medically Necessary by the Medical Director.

8.47 Injectible medications are covered with a 20% copay with a limitation of $1,000 per perscribed dosage.

8.48 Provision or payment of services when not rendered in accord with SLVHMO policies or procedures, or by Non-participating Providers (Medical Emergencies excepted).

8.49 Conditions covered by Worker's Compensation, automotive insurance, or other liability insurance coverage.

8.50 Conditions for which care or reimbursement is available from a government agency or program, including military service connected conditions, or services rendered while incarcerated.

8.51 Blood, blood derivatives and components, blood processing fees in whatever manner billed, and/or blood donor fees.

8.52 Mental health care, alcoholism, drug abuse and additional services are provided only in accordance with this benefit schedule.

HMO Health Plans, Inc. d/b/a San Luis Valley HMO, Inc.
COLORADO LARGE GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT

ARTICLE 1. - INTRODUCTION

1.1 THIS CONTRACT is entered into between HMO Health Plans, Inc. d/b/a San Luis Valley HMO, Inc., a Colorado corporation (referred to herein as "SLVHMO") and the Subscriber Group named on the attached Signature Sheet.

1.2 SLVHMO is an authorized health maintenance organization in the State of Colorado.

1.3 Subscriber Group desires to make available prepaid comprehensive health care services to eligible persons who participate in its health care benefits program.

1.4 In consideration of the mutual promises of the parties and the periodic payment to SLVHMO of the required Premiums and subject to the terms and conditions contained in this Contract, SLVHMO agrees to provide eligible Employees of the Subscriber Group and their eligible Dependents with Medical and Hospital Services and other benefits specified in this Contract.

1.5 It is agreed by the parties that this is not an indemnity health insurance Contract but is an agreement to provide eligible Employees of the Subscriber Group and their eligible Dependents with health care benefits as specified by this Contract. All interpretations of this Contract shall be guided by such nature of this Contract.

ARTICLE 2. - DEFINITIONS

The following terms, when used in this Contract, are defined as follows:

2.1 "Anniversary Date" means an anniversary of the Effective Date as identified on the Signature Sheet of this Contract.

2.2 "Authorized Home Health Treatment Plan" means a plan of home care requiring skilled nursing or physical therapy or other rehabilitative services described under Home Health Care in the Basic Benefit Schedule, which is provided by a participating provider pursuant to a written referral.

2.3 "Basic Health Benefit Plan" means: A health benefit plan developed pursuant to 10-16-105 (7.2), C.R.S., 1994, and as amended.

2.4 "Benefit Schedule" means the attached exhibits identified as the SLVHMO Benefit Schedule(s) which set forth the medical, hospital and other benefits provided by SLVHMO.

2.5 "Case Management" means that SLVHMO will have the right to authorize benefits for services and supplies excluded or not specifically covered under this Contract as a substitute for other, possibly more costly, covered services or supplies. Such alternative benefits shall be determined by SLVHMO, in advance, in cooperation with the Member and the Member's Primary Care Physician and will only be covered upon written referral. SLVHMO's decision in any specific instance to authorize benefits that would not otherwise be covered under this Contract shall not commit SLVHMO to cover the same or similar benefits for the same or any other Member in other instances. By authorizing alternative benefits, SLVHMO shall not waive its right to enforce all terms, limitations and exclusions of this Contract.

2.6 "Child" means: an unmarried Child under age 19 who lives within the Service Area or an unmarried Child under the age of 24 who is a full-time student, who is chiefly dependent upon the Subscriber or Subscriber's Spouse for financial support, and an unmarried Child *of any age* who is medically certified as disabled and dependent upon the parent.

2.7 "Continuing Care" as defined in 10-16-413.5, C.R.S. means "furnishing, pursuant to an agreement, shelter, food, either nursing care or personal services whether such nursing care or personal services are provided in a facility or another setting designated by the agreement for continuing care, nursing care, or personal care services, to an individual not related by consanguinity or affinity to the provider furnishing care upon payment of an entrance or rental fee".

2.8 "Contract" or "Agreement" means this Colorado Large Group Medical and Hospital Service Agreement", all attached Benefit Schedules and Copayment Schedules, the Signature Sheet, any exhibits, supplements, addenda, attachments, amendments, endorsements, applications, health statements or riders, and any information submitted as part of an application for this Contract or for membership in SLVHMO.

2.9 "Contract Year" means the 12-month period between the Group Effective Date of this Contract and the first Anniversary Date and successive 12-month periods beginning on each Anniversary Date thereafter.

2.10 "Copayment" means the amount stated in the attached exhibit identified as "Copayment Schedule" to be paid by Members directly to providers for services at the time services are provided.

2.11 "Credible Coverage" means benefits or Employee welfare benefit plan or group health insurance or health benefit plan; an individual health benefit plan; a state health benefits risk pool (including but not limited to the Colorado uninsurable health insurance plan); Chapter 55 of title 10 of the United States code, a medical care program of the federal Indian health service or of a tribal organization, a health plan offered under chapter 89 of title 5, United States code, a public health plan, or a health benefit plan under section 5(e) of the federal "Peace Corps Act" (22 U.S.C. Sec. 2504(e)); a health plan provided through Medicare or Medicaid.

2.12 "Custodial Care" means care that does not require the continuing services of skilled medical or allied health professionals or that is designed primarily to assist a Member in activities of daily living, whether provided in an institution or in the home. Custodial Care includes but is not limited to medical care and services which can reasonably be provided to a Member by a medically non-licensed individual such as a parent, Spouse, Child or other resident of the home, help in walking, getting in and out of bed, bathing, dressing, use of the toilet or commode, feeding, preparation of special diets, and supervision of medications that are ordinarily self-administered.

2.13 Dependent" means any member of a Subscriber's immediate family who meets all eligibility and Enrollment requirements of this Contract.

2.14 "Dependent Coverage" means coverage provided to a Dependent under a Two Party Membership, Employee plus Children or Family Membership.

2.15 "Developmental Disability" or "Physical Handicap" shall be defined according to applicable laws and regulations. The determination of the Medical Director shall be final with respect to the determination of the existence of either such condition, subject only to Article 8 hereof.

2.16 "Durable Medical Equipment" means equipment 1) which can withstand repeated use; 2) the only function of which is for treatment of a medical condition or for improvement of function related to the medical condition; 3) which is of no use in the absence of the medical condition; 4) prosthetic devices and 5) which is appropriate for home use.

2.17 "Effective Date" means the date of this Contract as stated on the Signature Sheet. The date coverage is effective for individual Subscribers and dependents is described herein.

2.18 "Emergency medical care" means services rendered in the diagnosis and treatment of a Medical Emergency. Claims for Emergency medical care shall be limited to the Usual, Customary and Reasonable rates in the geographic area in which the Medical Services are provided. All claims for Emergency medical

care must be accompanied by sufficient documentation to establish the medical necessity and emergency nature of the services. "Medical Emergency" means circumstances which a reasonably prudent person would regard as the sudden, unexpected onset of an acute illness or injury requiring immediate medical care which, if not immediately diagnosed and treated, could lead to further disability or death. Heart attack, poisoning, loss of consciousness or respiration, convulsions, and excessive uncontrolled bleeding are examples of a Medical Emergency.

(a) In the event a Member is confronted with a Medical Emergency, the Member has the option to dial the emergency telephone access number 9-1-1 or other local emergency number if 9-1-1 service is not available.

2.19 "Employee" means any officer, manager, or Employee of the Subscriber Group, the partners (if the Subscriber Group is a partnership), the officers, managers, and Employees of subsidiary or affiliated corporations (if Subscriber Group is a corporation), and the individual proprietors, partners and Employees of individuals and firms, the business of which is controlled by the Subscriber Group by stock ownership, Contract, or otherwise. To qualify as an Employee, an individual must work a minimum of 24 hours per week at the business of the Employer and otherwise meet the specific eligibility requirements of the Employer and have a bona fide Employee/employer relationship with the Subscriber Group.

2.20 "Enrollment," "Enroll" or "Enrolled" means the completion and signing of the necessary SLVHMO Enrollment forms by or on behalf of an eligible person and acceptance of such Enrollments by SLVHMO.

2.21 "Experimental or Investigational" means medical, surgical or other health care procedures, treatments, devices, drugs, products or services (collectively, "health care services") which are determined by SLVHMO in its sole discretion to be experimental or investigational, and complications directly caused thereby, are expressly excluded from coverage. Health care services will be considered experimental or investigational if there is a reasonably substantial, qualified, responsible, relevant segment of the medical community which does not accept the service as proven to be safe and effective in treating a particular illness or condition and in improving the length and quality of life.

In determining whether health care services are Experimental or Investigational, SLVHMO will evaluate the services with regard to the particular illness or disease involved and will consider factors which SLVHMO determines to be most relevant under the circumstances, such as: the demonstrated effectiveness of the services in improving the length and quality of life; the incidence of death and complications associated with the services; alternative methods of treatment; whether the services are provided under an Experimental or Investigational protocol or study; whether the services are under continued scientific testing and research and reports in current medical and scientific literature concerning such testing and research; the positions of governmental agencies and other institutions (including without limitation Medicare, the Agency for Health Care Policy and Research and the American Medical Association) regarding the Experimental or Investigational nature of the services; whether the FDA has approved drugs or devices for the use proposed; and the patient's physical, mental and psychological condition.

2.22 "Home Health Care" means a program of care provided by a public agency or private organization or a subdivision of such an agency or organization, which: (1) is primarily engaged in providing skilled nursing services in homes or places of residence of its patients; (2) is certified by Medicare; and (3) has a written agreement with SLVHMO as an agency or organization to provide Home Health Care to Members under this Contract.

2.23 "Hospice" means a facility, agency or service that is certified by Medicare to establish and manage hospice care programs which provide physical and/or emotional support of terminally ill patients and family members. Care must be provided by or under the supervision of a registered nurse.

2.24 "Hospital" means an institution which is either:

(a) An institution which is primarily engaged in providing, on an inpatient basis, medical care and treatment for sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be affiliated with the institution and under the institution's governance; or

(b) An institution not meeting all the requirements of (a) above, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations or pursuant to Title XVIII of the Social Security Act as amended.

In no event shall the term "Hospital" include a convalescent nursing home or any institution or part thereof which is used principally as a convalescent facility, rest facility, or nursing facility.

2.25 "Hospital Services" means those Medically Necessary services for inpatients and outpatients which are generally and customarily provided by acute care general hospitals, and which are prescribed, directed, or authorized by a Physician in accordance with this Contract and within the rules, procedures and policies of SLVHMO. "Hospital Services" shall also include Medically Necessary services rendered in the emergency room and/or the outpatient department of any Hospital. Except for Emergency medical care, Hospital Services are benefits only when authorized by a written referral. In the event of a Medical Emergency, Hospital Services must be obtained from a participating provider if one is reasonably available.

2.26 "Independent Physician Association" or "IPA" means a physicians' group which has Contracted with SLVHMO as a participating provider.

2.27 "Large Employer" means any municipal or governmental corporation, unit, agency, or department thereof, and the proper offices, as such, of any unincorporated municipality or department thereof, as well as private individuals, partnerships, and corporations that, on at least 50% of its working days during the preceding calendar quarter, employed more than 50 Employees, the majority of whom were employed within the State of Colorado. In determining the number of Employees, companies that are affiliated companies or that are eligible to file a combined tax return for the purposes of state taxation shall be considered on employer. "Employer" also means any association, including a labor union, which has a constitution and bylaws. An Employer must be organized and maintained in good faith for purposes other than that of obtaining health benefits. An Employer is limited to any organization or other person or group that would, under Colorado law, be eligible for a group life insurance policy or group sickness and accident policy or Contract.

2.28 "Medical Director" means a Medical Director of SLVHMO or his or her designee. A decision of the Medical Director which substantially affects a Member is subject to Article 8 hereof, and will be made in the exercise of the Medical Director's reasonable judgment, subject to all of the terms and conditions of this Contract.

2.29 "Medical Services" means (except as expressly limited or excluded by this Contract) those Medically Necessary health care services which are performed, prescribed or directed by a Physician.

2.30 "Medically Necessary" means the most appropriate, useful, and cost-effective care according to accepted principles of good medical practice, as determined by SLVHMO or a Medical Director and also means care that can be safely provided to a Member for prevention, diagnosis, or treatment of the Member's medical condition and which is not excluded or limited by this Contract.

2.31 "Member" or "SLVHMO Member" means any Subscriber or dependent who satisfies all of the requirements of this Contract, who has been Enrolled by SLVHMO and for whom the current monthly Premium has been received by SLVHMO.

2.32 "Nonparticipating Provider" means any licensed or certified Physician, health professional, Hospital, home health agency, pharmacy, or other licensed or certified entity or person who is not a participating provider at the time services are rendered to a Member.

2.33 "Open Enrollment Period" means the period of time established by Subscriber Group and approved by SLVHMO during which eligible individuals may Enroll or change their Enrollment for coverage pursuant to the Contract.

2.34 "Participating Physician" means any Physician who has entered into a Contract or other arrangement to provide Medical Services to SLVHMO Members with an expectation of receiving payment, other than Copayments, directly or indirectly from SLVHMO and whose Contract or other arrangement is in effect at the time such services are rendered.

2.35 "Participating Provider" means a licensed or certified Physician, health professional, Hospital, home health agency, pharmacy, or other licensed or certified entity or person who has entered into a Contract or other arrangement to provide health care services to SLVHMO Members with an expectation of receiving payment, other than Copayments, directly or indirectly from SLVHMO and such Contract or other arrangement is in effect at the time such services are rendered.

2.36 "Physician" means any doctor licensed to practice medicine or osteopathy in Colorado or in the state in which medical care is rendered and who is acting within the scope of such license.

2.37 "Plan" or "Health Plan" means a SLVHMO Medical and Hospital Service Agreement then or to be in effect with respect to a Member.

2.38 "Premium" means the payment made by the Subscriber Group to SLVHMO for health care coverage. Premiums are calculated and set at a monthly amount and must be prepaid prior to the month of coverage to maintain such coverage. SLVHMO has no responsibility to extend coverage beyond the month for which Premiums have been received or to send Subscriber Group billings or statements for any period of coverage. The Subscriber Group may elect to prepay its Premiums in advance. Premiums are set on a monthly basis and in no event will SLVHMO refund or accept any partial or prorated Premium for any given month. If effective date of coverage for Employee or dependent falls on the first day of the month through the fifteenth day of the month, full Premiums are due for that month; however, if effective date of coverage is the sixteenth day of the month through the end of the month, no Premiums are due for that month.

2.39 "Primary Care Physician", "Primary Physician" or "PCP" means the Participating Physician who is authorized by SLVHMO to act as a Primary Care Physician and who is designated by the Member as the Physician through whom the Member must obtain all of the health care benefits provided by this Contract (except annual gynecological examinations, urgent care and Emergency medical care). Primary Care Physicians are listed in the SLVHMO Provider Directory. If the Member does not choose a PCP within the first 30 days after coverage is effective, SLVHMO will designate a PCP for the Member and the Member will be notified as such. In the event SLVHMO designates a Member's PCP, such designation will be effective until such time as the member chooses a different PCP.

2.40 "Prosthetic Arm and/or Leg" means an artificial device to replace in whole or in part an arm or a leg.

2.41 "Prosthetic Devices" means artificial substitutes that are required to replace all or any part of a body organ or extremity.

2.42 "Service Area" means all the Colorado counties in which SLVHMO is authorized to do business as a health maintenance organization by the Colorado Division of Insurance. The Service Area is designated in the materials accompanying this Agreement.

2.43 "Signature Sheet" means the sheet attached to this Contract and identified as such.

2.45 "Skilled Nursing Facility" has the same meaning as Extended Care Facility in Title XVIII of the Social Security Act and regulations but is limited to those facilities with a Contract or other arrangement with SLVHMO.

2.46 "Skilled Nursing Service" has the same meaning as Extended Care Service in Title XVIII of the Social Security Act and regulations except that it does not include a requirement of prior hospitalization, is interpreted as if all Members were covered under both parts of Title XVIII and applies only to services performed, prescribed, or directed by a Participating Physician. "Post-Hospital Extended Care Service" has the same meaning as Title XVIII of the Social Security Act and regulations but applies only to services performed, prescribed, or directed by a Participating Physician.

2.47 "Spouse" means an individual of the opposite sex legally married to the Subscriber.

2.48 "Standard Health Benefit Plan" means: A health plan developed pursuant to 10-16-105 (7.2), C.R.S., 1994, and as amended.

2.49 "Subscriber" means an Employee who is entitled under the established practices of the Subscriber Group to participate in health care benefit programs arranged by the Subscriber Group, who meets applicable requirements of this Contract, and who has Enrolled hereunder by submitting an Enrollment application which has been approved by SLVHMO, and for whom the monthly prepayment has been received by SLVHMO in accordance with the terms hereof. One person from each family unit Enrolled as a Member hereunder, who signs and executes the necessary Enrollment application form shall be considered the Subscriber under this Contract and shall exercise all rights, privileges, and responsibilities of a Subscriber with respect to SLVHMO.

2.50 "Urgent Care" means Medically Necessary Medical Services which are provided without a written referral for an unforeseen acute medical condition that requires the Member to seek immediate treatment in order to prevent serious deterioration of the Member's medical condition when the Member is unable to contact his or her Primary Care Physician, provided that such Medical Services are not provided by a hospital or emergency room. Members may not use hospital emergency rooms to receive urgent care. Emergency rooms cannot be used for elective or non-emergency care. Coverage for urgent care is limited to the lesser of Usual, Customary and Reasonable rates in the geographic area in which the Medical Services are provided or the Contracted rate agreed to by the urgent care Center. All claims for urgent care must be accompanied by sufficient documentation to establish the medical necessity and urgent nature of the treatment or services. All claims for urgent care will be subject to review by the Medical Director whose determination regarding the existence of a need for urgent care shall be final, subject only to Article 8 hereof.

2.51 "Usual, Customary, and Reasonable." The "usual" fee is that fee usually charged, for a given service, by an individual Physician to his or her private patients (i.e., his or her own usual fee). A fee is "customary" when it is within the range of the usual fees charged by Physicians of similar training and experience, for the same service within the same specific and limited geographic area (socio-economic area of a metropolitan area or socio-economic area of a county) as determined by SLVHMO. The fee is "reasonable" when it meets the above two criteria or is justifiable as determined by SLVHMO in consideration of the special circumstances of the particular case in question. In no event shall a fee exceeding 130% of the Medicare allowable based on resource based relative value scale (RBRVS) or diagnostic related group (DRG) methodology be considered "reasonable" for purposes of this Contract.

2.53 "Written Referral" or "Referral" means the established procedure, which must include written prior authorization by the Medical Director, by which the Medical Director determines that Medical Services to be provided to a Member are covered under this Contract. All services not provided by a Member's Primary Care Physician require a written referral except the following services: visits to a participating Physician or certified nurse midwife for reproductive health or gynecological care; visits to a

Physician covering in the absence of the Member's Primary Care Physician; Emergency medical care; urgent care; and routine laboratory or x-ray tests. The Primary Care Physician should initiate the request for a written referral. A copy of SLVHMO's response, whether approval or denial, to every such request will be sent to the Member, the Primary Care Physician, and the referral provider. Coverage will be provided for any Medical Services which require a written referral only if the Member has received a copy of the written referral from SLVHMO before receiving the service. The written referral will specify the provider, services and dates of service authorized. The written referral guarantees payment by SLVHMO for the authorized services, provided all eligibility and Enrollment requirements are met by the Member at the time service is rendered. In unusual cases where specialty treatment is urgently needed but which do not qualify as Medical Emergencies, prior approval by the Medical Director shall be obtained by telephone, with subsequent confirmation through a written referral to be requested by the next business day. Prior approval by telephone shall not be required if the diagnosis that treatment is urgently needed occurs after normal business hours and telephone authorization cannot be obtained within a reasonable time, but subsequent confirmation through a written referral shall be requested by the next business day.

ARTICLE 3. - ELIGIBILITY

3.1 To be eligible to Enroll as a Subscriber, a person must, at the time of Enrollment and throughout the term of this Contract: be an Employee of the Subscriber Group or be entitled to coverage under a trust agreement or other established standard of the Subscriber Group as agreed to by SLVHMO; comply with all applicable requirements of this Contract and reside or work within the Service Area. A Subscriber may maintain eligibility while on temporary work assignment outside the SERVICE AREA for a period not to exceed ninety days.

3.2 To be eligible to Enroll as a Dependent, a person must be:

1) The Subscriber's Spouse, provided he or she lives or works within the Service Area or is on temporary work assignment outside the Service Area for a period not to exceed ninety days; or

2) A Child of the Subscriber who is either:

a) An unmarried Child under the age of 19, living in the Service Area, or an unmarried Child under the age of 24 who is a full-time student, who is chiefly dependent on the Subscriber or Subscriber's Spouse for financial support. In the event a dependent Child does not live in the Service Area, said dependent Child will only be eligible to receive Emergency and urgent care (as defined herein) while residing out of the Service Area. SLVHMO may at any time request proof of financial dependency.

b) Coverage of any Child of a Subscriber or Subscriber's Spouse shall not be terminated by the Child's attaining the relevant limiting age while the Child is unmarried and medically certified as disabled and dependent upon the parent. Proof of incapacity and dependency must be furnished to SLVHMO within thirty-one (31) days of the Child's attaining the limiting age or, if the Child is over the limiting age, within thirty-one (31) days of the Child's the date of disability. Proof of any claimed incapacity and dependency must be furnished at reasonable intervals during the first two years after the limiting age is reached and annually thereafter.

3.3 A person who is otherwise eligible for coverage under this Contract who is eligible for Part B of Medicare may Enroll in SLVHMO, or continue membership if presently Enrolled, if the person Enrolls in Part B of Medicare for which he or she is entitled and provides SLVHMO with a copy of his/her Medicare cared. Coordination of Benefits will be made according to provisions established by federal law.

3.4 Child who is a dependent and Enrolled as a Member will continue as an eligible dependent through the last day of the month in which such dependent loses eligibility as a dependent, attains age

nineteen (19) or twenty-four (24), whichever is applicable (see Section 3.2 hereof). A Spouse who is a dependent and Enrolled as a Member will continue as an eligible dependent through the last day of the month in which a Decree of Dissolution or Legal Separation is entered dissolving the Spouse's marriage to or effecting a legal separation from the Subscriber. dependent Coverage will terminate the last day of the month in which a Member ceases to be an eligible dependent.

3.5 SLVHMO may, in its sole discretion, deem ineligible any person who has previously had his or her membership terminated for: (1) failing to pay Premiums or make Copayments; (2) making an incomplete statement or a misstatement in any claim for service or in the initial application or other information provided to SLVHMO; (3) misusing a membership card; or (4) failing to maintain a satisfactory Provider/Member relationship.

3.6 During the term of this Contract, Subscriber Group shall make no change in its eligibility standards for purposes of this Contract unless such changes is agreed to by SLVHMO.

3.7 Any ineligible person Enrolled under this Contract will not be entitled to benefits hereunder. SLVHMO will refund to the Subscriber any Premium paid for the ineligible person in excess of any benefits paid for the time the person was ineligible or for the sixty (60) days prior to SLVHMO's discovery of the ineligibility, whichever is shorter (the "refund period"). SLVHMO shall also be entitled to repayment from the ineligible person and the related Subscriber for the cost of benefits provided during the refund period in excess of the Premium received by SLVHMO for the ineligible person for that period. If the ineligible person was carried by Subscriber Group as a Subscriber, SLVHMO shall also be entitled to repayment from the Subscriber Group for the cost of benefits provided during the refund period in excess of the Premium received by SLVHMO for the ineligible person during that period.

3.8 A Member is a Timely Enrollee for Member insurance coverage if: (1) the Member (a) submits a completed Enrollment application through the Subscriber Group to SLVHMO on or before the date of eligibility or within 30 days after such date; or (b) qualify under one of the Late Enrollee Exceptions described in Section 3.10.

3.9 A Member is a Late Enrollee for Member and/or dependent insurance coverage is such insurance is contributory and (a) the Member submits a completed Enrollment application through the Subscriber Group more than 30 days after his or her eligibility under this Contract; or (b) the Member elects to terminate coverage and then, more than 30 days later, requests to be insured again.

3.10 A Member will not be considered a Late Enrollee for Member and/or dependent insurance coverage if any of the following conditions apply: (a) request for Enrollment is made within 30 days after a qualifying previous coverage terminates due to termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a Spouse, or divorce, and coverage had not been previously requested under this Contract solely because the individual was covered under the qualifying previous coverage; or (b) a court has ordered that coverage be provided for a Spouse or minor Child under a covered Member's plan and request for Enrollment is made within 30 days after issuance of the court order; or (c) the Subscriber Group offers multiple health insurance plans and the Member elects a different health insurance plan during an Open Enrollment Period.

ARTICLE 4. - ENROLLMENT AND EFFECTIVE DATE

4.1 Employeees and their Dependents may Enroll by submitting a completed application form through the Subscriber Group to SLVHMO during the Open Enrollment period specified on the Signature Sheet or within 30 days after an event occurs which makes the Employee or Dependents eligible for coverage. Coverage shall become effective on the date specified on the Signature Sheet, provided that a completed application form and the required Premium payment are received prior to the person's first day of eligibility.

4.2 SLVHMO shall have the right, at reasonable times, to examine Subscriber Group's records, including payroll records, with respect to eligibility and monthly Premiums under this Contract. Subscriber Group shall have the right, at reasonable times, to examine SLVHMO's records pertaining to Subscriber Group with respect only to Enrollment, eligibility and receipt of monthly Premiums under this Contract.

4.3 A Subscriber may Enroll a Dependent during any Open Enrollment Period, or by obtaining dependent coverage within 30 days of acquisition of the dependent. Newborn Children and Children placed for adoption (as defined in Article 2 hereof) may also be Enrolled under the terms of Section 4.5.

4.4 When a Subscriber acquires a new Spouse, coverage will be effective the date specified on the Signature Sheet required with the change in coverage due to the addition of a Spouse. Subscribers who wish to Enroll a new Spouse must provide SLVHMO with any supporting documentation (i.e., marriage license) upon SLVHMO's request.

4.5 Subscribers dependent newborn Children and Children placed for adoption are automatically covered for 31 days regardless of Enrollment in the plan. To obtain dependent coverage beyond 31 days a Subscriber must Enroll the newborn Child with SLVHMO within 31 days after the birth or placement for adoption by furnishing notification of the birth or placement for adoption to SLVHMO. No Premium will be charged for the first 31 days regardless of whether the newborn Child is Enrolled for coverage beyond the first 31 days. Notification to SLVHMO shall be by submission to SLVHMO of a completed change form.

A Child is considered placed for adoption when there are circumstances under which a person assumes or retains a legal obligation to partially or totally support a Child in anticipation of the Child's adoption. A placement terminates at the time such legal obligation terminates.

4.6 If a Member is confined as an inpatient in a health care facility on the date coverage would otherwise become effective for that Member, services and benefits will not be covered under this Contract for that Member until the Member is discharged from the facility.

4.7 If a Member is confined as an inpatient in a health care facility on the date coverage is terminated by the Subscriber Group due to replacement coverage by another carrier, SLVHMO remains liable to the extent of its accrued liabilities, extension of benefits, and benefits for covered Members until discharge from the inpatient facility.

4.8 Subscriber Group shall notify SLVHMO no later than the next billing cycle of any changes which may affect Member eligibility.

4.9 Subscriber Group shall require each Member to disclose to SLVHMO at the time of Enrollment, at the time of receipt of covered services and supplies, and from time to time as requested by SLVHMO, the existence of any other group insurance coverage Member may have, the identity of the carrier, and the group through whom the coverage is provided.

ARTICLE 5. - PARTICIPATING PROVIDERS

5.1 Each Member must select a Primary Care Physician within 30 days after coverage is effective. Members should consult SLVHMO's participating provider Directory for a list of participating providers authorized to act as Primary Care Physicians. This selection must be identified on the Enrollment application at the time of Enrollment. In making such a selection, if that Primary Care Physician is a member of a Contracting medical group, the Member may also be choosing the medical group from which all covered specialist Physician and associated Hospital services are received, except when a written referral is made for services outside the medical group or for Emergency medical care. Members should be aware that physicians do not have admitting privileges at all hospitals. Members should check with

their chosen Primary Care Physician to make sure they understand at which participating hospitals they have privileges to admit patients.

5.2 SLVHMO does not guarantee the availability of any Primary Care Physician or participating provider. SLVHMO reserves the right to direct Members to participating providers other than those requested by the Member.

5.3 A Member may change his or her Primary Care Physician by calling the SLVHMO Membership Services Department. Upon SLVHMO approval of the new selection, the new selection will become effective the fist day of the month following the change. A Member's Primary Care Physician may be changed at the Member's request no more than three times in any calendar year.

5.4 If a Member receives care from a nonparticipating physician or other nonparticipating provider without a required written referral, the Member shall be responsible for the cost of those services. Failure of the provider to obtain the written referral shall in no way relieve the Member of the financial responsibility for services received from that provider.

5.5 Upon Enrollment, each Member will be issued a SLVHMO identification card. It is the Member's responsibility to notify SLVHMO if the card is not received from SLVHMO within a reasonable time after the Member's effective date of coverage. In addition, it is the Member's responsibility to present the card to each health care provider at the time of service. Failure to do so could result in the Member's being responsible for the cost of the services rendered.

5.6 Cards issued by SLVHMO to Members are for identification only. Possession of a SLVHMO identification card confers no right to service or other benefits. The holder of a SLVHMO identification card must be a Member on whose behalf all amounts under this Agreement have actually been paid. Any person receiving services or other benefits to which he is not entitled shall be responsible for the payment of the full cost of such services. If any Member permits the use of his SLVHMO identification card by any other person, such card may be reclaimed by SLVHMO, and all rights of such member and his/her dependents may be terminated without notice at the election of SLVHMO. Such Member shall be liable to SLVHMO for all associated costs.

5.7 To ensure the maximum available benefits under this Contract, Members should obtain all medical services from participating providers and in accordance with written referral requirements, even if the Member expects payment to be made by another plan or a third party.

5.8 For personal reasons, a Member may refuse to accept a procedure or treatment recommended by the attending Physician. In such situations, SLVHMO shall not have any further obligation to provide coverage for the condition for which the Member refused treatment.

ARTICLE 6. - DELEGATION OF AUTHORITY

6.1 Subscriber Group hereby delegates and vests with SLVHMO the authority to determine whether a treatment, procedure, or other type of health care is Medically Necessary or otherwise covered under the terms of this Contract. A final decision by SLVHMO regarding coverage shall be final unless overturned by a court or arbitrator. For these purposes, SLVHMO's final decision shall be the decision reached after all levels of SLVHMO's internal grievance procedure have been exhausted.

ARTICLE 7. - MONTHLY PAYMENTS (PREMIUMS)

7.1 The monthly Premium rate is set forth on the Signature Sheet. Premium payments are prepaid for each month, or portion thereof, that coverage is effective, unless otherwise stated in the Group Contract. If the State of Colorado or any other taxing authority imposes upon SLVHMO any new or additional tax or

license fee which is levied upon or measured by Premium, by SLVHMO's gross receipts, or by any portion of either, then SLVHMO may amend this Contract to increase the Premium by an amount sufficient to cover all such taxes or license fees rounded to the nearest cent, effective as of the date stated in a notice sent to Subscriber Group. The effective date of such a Premium increase shall not be earlier than the date of the imposition of such tax or license fee increase. SLVHMO shall also have the right to change the Premium as of any date that the extent or nature of the risk under this Contract is changed by amendment to this Contract or by reason of any change mandated by law or regulation.

7.2 Each monthly Premium shall be calculated on the basis of SLVHMO records reflecting the number of Subscribers and Dependents in each coverage classification, as set forth on the Signature Sheet, at the time of calculation and at the Premium rate then in effect. SLVHMO reserves the right to adjust Premium revenue based on actual Enrollment. Subscriber Group shall submit to SLVHMO the entire Premium due on or before the 1st day of the month for which coverage is provided. Subscriber Group assumes responsibility for collection of the contributory portion of the Premium from each Subscriber, if any.

7.3 Only Members for whom the Premium is actually received shall be entitled to benefits, and then only for the period to which such Premium is applicable. If the required Premium for a Member is not received on or before the first day of the month for which coverage is provided, SLVHMO reserves the right to terminate all rights of the Member automatically, without notice, effective the first day after the date through which Premiums have been paid, unless otherwise stated in the Group Contract. Thereafter, the member will be reinstated at SLVHMO's discretion only be renewed application and re-Enrollment in accordance with all requirements of this Contract.

7.4 SLVHMO reserves the right to change the Premium and any other provisions of this Contract effective on any anniversary date. Changes to the Premium and any other provisions of this Contract may be made at any other time by agreement of the parties. Written notice of any such change will be given to Subscriber at least 30 days prior to the effective date of the change. Subscriber Group's agreement to such changes shall be established by continuation of payment for coverage hereunder after the effective date of such change, provided that payment is in accordance with the amended Premium. If Subscriber Group does not submit payment at the amended Premium rate, then the notice of change will be treated as a notice of termination and this Contract will terminate at midnight on the date prior to the date the change was to have taken effect.

7.5 Subscriber Group shall provide SLVHMO with notice of changes in Member eligibility and Enrollment within 30 days of the effective date of such changes. SLVHMO will make retroactive adjustments for Premium if notice is given to SLVHMO within 30 days of any additions or terminations of Members and changes in coverage classification not reflected in SLVHMO records at the time the monthly Premium is calculated by SLVHMO. However, in no event shall SLVHMO refund to a Subscriber Group any Premiums paid for an ineligible Member if the request for such refund is made later than 60 days after the receipt of payment by SLVHMO for said ineligible Member. SLVHMO will not refund any partial or prorated Premium for any given month, but will refund to the Subscriber Group any full monthly Premium payments made in advance.

ARTICLE 8. - EXCLUSIONS AND LIMITATIONS

8.1 Benefits provided by this Contract may be revoked or modified from time to time and year to year as Subscriber Group and SLVHMO may agree. No Member acquires a vested right to continue to receive a benefit as set forth in this Contract on or after the effective date of any revocation or change to such benefit. A Member's right is to receive only such benefits as are expressly provided for and in effect on the date of each treatment. Upon termination of this Contract or a Member's coverage under this Contract, a Member's right to continued benefits consists solely of those benefits expressly set forth in Article 11.

8.2 Members are entitled to receive benefits subject to the exclusions and limitations as stated in any provision of this Contract.

8.3 Benefits are available only as Medically Necessary and, except for annual gynecological examinations, Emergency medical care and urgent care or upon written referral, only in the Service Area through Primary Care Physicians. A Member shall contact his or her Primary Care Physician directly at the phone number listed on the Member's SLVHMO identification card. Members temporarily residing outside the Service Area, such as those on temporary (not more than ninety days) work assignments and Enrolled students, are covered outside the Service Area for emergency medical care and urgent care only; all other covered medical services must be received in the Service Area through the Primary Care Physician, including follow-up care related to a medical emergency.

8.4 Coverage for the services of a nonparticipating provider for urgent care outside the Service Area or emergency medical care is limited to a usual, customary and reasonable fee.

8.5 Medical Services for certain conditions or certain treatment procedures may be provided only at participating providers designated by SLVHMO as specialty care centers. SLVHMO shall have the right to require a Member to use a designated specialty care center as a condition to receiving coverage under this Contract.

8.6 Specialty care centers may be located anywhere in the United States, so Members may be required to travel out of the Service Area to receive care. All travel arrangements and costs are the responsibility of the Member. SLVHMO will not pay transportation, board, lodging or any other expenses related to travel for the Member receiving the medical treatment or their family.

8.7 Members who receive medical services without a written referral required pursuant to this Agreement will have any and all claims for such services denied by SLVHMO. Claims for emergency medical care and urgent care must be accompanied by documentation as set forth in this agreement.

8.8 All benefits, exclusions and limitations set forth in the attached Benefit Schedules are incorporated herein by this reference.

8.9 To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within the control of SLVHMO results in the facilities, personnel, or financial resources of SLVHMO or participating providers being unavailable to provide or arrange for the provision of a basic or supplemental health service in accordance with the requirements of this Contract, SLVHMO is required only to make a good faith effort to provide or arrange for the provision of the service, taking into account the impact of the event. For purposes of this paragraph, an event is not within the control of SLVHMO if SLVHMO cannot exercise influence or dominion over its occurrence. If in the event of a labor dispute involving a participating provider, the provision of Medical Services under this Contract is delayed or rendered impractical, SLVHMO will use its best efforts to arrange Medical Services covered under this Contract, but provision of non-emergency care may be deferred until after resolution of the labor dispute.

8.10 If a Member is hospitalized without a written referral due to a Medical Emergency, the Member shall, or shall cause the hospital or the Subscriber to, notify SLVHMO by telephone of the hospitalization on the first business day after the admission or as soon as medically possible. In the event that a Member is unable to personally contact SLVHMO or is unable to instruct some other person to do so, the notification period will not begin until such time as the Member is again able to notify SLVHMO. If a Member is conscious and able to communicate with others, he or she shall be deemed capable of notifying SLVHMO. SLVHMO reserves the right to not reimburse the cost of treatment if the required notice is not provided.

8.11 If a Member receives a bill for medical services from a participating provider, a claim for payment or reimbursement must be made in writing to SLVHMO's Membership Services Department within 60 days after the Member receives the bill, accompanied by itemized statements and receipts. If a Member receives Emergency medical care or urgent care from a nonparticipating provider, a claim must be submitted within

60 days from the date services were rendered. The claim must indicate the diagnosis, type of treatment rendered, date of service, name and address of provider, charge for care, name of Member and SLVHMO member identification number. The Member may also be requested to submit written proof if the Member has paid the bill. SLVHMO is not liable for payment or reimbursement of any claim if the claim is received by SLVHMO more than 60 days after the Member receives the bill or after services were rendered, as described above.

8.12 Any complaint or grievance brought to recover on this Contract shall be limited to the complaint and grievance procedure under Article 10. No complaint or grievance, to include but not limited to complaints regarding denial of claims for payments or for services (or request for arbitration), may be brought more than one year after the event which precipitates the action.

ARTICLE 9. - TERM AND TERMINATION

9.1 This agreement shall be in effect for the period specified on the Signature Sheet attached hereto and made a part hereof by reference. Notwithstanding any other provision in this Contract to the contrary, this Contract is renewable, at the option of the Subscriber Group with respect to all Members and dependents.

9.2 If the total monthly Premiums and charges with respect to all Members which are due under this Contract are not received by the first of the month for which Premiums are due, SLVHMO reserves the right to terminate this Contract without notice or any act by SLVHMO effective at the end of the period for which monthly Premiums and charges have been paid, unless as otherwise agreed upon, in writing, as part of this contract.

9.3 In the event of fraud or deception by Subscriber Group or Member, SLVHMO may terminate this Contract by providing written notice. Termination shall be effective on the date set forth in such notice.

9.4 If this Contract is terminated pursuant to Article 9, Sections 9.2 or 9.3, any Member who is hospitalized at the effective date of termination shall continue to receive benefits hereunder for that care until the Member is discharged.

9.5 In the event any Subscriber fails to make satisfactory arrangements for payment of any amount due, including the required Copayments, to SLVHMO or a provider, as to himself or herself and any Member (dependent) Enrolled with him or her, SLVHMO may refuse to accept further monthly Premiums with respect to that Subscriber and all of that Subscriber's dependents, and the Subscriber's membership and that of all Members (dependents) Enrolled with the Subscriber will be terminated at the end of the period for which monthly Premiums have been paid and accepted by SLVHMO.

9.6 Coverage under this Contract for a Member also will terminate on 10 days' written notice if there is a breakdown in the Physician (Provider)/Patient (Member) relationship and a satisfactory relationship cannot be established. A breakdown occurs if a Member repeatedly changes Primary Care Physicians without reasonable explanation or justification or under circumstances which evidence a disregard for treatment recommendations made by the Physician. Breakdown in the Physician/Patient relationship also includes failure to comply with recommended treatment as follows. If a Member refuses to accept recommended procedures for treatment and the Participating Physician believes that no professionally acceptable alternative exists, the Member will be so advised. If the Member still refuses to accept the recommended procedure for treatment, an opinion shall be obtained from another Participating Physician. If that opinion concurs that the recommended course of treatment is appropriate and a Member still refuses to accept the recommended treatment, SLVHMO may terminate the coverage of the Member in accordance with this paragraph.

9.7 Coverage under this Contract for a Member may also terminate on 10 days' written notice: (1) if the Member fails to provide necessary information or documentation which is reasonably available to the

Member about other insurance under which the Member is an insured, for coordination of benefits or for subrogation, within 30 days of the date of a written request by SLVHMO; (2) the Member knowingly permits another to use his or her SLVHMO identification card or has otherwise misused the SLVHMO health plan; or (3) the Member has repeatedly failed to comply with this Contract or has abused or obstructed staff or other patients.

9.8 Coverage under this Contract for a Member will also terminate on 10 days' written notice: (1) if a Member knowingly presents a claim for a payment that falsely represents that the services or supplies were Medically Necessary in accordance with professionally accepted standards; (2) if a Member knowingly makes a false statement or false representation of a material fact to SLVHMO for use by SLVHMO in determining rights to a health care payment; and (3) if the Member conceals the occurrence of any event affecting his or her initial or continued right under this Contract or conceals or fails to disclose any information with intent to obtain services, supplies, or payment to which the Member or any other person is not entitled. Termination under this paragraph shall be retroactive to the date of the event upon which the termination is based. SLVHMO shall refund Premiums received between the date of the event and the date of termination and shall have the right to obtain a refund from the Member for all medical services paid for between the date of the event and the date of termination. All claims for medical services unpaid as of the date of termination will be denied.

9.9 After the effective date of a termination pursuant to any paragraph of this Article 9, neither the participating providers nor SLVHMO shall have any further obligation to provide care for the condition under treatment and no claim shall be paid by SLVHMO for treatment arising after such termination date, except as provided herein.

9.10 If a Member ceases to meet the eligibility requirements herein, SLVHMO in its discretion may terminate the Member effective at midnight on the last day on which the Member met all such requirements.

9.11 The membership of a Subscriber and all dependents shall terminate in the event that the Subscriber leaves employment with the Subscriber Group or otherwise becomes ineligible, unless the Subscriber or any dependent continues or converts his or her membership in accordance with Article 11.

9.12 If the membership of a Subscriber is terminated, then the membership of all dependents of the Subscriber shall also be terminated, except as required by Article 11. If the membership of a dependent is terminated pursuant to 9.2, 9.5, 9.6, 9.7, or 9.8 then only the membership of that dependent shall be terminated.

9.13 In maternity cases under care at the effective date of termination, SLVHMO will not continue obstetrical care unless Member is eligible for continuation or conversion pursuant to Article 11 and elects to Enroll in such coverage.

9.14 Except as expressly provided in this article, all rights to benefits hereunder shall cease as of the effective date of termination.

ARTICLE 10. - RIGHTS OF SLVHMO MEMBERS

10.1 SLVHMO shall have access to information from medical records of Members and information received by Physicians in the course of the Physician/Patient relationship and the right to use such information as is reasonably necessary in connection with the administration of SLVHMO or this Contract, for records review incident to any coverage determination, peer review, quality assurance program or utilization review program or in connection with any information submitted in court or to public or private boards, committees or agencies. All provisions of law or professional ethics forbidding, restricting or

treating as privileged or confidential such information are waived by or on behalf of each Member hereunder. Members shall sign any specific releases necessary to effect this provision and failure to do so may result in loss of benefits. Except as provided above, all such information shall be confidential and shall not be disclosed except as allowed by federal and state law.

10.2 A Member may not be cancelled or non-renewed on the basis of the status of his or her health or health care needs, provided however, that this paragraph shall not negate, waive, alter or otherwise change any other provisions of this Contract. Subscriber Group must conform to underwriting requirements on the group effective date hereof and throughout the term of this Contract and all succeeding terms.

10.3 A Member aggrieved by denial of a claim or any other act of SLVHMO may file a grievance.

Appeals of adverse determinations

For purposes of this section, "covered person" includes the designated representative of a covered person.

I. Standard Appeals

A health carrier shall establish written procedures for the review of an adverse determination involving a situation where the time frame of the review would not jeopardize either the life or health of the covered person or the covered person's ability to regain maximum function. For the purposes of this regulation, this process shall be called a "standard appeal." A standard appeal shall be available to, and may be initiated by, the covered person or the representative of a covered person.

A. First Level Appeal Review

1. A health carrier shall establish written procedures for a standard appeal of an adverse determination. The procedures shall specify whether a first level appeal request must be in writing or may be submitted orally. Pursuant to Section 10-3-1104(1)(i), C.R.S., all written requests for a standard first level appeal review must be entered into the carrier's complaint record. Appeal procedures shall be available to the covered person and to the provider acting on behalf of the covered person.

2. Appeals shall be evaluated by a physician who shall consult with an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The physician and clinical peer(s) shall not have been involved in the initial adverse determination.

3. For standard appeals the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within twenty (20) working days following the request for an appeal. The written decision shall contain:

a) The name, title and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consults. (For the purposes of this section, the physician and consulting clinical peers shall be called "the reviewers.");

b) A statement of the reviewers' understanding of the reason for the covered person's request for an appeal;

c) The reviewers' decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;

d) A reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria; and

e) A description of the process for submitting a grievance in writing requesting a further, second level appeal review of the case.

4. In any case where the standard review process does not resolve a difference of opinion between the health carrier and the covered person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the covered person may submit a written grievance, requesting a second level review, unless the provider is prohibited from filing a grievance by federal or other state law.

B. Second Level Appeal Review

1. With respect to a second level appeal review of a grievance concerning an adverse determination, a health carrier shall appoint a second level grievance review panel for each grievance. The panel shall include a minimum of three people. A majority of the panel shall be comprised of persons who were not previously involved in the grievance. However, a person who was previously involved with the grievance may be a member of the panel or appear before the panel to present information or answer questions.

2. A health carrier shall ensure that a majority of the persons reviewing a grievance involving an adverse determination are health care professionals who have appropriate expertise. Such reviewing health care professionals shall meet the following criteria: not have been involved in the care previously; not be a member of the board of directors of the health plan; not have been involved in the review process for the covered person previously; not have a direct financial interest in the case or in the outcome of the review, and not be an Employee of the health plan. A health carrier shall issue a copy of the written decision to the covered person and to a provider who submits a grievance on behalf of a covered person.

3. A health carrier's procedures for conducting a second level panel review shall include the following:

a) The review panel shall schedule and hold a review meeting within forty-five (45) working days of receiving a request from a covered person for a second level review. Whenever a covered person has requested the opportunity to appear in person before authorized representatives of the health carrier, the review meeting shall be held during regular business hours at a location reasonably accessible to the covered person. In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology. The covered person shall be notified in writing at least fifteen (15) working days in advance of the review

date. The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person.

b) Upon the request of a covered person, a health carrier shall provide to the covered person all relevant information that is not confidential or privileged under state or federal law.

c) A covered person has the right to:

(1) Attend the second level review;

(2) Present his or her case to the review panel in person or in writing;

(3) Submit supporting material both before and at the review meeting;

(4) Ask questions of any representative of the health carrier prior to the hearing and question any panelist at the hearing; and

(5) Be assisted or represented by a person of his or her choice.

d) The notice shall advise the covered person of the rights specified in this section 8.1.B;

e) If the health carrier desires to have an attorney present to represent the interests of the health carrier, it shall notify the covered person at least fifteen (15) working days in advance of the review that an attorney will be present and that the covered person may wish to obtain legal representation of his or her own. Within five (5) working days in advance of the review, the covered person shall inform the carrier if the covered person intends to have an attorney present to represent such person's interests.

f) The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review.

g) The review panel shall issue a written decision to the covered person within five (5) working days of completing the review meeting. The decision shall include:

(1) The names, titles, and qualifying credentials of the members of the review panel;

(2) A statement of the review panel's understanding of the nature of the grievance and all pertinent facts;

(3) The rationale for the review panel's decision;

(4) Reference to evidence or documentation considered by the review panel in making that decision;

(5) In cases involving an adverse determination, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination, and additional appeal, review, arbitration or other options available to the covered person, if any; and

(6) Notice of the covered person's right to contact the commissioner's office. The notice shall contain the telephone number and address of the commissioner's office.

4. A complaint record entry shall be made for all second level appeals, pursuant to Section 10-3-1104(1)(i), C.R.S., and insurance regulation 6-2-1.

C. Independent External Review

If the member has gone through the SLVHMO's first and second level appeal process regarding a denial based on medical necessity and is still dissatisfied with the decision of the review panel, s/he may request an independent external review. If the initial and second level review decisions to deny were made because of a non-covered benefit, an independent external review cannot be requested.

The request must be made in writing to SLVHMO within sixty (60) calendar days after receipt of the second level appeal decision. This request must include a completed Appendix A: Request for Independent External Review of Carrier's Final Determination from the Division of Insurance. This form can be requested from SLVHMO or obtained from the Division of Insurance. If the member desires an expedited review, s/he must state this in the written request.

1. Upon receipt of a request for an independent external review, each appeal is stamped with the date of receipt and forwarded to the Grievance and Appeals Coordinator. The request may be made by the covered member or the designated representative of the member requesting the independent external review.

2. Upon receipt of a request for an independent review of a denial, SLVHMO will contact the Division of Insurance and send the request for independent external review to them. The Division of Insurance or its Contractor will inform SLVHMO of the name of the certified independent external review entity that has been selected by the Division of Insurance to conduct the review.

3. SLVHMO will notify the member in writing that their request for independent review has been sent to the Division of Insurance. This notification will include information about the certified independent review entity that has been selected to conduct the review.

4. SLVHMO will provide the independent review entity with the following:

a.) Information submitted to SLVHMO by the member requesting the review or by the physician or health care professional who is supporting the member's request.

b.) Relevant information used by SLVHMO to determine medical necessity, appropriateness, effectiveness or efficiency of the proposed service or treatment.

c.) Copies of any previous denial letters issued by SLVHMO concerning the individual case under review.

5. The external review entity sends notice of the expert determination directly to the member as well as to SLVHMO and to any health care professional who supported the request for review. This determination is sent within thirty (30) working days of receipt by SLVHMO of the request for external review.

6. If so requested by the member, SLVHMO will provide him/her with all relevant information which was submitted to the external review entity, as long as the information is not considered confidential or privileged under state or federal law.

7. San Luis Valley HMO will submit to the Colorado Division of Insurance an annual report on independent external review activities related to Enrollees or Subscribers. This report will be completed using Appendix D: Independent External Review Reporting Form for Health Carriers and will include activities for a twelve month calendar year.

II. Expedited Appeals

The expedited appeal process is maintained in order to make organization determinations and reconsideration determinations in the event that the time frame of a standard appeal set forth in Section 8.1.A or B would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. Such procedures shall be consistent with the provisions of Section 6.G. of this regulation concerning claims for emergency services. An expedited appeal shall be available to, and may be initiated by, the covered person or the provider acting on behalf of the covered person.

A. Expedited appeals may be made orally or in writing.

B. Necessary information as well as the decision of SLVHMO can be transmitted by telephone, facsimile or similar expeditious method.

C. A health carrier shall provide expedited review to all requests concerning an admission, availability of care, continued stay or health care service for a covered person who has received emergency services but has not been discharged from a facility.

D. The Medical Director of SLVHMO or the clinical peer in the same or similar specialty as would typically manage the case under review will make a decision and notify the covered member as expeditiously as the medical condition required, but no more than seventy-two (72) hours after the review is commenced. If the expedited review is a concurrent review determination, the service will be continued without liabilities to the member until the member has been notified of the determination.

E. A health carrier shall provide written confirmation of its decision concerning an expedited review within two (2) working days of providing notification of that decision, if the initial notification was not in writing. In the case of an adverse determination, the written decision shall contain the provisions specified in Section 8.1.A.3(a) through (e) of this regulation.

F. SLVHMO shall provide reasonable access, not to exceed one (1) working day after receiving a request for an expedited review, to a clinical peer who can perform the expedited review.

G. In any case where the expedited review process does not resolve a difference of opinion between the health carrier and the covered person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the covered person may submit a written grievance, unless the provider is prohibited from filing a grievance by federal or other state law. The written grievance in this case shall be handled by the carrier as a standard second level appeal review pursuant to Section 8.1.B of this regulation.

H. A health carrier shall not provide an expedited review for retrospective adverse determinations.

I. For the purposes of Section 10-3-1104(1)(i), C.R.S., and insurance regulation 6-2-1 concerning complaints and complaint records, an expedited review shall not be considered a complaint.

1. A Member aggrieved by the decision following a complaint Committee review is entitled to arbitration of his or her claim in accordance with the rules of the American Arbitration Association and Section 10.4 of this Contract. SLVHMO will provide information about arbitration to a Member upon request.

10.4 A Subscriber Group or Member aggrieved by any SLVHMO action must first exhaust the grievance procedure as set forth in Section 10.3. When the grievance procedure is exhausted, an aggrieved Subscriber Group or Member must submit his or her claim to arbitration. The arbitration shall be conducted in accordance with this Section 10.4 and the Commercial Rules of the American Arbitration Association in effect at the time the arbitration is commenced, before an arbitrator(s) is/are selected by mutual agreement of the Subscriber Group or Member and SLVHMO or, failing agreement, the American Arbitration Association. Information regarding the arbitration rules is available from SLVHMO's Membership Services Department.

(a) This arbitration agreement shall bind SLVHMO, Subscriber Group and the Subscriber and his or her dependents. By Enrolling with SLVHMO, the Subscriber Group, Subscriber and his or her dependents agree to submit to arbitration in accordance with this Article 10 any and all claims or grievances, including claims for errors or omissions of SLVHMO relating to the rendition of medical services. SLVHMO, the Subscriber Group, both on its behalf and on behalf of its Employees, and the Subscriber, both on his or her behalf and on behalf of any of his or her dependents, elect to have such disputes determined by arbitration and acknowledge they are giving up any and all legal rights they may have for such disputes to be decided by a jury or in a court of law.

(b) Any claim arising from alleged violation of a legal duty incident to this Contract, irrespective of the legal theory upon which the claim is asserted, shall be submitted to arbitration if the claim is asserted by a Subscriber Group or Member or by a Member's heir or personal representative ("Claimant") against one or more of the following ("Respondent"): (1) SLVHMO, (2) any participating provider, (3) any provider who provided health care services pursuant to a

written referral, or (4) any Employee of the foregoing. Claimant shall initiate the claim by serving at least one Respondent with notice of the nature of the claim and demand for arbitration. Claimant shall serve all Respondents reasonably servable, and the arbitrators shall have jurisdiction only over Respondents actually served. The notice and demand must be served in the following manner: Natural persons must be served as in a Colorado civil action and any other Respondent must be served by registered letter, postage prepaid, addressed to Respondent in care of SLVHMO.

(c) All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding and all Respondents duly served in connection therewith shall be parties. A claim (including a claim for arbitration) shall be waived and forever barred if (1) notice thereof is received more than one year after the event which precipitates the action, or (2) the Claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

(d) Following the initial service, all notices or other papers required to be served or convenient in the conduct of arbitration proceedings shall be served by mailing the same, postage prepaid, to such address as each party gives for this purpose.

(e) With respect to any matter not herein expressly provided for, the arbitration shall be governed by the Commercial Rules of the American Arbitration Association.

10.5 SLVHMO may, in its sole discretion, at any time during the grievance procedure offer a compromise settlement. The Member has no obligation to accept such an offer, but if he or she accepts the offer, payment shall be in full settlement of the claim. If the Member has not accepted the offer, SLVHMO shall be entitled to revoke it at any time. The offer of such a settlement shall not waive SLVHMO's right to enforce all terms, limitations and exclusions of this Contract.

10.6 Should a Member have a problem or grievance regarding a provider, the Member has the right to contact the Colorado Department of Public Health and Environment for help. SLVHMO will provide the address and necessary information for any Member seeking such action. Members should be aware that the Colorado Department of Public Health and Environment only has jurisdiction over Colorado providers. For providers outside of Colorado, the Member should seek health from the Department of Health for the state in which the provider is located. At the Member's request, SLVHMO will help locate the appropriate authority in the state where the provider is located for the Member.

ARTICLE 11. - CONTINUATION; CONVERSION

11.1 If Employer is required to offer continuation coverage under the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and any regulations thereunder, as now in effect or as amended from time to time, then SLVHMO shall provide such coverage to Members, but only to the extent Employer is required by federal law to offer such coverage. All provisions of this Contract not expressly superseded by COBRA shall apply to such COBRA continuation coverage.

(a) Employer is solely responsible for (i) assuring compliance with COBRA; (ii) giving Members timely notice, in accordance with COBRA, of their continuation coverage option; (iii) notifying SLVHMO within 15 days of a Member's election to continue coverage and the applicable maximum coverage period; and (iv) notifying SLVHMO of any event which terminates Employer's obligation to provide the Member with COBRA continuation coverage before the end of the maximum coverage period.

(b) A Member must apply for COBRA continuation coverage within 60 days of the termination date of coverage, or the date the Member receives specific notice of his or her COBRA continuation coverage rights, whichever is later.

(c) If Employer fails to give the Member notice of any COBRA continuation rights or to give SLVHMO notice of any COBRA election, each within the time stated in 11.1(a) above, SLVHMO shall be entitled to charge Employer and Employer shall pay the greater of (1) charges for medical services incurred by the Member prior to notice to SLVHMO of the Member's exercise of COBRA rights or (2) the applicable Premium amount for coverage retroactive to the date of the Member's qualifying event under COBRA. In any event, SLVHMO will provide COBRA continuation coverage only for the minimum period required to enable Employer to meet its obligations under COBRA and, for purposes of this Section, such period will always begin on the date of the Member's qualifying event. If SLVHMO, in the exercise of reasonable judgment, determines that Employer willfully failed to give timely notice to a Member of any required COBRA continuation rights, SLVHMO may refuse to provide COBRA continuation coverage to the Member.

(d) The cost of COBRA continuation coverage payable to SLVHMO will be 100 percent (or 102 percent if SLVHMO provides administrative services) of the applicable group rate (including any portion previously paid by employer), except where COBRA continuation coverage has been extended due to disability in which case the cost will be 150 percent of the applicable group rate for the period of extension.

(e) The provisions of this Section 11.1 will terminate if this Contract terminates. Employer's violation of its obligations under Section 11.1(a) shall constitute grounds for termination of this Contract.

11.2 In the event a Subscriber Group is not eligible for COBRA continuation such Subscriber Group's Members shall be eligible to continue coverage pursuant to Colorado Continuation of Coverage regulations, through which the Member or any of the Member's dependents has the right to continue coverage under this Agreement for a period of eighteen months after loss of coverage due to the termination of employment of a Member, the death of any such Member, or change in marital status of any said Member, or until the Member or dependent becomes eligible for other group coverage, whichever occurs first.

(a) The Colorado Continuation of Coverage will be available only if, on the date the Member's or dependent's coverage would otherwise cease:

(i) this Agreement is in force;
(ii) the Member's/Subscriber's insurance class has not been removed from this Agreement;
(iii) the person seeking continuation does not qualify for Medicare or Medicaid;
(iv) the Member has not failed to pay any required Premium;
(v) the Member had been continuously insured under this agreement, or under any group policy providing similar benefits which this agreement replaced for at least six months immediately prior to termination.

11.3 Upon termination of the Agreement by SLVHMO or the Subscriber Group Conversion to a self-paid individual Basic or Standard Health Benefit Plan is available to Members who are not eligible for the Colorado Continuation Coverage referenced in Section 11.2 or COBRA continuation of coverage. No evidence of good health is required. Individual coverage will begin at the time group coverage ends, (for reasons other than replacement with another group policy or fraud and abuse in processing and utilizing coverage) provided written application is made and the first month's Premium is paid to SLVHMO within 31 days following termination of group coverage. Reasons for termination include but are not limited to the Subscriber Group no longer meeting participation requirements, cancellation due to nonpayment of

Premiums or the Subscriber Group or SLVHMO exercising the right to terminate this Agreement. If these procedures are not followed, conversion to individual coverage will not be allowed.

(a) The individual Basic or Standard Health Benefit Plan may provide a lower level of benefits than the group plan. Premiums will be in accordance with SLVHMO's prevailing rates for conversion coverage and will be due monthly, payable in advance beginning with the first day of coverage. Premiums must be paid directly to SLVHMO. In the event either SLVHMO or Subscriber Group does not renew, or cancels or otherwise terminates this Contract, or COBRA or Colorado Continuation Coverage benefits are exhausted, a self-paid individual Basic or Standard Health Benefit Plan may be available pursuant to Section 10-16-108(4)(b)C.R.S. to any person who was covered hereunder at the time of termination unless the person is eligible to obtain other group medical coverage. However, if the new group medical coverage excludes a condition covered under this Contract, coverage under this Contract may be continued only for 18 months, or until the new group medical plan covers such condition, whichever occurs first.

(b) SLVHMO reserves the right to deny conversion coverage to a Member who is eligible under another group plan or policy, Contract or agreement; is eligible for continuation coverage referenced in Section 11.2 above, or COBRA continuation coverage. Such other coverage must not contain operable exclusions for pre-existing conditions or waiting periods greater than those remaining under the terminated plan.

(c) Dependents may convert individually to a Basic or Standard Health Benefit Plan pursuant to Section 10-16-108(4)(b)C.R.S.

(d) Any Subscriber whose coverage under this Contract ends when the Subscriber's employment or membership is terminated for fraud or abuse in procuring or utilizing coverage, will not be eligible for conversion to a self-paid individual Basic or Standard Health Benefit Plan, though the Subscriber's dependents will be eligible. Dependents who are not Enrolled when they first become eligible will not be eligible for conversion coverage nor will any person eligible for any type of Medicare.

ARTICLE 12. - COORDINATION OF BENEFITS

12.1 Benefits Subject to this Provision: All of the benefits and services provided under this Contract are subject to the determination of responsibility for the payment of eligible expenses in accordance with the coordination of benefits rules set forth below. In order to obtain coverage under this article, a Member must have sought and received care in accordance with all the terms and conditions of this Contract.

12.2 Plan

(a) For purposes of this article, "plan" means group insurance policies or blanket disability insurance policies and health care service Contractors, preferred provider organization and health maintenance organization group agreements issued by insurers, health care service Contractors and health maintenance organizations, labor-management trustee plans, labor organization plans, employer organization plans or Employee benefit organization plans, governmental plans, and coverage required or provided by any statute.

(b) The term "plan" shall be construed separately with respect to each policy, Contract, or other arrangement for benefits or services, and separately with respect to the respective portions of any such policy, Contract, or other arrangement which do and which do not reserve the right to take the benefits or services of other policies, Contracts, or other arrangements into consideration in determining its benefits.

(c) "Plan" does not include individual or family health or other insurance policies of any type except group type policies which are not available to the general public and which can only be obtained and maintained because of a covered person's membership in or connection with a particular organization or group. "Plan" does not mean group or group type hospital indemnity benefits of $100 per day or less for Subscribers to agreements executed in Colorado and does not include coverage on preschool, grammar school, high school, and college students for accidents only, including athletic injuries, either on a 24-hour basis or a to and from school basis.

12.3 Allowable Expense: "Allowable expense" means the usual, customary and reasonable charge for any necessary health care service or supply when the service or supply is covered at least in part under any of the plans involved. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under the above definition unless the covered person's stay in a private hospital room is considered Medically Necessary under at least one of the plans involved.

12.4 Claim Determination Period: "Claim determination period" means calendar year.

12.5 Right to Receive and Release Information: For the purposes of administering this Article 12, SLVHMO may, with such consent as may be necessary, release to or obtain from any insurance company or other person or organization any information with respect to any person which it reasonably deems to be necessary. This specifically includes any records relating to alcohol, drug abuse and mental health. Any Member claiming benefits under this Contract shall furnish such information as may be reasonably necessary to implement this paragraph.

12.6 Facility of Payment: Whenever services which should have been rendered under this Contract have been provided by another plan, SLVHMO shall have the right, at its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this Article 12. Any amount so paid shall be deemed to be a benefit provided under this Contract and, to the extent of such payment for covered services, SLVHMO shall be fully discharged from liability under this Contract.

12.7 Right of Recovery: Whenever payments have been made by SLVHMO with respect to covered services in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, SLVHMO shall have the right to recover such payments to the extent of such excess from one or more of the following, as SLVHMO may determine: any persons to, or for, or with respect to whom such payments were made, any other insurers, any service plans or any other organizations or other plans.

12.8 Effect on Benefits:

(a) This provision shall apply in determining the benefits for a person covered under this Plan for a particular claim determination period if, for the allowable expenses incurred as to such person during such period, the sum of:

(i) The benefits that would be payable under this Plan in the absence of this provision, and

(ii) The benefits that would be payable under all other plans in the absence therein of provisions of similar purpose to this provision would exceed such allowable expenses.

(b) As to any claim determination period with respect to which this provision is applicable, the benefits that would be payable under this Plan in the absence of this provision for the

allowable expenses incurred as to such person during such claim determination period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such allowable expenses under all other plans, except as provided in subsection (c) of this section, shall not exceed the total of such allowable expenses. Benefits payable under another plan include the benefits that would have been payable had claim been duly made therefore.

(c) If

(i) Another plan which is involved in subsection (b) of this section and which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and

(ii) The rules set forth in subsection (d) of this section would require this Plan to determine its benefits before such other plan then the benefits of such other plan will be ignored for the purposes of determining the benefits under this Plan.

(d) For the purpose of subsection (c) of this section, the rules establishing the order of benefit determination are:

(i) The benefits of a plan which covers the person on whose expenses claim is based other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent.

(ii) Except for cases of a person for whom claim is made as a dependent Child whose parents are separated or divorced, the benefits of a plan which covers the person on whose expenses claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a plan which covers such person as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either plan does not have the provisions of this subsection regarding dependents, which results either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of this subsection shall not apply, and the rule set forth in the plan which does not have the provisions of this subsection shall determine the order of benefits. In the case of a person for whom claim is made as a dependent Child, however,

(1) When the parents are separated or divorced and the parent with custody of the Child has not remarried, the benefits of a plan which covers the Child as a dependent of the parent with custody of the Child will be determined before the benefits of a plan which covers the Child as a dependent of the parent without custody; or

(2) When parents are divorced and the parent with custody of the Child has remarried, the benefits of a plan which covers the Child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that Child as a dependent of the stepparent, and the benefits of a plan which covers that Child as a dependent of the step-parent will be determined before the benefits of a plan which covers that Child as a dependent of the parent without custody; or

(3) Notwithstanding items (1) and (2) of this subdivision, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the Child, the benefits of a plan which covers the Child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the Child as a dependent Child.

(iii) When (i) and (ii) of this subsection do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time, provided that:

(1) The benefits of a plan covering the person on whose expenses claim is based as a laid off or retired Employee, or dependent of such person, shall be determined after the benefits of any other plan covering such person as an Employee, other than a laid off or retired Employee, or dependent of such person; and

(2) If either plan does not have a provision regarding laid off or retired Employees, which results in each plan determining its benefits after the other, then the provision of (1) of this subsection shall not apply.

(iv) If none of the above rules determines the order of benefits, the benefits of the plan which covered an Employee, Member or Subscriber longer are determined before those of the plan which covered that person for the shorter time.

(e) When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any claim determination period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

12.9 Coordination of benefits between this Contract and Medicare will be in accordance with federal laws and regulations.

ARTICLE 13. - SUBROGATION

13.1 The benefits of this Contract will be available to a Member who is injured in an accident or by another party, subject to the exclusions and limitations of this Contract. If SLVHMO provides benefits for the treatment of an injury, whether or not caused by another party, it shall, to the extent of all payments made by SLVHMO or the value of Medical Services for which SLVHMO provided coverage as well as costs of suit and attorney's fees incurred by SLVHMO:

(a) be subrogated to the right of the Member or the Member's representative to recover compensation for the injury; and

(b) have a security interest in any recoveries.

As a condition of receiving the benefits of this Contract for the injury, the Member or the Member's representative shall:

(a) give SLVHMO, in writing, the name and address of the party who caused the injury, if any, the facts of the accident, and any other information reasonably necessary to protect SLVHMO's rights hereunder;

(b) if the injury was caused by another party, provide SLVHMO with all information about the other party's liability insurer(s) known to the Member or Member's representative; and

(c) notify SLVHMO of any personal injury protection, underinsured or uninsured motorist insurance or any other insurance under which the Member is or may be entitled to recover compensation and provide to SLVHMO a copy of any such insurance policy.

(d) The Member or the Member's representative shall cooperate fully with SLVHMO in recovering any amount SLVHMO has paid. The Member or Member's representative shall notify SLVHMO within 60 days of submitting or filing a claim or legal action against a third party. The Member or the Member's representative shall provide SLVHMO with prior written notice of any intended settlement and shall not settle any claim or relinquish or waive the right to compensation from any insurer or other person without SLVHMO's prior written consent.

ARTICLE 14. - RELATIONSHIPS

14.1 The relationship between Subscriber Group and a Subscriber is that of employer and Employee and is defined by the employment Contract. SLVHMO has no involvement in that relationship. The relationship between Subscriber Group and SLVHMO is that of purchaser and seller and is entirely governed by the provisions of this Contract. In addition, Subscriber Group acts as the agent of those Employees who are Subscribers with respect to all terms and provisions of this Contract. Because the Subscriber pays the Premium to SLVHMO indirectly through his or her agent, the Subscriber Group, the relationship between a Subscriber and SLVHMO is also that of purchaser and seller and is entirely governed by the provisions of this Contract.

14.2 The relationship between SLVHMO and participating providers is that of independent Contractors. participating providers are independent professionals who operate their own offices and businesses, make their own medical decisions, and provide services to entities and patients other than SLVHMO and SLVHMO Members. participating providers agree to methods and rates of payment from SLVHMO, concurrent and retrospective review by SLVHMO of medical services provided to Members, and SLVHMO's medical management procedures. To be covered by SLVHMO, non-Emergency and non-urgent medical services provided to Members must be obtained from participating providers.

14.3 The fact that Members and participating providers each have Contractual relationships with SLVHMO does not prevent a Member from obtaining nor a participating provider from providing services that are not covered by SLVHMO. SLVHMO has no direct control over the examination, diagnosis or treatment of a Member. SLVHMO does perform medical management, including but not limited to case review for purposes of determining coverage, consultation with providers regarding written referrals, and concurrent and retrospective review of medical services provided to Members. These procedures are not intended to create a physician-patient relationship or to replace the relationship between a Member and his or her physician. A Member is always entitled to obtain, at his or her own expense, services not covered under the terms of this Contract.

14.4 The Subscriber Group agrees to indemnify and hold harmless SLVHMO and its directors, officers and Employees against any loss and all claims, lawsuits, settlements, judgments, costs, penalties, and expenses (including attorneys' fees) resulting from or arising out of the willful misconduct or dishonest, fraudulent, reckless, unlawful, or negligent acts or omissions of the Subscriber Group, any of its directors, officers, or Employees or any Members Enrolled under this Contract, except to the extent that such losses, claims, lawsuits, settlements, judgments, costs, penalties, or expenses result from the misconduct or dishonest, negligent, unlawful, reckless, or fraudulent act on the part of SLVHMO or any of its directors, officers, Employees, or parent, subsidiary, or otherwise affiliated entities.

14.5 SLVHMO shall use ordinary care in the exercise of its power and in the performance of its obligations under this Contract.

14.6 SLVHMO agrees to indemnify and hold harmless the Subscriber Group, its officers, and Employees against any loss and all claims, lawsuits, settlements, judgments, costs, penalties, and expenses (including attorneys' fees) resulting from or arising out of the willful misconduct or dishonest, fraudulent, reckless, unlawful, or negligent acts or omissions of SLVHMO or any of its directors, officers, or Employees, or parent, subsidiary, or other affiliated entities except to the extent that such losses, claims,

lawsuits, settlements, judgments, costs, penalties and expenses result from the misconduct or dishonest, fraudulent, reckless, negligent or unlawful acts or omissions of the Subscriber Group, its directors, officers or Employees or any Members Enrolled under this Contract.

ARTICLE 15. - MISCELLANEOUS

15.1 By this Contract, Subscriber Group makes SLVHMO coverage available to all eligible persons. By electing medical and hospital coverage pursuant to this Contract, or accepting benefits hereunder, all Members legally capable of Contracting and the legal representatives of all Members incapable of Contracting agree to all terms, conditions, and provisions hereof.

15.2 This Contract may be amended, modified, or terminated by mutual agreement between SLVHMO and Subscriber Group without the consent or concurrence of any Member. Any modification or amendment must be in writing and signed by SLVHMO. No person other than a duly authorized officer of SLVHMO has authority to act on behalf of SLVHMO to change this Contract or to waive any of its provisions. SLVHMO may submit any proposed amendment or modification in writing to Subscriber Group at least 30 days prior to the effective date of the amendment. Subscriber Group's agreement to such amendments shall be established by continuation of payment for coverage hereunder.

15.3 Members or applicants for membership shall complete and submit to SLVHMO such applications and other forms or statements as SLVHMO may reasonably request. Failure to do so may result in loss of benefits.

15.4 Cards issued by SLVHMO to Members are for identification only. Possession of a SLVHMO identification card confers no right to services or other benefits. The holder of a SLVHMO identification card must be a Member on whose behalf all amounts due under this Contract have actually been paid. Any person receiving services or other benefits to which he or she is not entitled shall be charged at the Usual Rates of the provider. If any Member permits the use of his or her SLVHMO identification card by any other person, such card may be reclaimed by SLVHMO, and all rights of such Member and his or her dependents may be terminated without notice at the election of SLVHMO. Such Member shall be liable to SLVHMO for all associated costs.

15.5 SLVHMO may adopt reasonable policies, procedures, rules and interpretations not inconsistent with this Contract to promote orderly and efficient administration of this Contract.

15.6 Any notice under this Contract shall be given by the U.S. mail, postage paid, addressed as follows:

(a) To SLVHMO at the address stated on the Signature Sheet;

(b) To Member at the latest address actually delivered to SLVHMO;

(c) To Subscriber Group at the address indicated on the Signature Sheet. Notice given by SLVHMO to Subscriber Group shall be deemed notice to all affected Subscribers and dependents in the administration of this Contract, including termination of this Contract. Upon receipt of notice from SLVHMO, Subscriber Group is responsible for providing copies to all affected Subscribers in the Subscriber Group within 30 days after receipt, or in the event notice is of termination of this Contract, then within 5 days after receipt.

15.7 This Contract constitutes the entire Contract between the Subscriber Group, Subscriber and SLVHMO and all statements made by the Subscriber Group and/or the Subscriber are deemed warranties.

15.8 The benefits of this Contract are personal to the Member. The Member may not assign such benefits nor may the Member assign or otherwise transfer any claim, right of recovery or right to payment arising under this Contract.

15.9 SLVHMO may assign this Contract to its successor in interest or an affiliate. SLVHMO reserves the right to Contract with other corporations, associations, partnerships, or individuals to provide services and supplies described in this Contract.

15.10 The rights of Members and the obligations of SLVHMO shall be determined solely by this Contract without regard to any other agreement or relationship between SLVHMO and any provider, Physician, employer or other person. No provider (except for services actually rendered by such provider) or any director, officer, Employee, agent or representative of SLVHMO is liable for the conduct of any provider in furnishing health care services.

15.11 Subscriber Group warrants that it presently has and will maintain throughout the term of this Contract all coverage required of it by applicable Worker's Compensation or employer's liability laws or other laws of similar purpose.

15.12 When services are provided to a Member by a participating provider in accordance with the terms of this Contract, the Member is responsible only for payment of the Contractually stated Copayments and deductibles, and non-covered services.

15.13 Subscriber Group and each Subscriber acknowledge that SLVHMO, as most prepaid health care organizations, operates on a system which may involve one, more or all of the following: medical management and utilization review. Subscriber Group and all Subscribers acknowledge that, absent a declaration that any of the foregoing is contrary to public policy in the State of Colorado, such system does not violate medical ethics nor constitute negligence, fraud, breach of trust or a tortuous breach of the physician/patient relationship.

15.14 SLVHMO relies substantially upon licensing and regulatory authorities, continuing education requirements, peer review committees, medical and hospital staff decisions, Provider representations and insurability in the selection of participating providers. SLVHMO is not responsible for the decisions of participating providers.

15.15 It is understood that nothing in this Contract shall entitle either party to this Contract to recover attorneys' fees from the other party in the event of litigation between the parties, except as provided for by statute.

15.16 Each party shall advise the other as to matters that come to their attention with respect to potential substantial legal actions involving matters related to this Contract, and shall promptly advise each other of legal actions commenced against each party that come to their attention. Each party shall fully cooperate with the other in the defense of any action arising out of matters related to this Contract by providing without additional fee all information relating to disputed claims and providing necessary testimony.

15.17 Waiver of any default shall not be deemed to be a waiver of any subsequent default. Waiver of breach of any provision of this Contract shall not be deemed to be a waiver of any other or subsequent breach and shall not be construed to be a modification of the terms of this Contract unless stated to be such in writing, signed by the parties and attached to this Contract.

15.18 Notwithstanding any other provision of this Contract, the provisions of this Contract which, on or after the group effective date, are in conflict with applicable state or federal laws or state or federal regulations, are hereby amended to conform to the minimum requirements of such laws or regulations.

15.19 This Contract is issued and delivered in the State of Colorado and is governed by the laws of the State of Colorado.

15.20 No benefit, right or any interest of any beneficiary under this Contract can be assigned or transferred and any such assignment or transfer shall be held invalid and void. Payment of any benefits

hereunder shall, at the exclusive option of SLVHMO, be made directly to the physician, hospital or institution providing their services, or to his or their representative, or directly to the beneficiary.

15.21 If any term, provision, covenant, or condition of this Contract is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions and the Contract shall remain in force and effect, and in no way shall be affected, impaired, or invalidated.

15.22 No failure on the part of SLVHMO to exercise, and no delay in exercising any right, power or remedy shall operate as a waiver thereof, nor shall any single or partial exercise of any right, power or remedy preclude any other further exercise thereof or the exercise of any other right, power or remedy.

15.23 The headings in this Contract are provided solely for convenience of reference and are not a part of this Contract or guides to interpretation hereof.