SUMMARY PLAN DESCRIPTION

SELF-FUNDED VISION PLAN FOR

COLORADO EMPLOYER BENEFIT TRUST

EFFECTIVE DATE: JULY 1, 2019

It is the intention of the Trust to hereby establish a program of benefits constituting an "Employee Welfare Benefit Plan" under the Internal Revenue Code of 1986, and any amendments thereto.

IN WITNESS WHEREOF, the Trust has executed this Summary Plan Description as of the Plan Effective Date shown.

By: [Signature]

Authorized Representative

Date: 5/30/19

Title: Board Chairman
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IMPORTANT MESSAGE

You should report ANY CHANGE IN ELIGIBILITY to your employer as soon as possible. Changes in eligibility include:

♦ Marriage or divorce
♦ Death of any dependent
♦ Birth or adoption of a child
♦ Dependent child reaching the limiting age
♦ Total disability
♦ Retirement
♦ Medicare eligibility

For specific details on maintaining coverage under the plan, refer to SECTION 3 - ELIGIBILITY.
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**SCHEDULE OF BENEFITS**

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<th>PLAN PAYS</th>
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<tr>
<td>Individual Deductible per Calendar Year</td>
<td></td>
<td></td>
<td>The vision plan does not have a deductible.</td>
</tr>
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</table>

All covered expenses under the plan are payable at the plan's customary, usual and reasonable limits. For vision exams that are eligible under CEBT’s medical and vision plan, the vision plan will be primary and the medical plan secondary.

**Change in Prescription**

If you have a change in prescription, you will be eligible for the exam and lens or contact benefit once each calendar year, instead of once per two calendar year period. If your prescription does not change the following year, your benefits will go back to the two calendar year benefit period.

<table>
<thead>
<tr>
<th>COVERED EXPENSES</th>
<th>PAYABLE AT</th>
<th>BENEFIT SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams (including eye refractions)</td>
<td>100% to a maximum benefit of $75 per calendar year</td>
<td>Limited to one exam per calendar year. This benefit includes a contact lens fitting fee.</td>
</tr>
<tr>
<td>Lenses</td>
<td>100% to a maximum benefit per two calendar years of:</td>
<td>Limited to once per two calendar years. You must choose between lenses/frames, contacts or eye surgery during the same two calendar year period. The plan will not provide coverage for lenses/frames, contacts or eye surgery during the same two calendar year period.</td>
</tr>
<tr>
<td>Single Vision</td>
<td>$75</td>
<td></td>
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<tr>
<td>Bifocal</td>
<td>$100</td>
<td></td>
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<tr>
<td>Progressive</td>
<td>$100</td>
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<tr>
<td>Trifocal</td>
<td>$150</td>
<td></td>
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<tr>
<td>Lenticular</td>
<td>$125</td>
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</tr>
<tr>
<td>Contacts</td>
<td>$150</td>
<td></td>
</tr>
<tr>
<td>Frames</td>
<td>100% up to a maximum benefit paid $150 per two calendar years</td>
<td>One set of frames per two calendar year period.</td>
</tr>
<tr>
<td>COVERED EXPENSES</td>
<td>PAYABLE AT</td>
<td>BENEFIT SUMMARY</td>
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<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Eye Refractive Surgery</td>
<td>100% up to a maximum benefit paid $200 per two calendar years</td>
<td>You must choose between lenses/frames, contacts or eye surgery during the same two calendar year period. The plan will not provide coverage for lenses/frames, contacts or eye surgery during the same two calendar year period.</td>
</tr>
<tr>
<td>Limitations and Exclusions</td>
<td>Not Payable</td>
<td>List of exclusions that apply to all covered expenses. A service that is normally covered may be excluded when provided with an excluded item.</td>
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HOW TO FILE A VISION CLAIM

You will receive a plan identification (ID) card. It will show your name, group number and the effective date of your coverage.

Follow the instructions on your ID card for filling claims. Be sure each bill shows the group number and participant number found on your ID card. The employee's name and the patient's name should also be included on each bill.

PAYMENT OF CLAIMS

The plan will make direct payment to the service provider. If you have paid the bill, please indicate on the original bill "paid by employee" and payment will be made to you. You will receive a written explanation of payment or reason for denial of any portion of a claim. The plan reserves the right to request any information required to determine benefits or process a claim. You or the service provider will be contacted if additional information is needed to process your claim.

CLAIM FILING LIMITS

You must provide the plan with written proof of your claim. Proof should be provided within 90 days after the date the claim was incurred. Your claim will not be denied if it was not reasonably possible to give such proof. However, unless you were legally incapacitated during the period, any claim received by the plan more than 12 months after the date the claim was incurred will not be covered under the plan.

If the plan is terminated, written proof of any claims incurred prior to the termination must be given to the plan within 90 days of its termination. Any claim received by the plan more than 90 days after it is terminated will not be covered under the plan.

If the employer terminates it’s participation with the trust, claims may be subject to different filing limitations, as found in the Employee Participation Agreement.
VISION BENEFITS

The following services and materials are payable as shown on the Schedule of Benefits when provided by a licensed optometrist, ophthalmologist or dispensing optician.

VISION EXAMS

Vision examinations, including refractions, will be payable as shown on the Schedule of Benefits. This includes a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities. Any maintenance fees or fitting fees associated with the purchase of contact lenses will also be considered a covered expense.

MATERIALS

Lenses/Contacts

When a vision examination indicates that corrective lenses are necessary to maintain your visual health, the cost of such lenses will be payable as shown on the Schedule of Benefits. Benefits include single vision, bifocal, trifocal and lenticular eyeglass lenses or hard, soft or disposable contact lenses.

Frames

The cost of one set of frames per two calendar years will be payable as shown on the Schedule of Benefits.

Eye Surgery

Eye surgeries used to improve/correct eyesight for refractive disorders (i.e. lasik surgery, radial keratotmy). Payable as shown on the Schedule of Benefits and limited to once per two calendar years. This benefit is in lieu of lenses/frames or contacts.
LIMITATIONS AND EXCLUSIONS

The plan does not provide benefits for:

1. Services or materials connected with:
   a. orthoptics or vision training procedures,
   b. corneal refractive therapy,
   c. ancillary supplies for contact lens,
   d. replacement of lost, stolen or broken lenses and/or frames,
   e. plano (non-prescription) lenses;

2. Medical or surgical treatment of the eye, except as specifically stated otherwise;

3. Any injury or sickness arising from or sustained in the course of any occupation or employment for pay, profit or gain. This will only apply when benefits are available or payable under any Workers’ Compensation or Occupational Disease Act or Law, regardless of whether a claim was filed for such benefits;

4. Any procedures or materials required as a condition of employment, including but not limited to, industrial safety glasses;

5. Charges made after the covered person’s termination date;

6. Services or supplies that are paid under any other provisions of this plan;

7. Drugs;

8. Any service or supply provided in connection with or as a result of any service or supply that is not a covered expense;

9. Any service or supply for which no charge is made, or for which you would not be required to pay if you did not have this coverage; or

10. Services provided by a person who ordinarily resides in your home or who is a family member.
SECTION 2  DEFINITIONS
DEFINITIONS

Certain words and phrases used in this Summary Plan Description are defined below as an explanation of how the terms are used in the plan. Defined words appear in italic throughout the plan.

_Actively at Work_
Performing on a regular, full-time basis all normal employment duties for at least 20 hours per week. Duties may be at the employer's business or another location if you are required to travel on the job. You will be actively at work on each day of paid vacation if you were actively at work on your last regular working day. You will be actively at work on each non-working holiday if you were actively at work on your last regular working day.

_Amendment_
A written document that changes the provisions of the plan. It must be duly authorized and signed by the plan administrator.

_Board of Trustees_
The Board of Trustees established by the Trust Agreement.

_Calendar Year_
A 12 month period of time that starts on January 1 and ends on December 31.

_Claims Administrator_
The person or firm employed by the plan administrator to provide clerical services to the plan. Clerical services include the processing of claims. If a claims administrator is not employed by the plan administrator, claims administrator will mean the employer.

_Covered Person_
The employee or any dependent, when you are properly enrolled in the plan.

_Customary, Usual and Reasonable_
The lesser of the fee most often charged by the provider or the maximum allowable fee as determined by the plan. The maximum allowable fee is set by comparing the service to a national database of fees. The database is adjusted to the locality where the service was performed.

_Dependent_
1. A covered employee's lawful spouse, as defined in the State where you reside, provided that:
   a. the spouse is not legally separated from the employee, and
   b. the employee is eligible to claim a marital status of married on their current Federal Income Tax Return as a result;

2. A covered employee's Civil Union partner, who meets the requirements of Colorado’s Civil Union Act;

3. A covered employee's married or unmarried: natural born, blood related child; step-child; foster child; a Civil Union partner’s child; legally adopted child; child placed in the employee's legal guardianship by court order; or a child placed with the employee for the purpose of adoption and for which the employee has a legal obligation to provide full or partial support; whose age is less than the limiting age.

   The limiting age for each dependent child is the last day of the month in which such child reaches age 26.
Definition of Dependent – continued

Right To Check Dependent Eligibility
The plan reserves the right to check the eligibility status of a dependent at any time during the year. You and your dependent have an obligation to notify the plan when the dependent’s eligibility status changes during the year. Please notify your employer of any status changes.

If, from the date a dependent child reaches a limiting age, all of the following conditions exist at the same time:

1. The child is mentally or physically handicapped;
2. The child is incapable of self-sustaining employment;
3. The child is dependent on the covered employee for support and maintenance; and
4. The child is unmarried,

that child will remain an eligible dependent of a covered employee or may be enrolled as the dependent of a new employee. If the child has not continuously satisfied all of the conditions above since reaching a limiting age, the child will not be eligible for coverage under the plan.

You must provide satisfactory proof that the above conditions exist on and after the date the limiting age is reached (Notice of Award of Social Security Income is acceptable). Such proof may not be requested more often than annually after two years from the date the first proof was provided. If satisfactory proof is not submitted, the child's coverage will cease on the date such proof is due.

If both parents are eligible for coverage under this plan through the same contributing employer, only one may enroll for dependent coverage.

Employee
You when you are: regularly employed by the employer; paid a salary or earnings by the employer; and actively at work. For purposes of this plan, employee does not include independent contractors or leased employees.

Employer
A contributing employer in the Colorado Employer Benefit Trust, who employs the covered employee. The employer is required by a Participation Agreement or Trust Agreement to make contributions to the plan or who, in fact, makes one or more contributions to the plan.

Expense Incurred
The customary, usual and reasonable fee charged for services and supplies. The date a service or supply is provided is the expense incurred date.

Late Applicant
An employee who enrolls for coverage more than 30 days after they are eligible to be covered. A dependent who is enrolled for coverage more than 30 days after they are eligible to be covered.

Medicare
Title XVIII, Parts A and B, of the Social Security Act as enacted and amended.

Named Fiduciary
Colorado Employer Benefit Trust, which has the authority to control and manage the operation of the plan, that was established by the Trust Agreement.
Definitions – continued

Plan
This plan of benefits as selected by the Trust Agreement. The term plan includes any schedules, attachments and amendments to the plan. Prior, current and successive plans will be considered one plan and not separate and distinct plans. This Summary Plan Description provides a description of the plan.

Plan Administrator
The entity, who is responsible for the day to day functions and engagement of the plan. The plan administrator may employ other persons or firms to process claims and perform other services.

Pre-Service Claim
Any claim for a benefit that is conditioned, in whole or in part, on obtaining prior approval from the plan for the medical care.

Post-Service Claim
Any claim that is not a pre-service claim

Total Disability or Totally Disabled
The inability at all times, due to injury or sickness, to perform each and every material duty of your job or occupation.

Trust
Colorado Employer Benefit Trust, the sponsor of this group plan.

Trust Agreement
The Agreement and Declaration of Trust establishing CEBT, dated August 9, 1976, as modified or amended.

Urgent Care
Any care that in the opinion of your qualified practitioner is an urgent care situation. Any care that the use of non-urgent care time frames would put your life, health or ability to regain maximum function at risk.

You and Your
You as the covered employee. Any of your dependents, unless otherwise indicated.
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SECTION 3    ELIGIBILITY
**ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE**

The Employee Coverage section applies to *employees* hired on or after the effective date of this *plan*. The Dependent Coverage section applies to *dependents* that are added on or after the effective date of this *plan*.

*Employees* who were covered under any plan that this *plan* replaces will be covered on the effective date of this *plan*. Coverage will include *dependents* of such an *employee*. *You* must have met the eligibility requirements of the *plan*.

**EMPLOYEE COVERAGE**

**Employee Eligibility**

*You* are eligible for coverage under the *plan* if the following conditions are met:

1. *Your employer* has elected to be a member of the Colorado Employer Benefit Trust;
2. *You* are an *employee* who meets the eligibility requirements of *your employer*; and
3. *You* satisfy the eligibility period as determined by *your employer* (not to exceed a maximum of 90 consecutive days of full-time employment); or
4. *You* are an elected or appointed official of *your employer*.

*You* are eligible to be covered on the completion date of *your employer’s* chosen eligibility period. This is *your* eligibility date.

**Employee Effective Date**

*You* must enroll on forms accepted by the *plan administrator*. Each *employee’s* effective date is determined as follows:

1. *Your completed forms are received by the plan administrator within 30 days of the date you are eligible. This is a timely enrollment. Your coverage will be effective on your eligibility date.*
2. *Your completed forms are received by the plan administrator more than 30 days after the date you are eligible. This is late enrollment. You will not be eligible for coverage until the next annual enrollment period.*

Coverage will begin at 12:01 AM, Standard Time, on *your* effective date. *You* must begin active work with the *employer* before coverage will be effective under the *plan*.

**DEPENDENT COVERAGE**

**Dependent Eligibility**

*A dependent* is eligible to be covered on the later of:

1. The date the *employee* is covered;
2. The date of the *employee's* marriage for a *dependent* acquired on that date;
3. The child's date of birth;
4. The date a court order places a child in the *employee's* home. The child must be under the *employee's* legal guardianship;
**Dependent Eligibility - continued**

5. The date a child is legally adopted;

6. The date a valid court order is issued which, by federal law or plan provision, requires the plan to provide coverage; or

7. For a Civil Union partner, the date you meet the definition of dependent as stated in the plan.

Dependents may only be covered if the employee is covered. Check with your employer on how to enroll for dependent coverage. Late enrollment may result in a delay of coverage.

When both parents are employees of the same contributing employer, only one may enroll for dependent coverage.

**Dependent Effective Date**

Each dependent must be enrolled on forms accepted by the plan administrator. Each dependent's effective date of coverage is determined as follows:

1. The completed forms are received by the plan administrator within 30 days of the dependent's eligibility date. This is a timely enrollment. That dependent is covered on their eligibility date.

2. The completed forms are received by the plan administrator more than 30 days after the dependent's eligibility date. This is a late enrollment. That dependent will not be eligible for coverage until the next annual enrollment period.

Coverage will begin at 12:01 AM, Standard Time, on the dependent's effective date. An employee may drop coverage for their covered dependents at any time by completing a CEBT Enrollment/Change Form.

**Newborn and Adopted Children**

A newborn child of a covered employee or dependent spouse is automatically covered during the first 31 days of life and an adopted child is automatically covered in the 31-day period immediately following placement for adoption. Coverage is only provided automatically under this plan in the absence of other coverage under another plan. Dependent coverage must be in force for coverage to continue past the first 31 days of life. If dependent coverage is not in force at the end of the 31 days, the child's coverage will terminate immediately.

**HIPAA SPECIAL ENROLLMENT RIGHTS**

If you have a special enrollment event, the plan will provide a new enrollment date for you to enter the plan as shown below. At that time, you will be able to enroll in the plan without being subject to the late applicant provisions of the plan. If the plan has more than one benefit option, you will be able to select from all options for which you are eligible.

**Loss of Other Coverage**

If you declined coverage under this plan in favor of other group or individual health coverage, or COBRA continuation, and coverage under that other plan ends:

1. Due to your exhaustion of the maximum COBRA period;

2. Due to your loss of eligibility, for any reason; or

3. Employer contributions cease toward the cost of the other coverage;

Vision Plan - Revised 7/1/19
Special Enrollment Rights – continued

Then a special enrollment event has occurred. At that time, an employee or dependent may be enrolled in this plan as follows:

1. When the employee has a loss of coverage, the employee and any dependent may enroll. The dependent does not have to have had a loss of coverage at that time to be enrolled;

2. When a dependent has a loss of coverage, that dependent, the employee and any other eligible dependent may enroll. The employee and other dependents do not have to have had a loss of coverage at that time to enroll.

You must enroll in this plan within 30 days of the date of a loss of other coverage to be a timely entrant to the plan. You must provide proof that the other coverage was lost due to one of the above shown reasons. Coverage under this plan will not be effective until such proof is provided. Coverage under this plan will be effective on the day coverage under the other group plan ends.

If you apply more than 30 days after the date the other coverage ends, you will not be eligible for coverage until the next annual enrollment period.

Marriage

If you, as the employee, are now getting married, a special enrollment event will occur on the date of your marriage. At that time, you may enroll in this plan. Any dependents acquired on the date of your marriage may also be enrolled at this time as well as any other dependents that were not previously covered under the plan.

You must enroll in this plan within 30 days of the date of marriage to be a timely entrant to the plan. Coverage under the plan will be effective on the day of your marriage. If you apply more than 30 days after the date of your marriage, you will not be eligible for coverage until the next annual enrollment period.

Birth, Adoption or Placement for Adoption

If you experience the birth of a dependent child, or the adoption or placement for adoption of a dependent child, a special enrollment event will occur on that date. At that time, you may enroll in this plan. Your dependent spouse and the newborn or adopted child may also be enrolled at this time as well as any other dependents that were not covered previously under the plan.

You must enroll in this plan within 30 days of the date of birth, adoption or placement to be a timely entrant to the plan. Coverage under the plan will be effective on the date of such an event. If you apply more than 30 days after the date of such an event, you will not be eligible for coverage until the next annual enrollment period.

MEDICAID/STATE CHILD HEALTH PLAN

If you and/or your dependents were covered under a Medicaid plan or State child health plan and your coverage is now being terminated due to a loss of eligibility, a special enrollment event will occur on the date Medicaid or the State child health plan coverage ends.

You must request coverage under this plan within 60 days after the date of termination of such coverage. Coverage under this plan will be effective on the date the other coverage ends. If you apply for coverage more than 60 days after the date the Medicaid or State child health plan coverage ends, you will be considered a late applicant under this plan.
Premium Assistance
Current employees and their eligible dependents may be eligible for a special enrollment event if the employee and/or dependents are determined eligible, under a state’s Medicaid plan or State child health plan, for premium assistance with respect to coverage under this plan. You must request coverage under this plan within 60 days after the date the employee and/or dependent is determined to be eligible for such assistance. If you apply for coverage more than 60 days after this date, you will be considered a late applicant under the plan.

RETIREE COVERAGE
Retiree employees and their dependents may, at their former employer’s option, continue coverage. The retiree must be at least 50 years old and:

1. Have either ten (10) years of continuous coverage with any participating employer; or
2. Have been employed by a participating employer for at least fifteen (15) years, or such other restrictions as the employer may impose. The retiree may continue coverage until age 65.

Retiree Coverage will continue until the date the retiree reaches age 65. At that time coverage will also end for any dependents of the retiree. The retiree must pay their portion of any plan contributions.

If the employer currently allows a covered retiree’s dependents to remain on the plan after the retiree turns age 65, CEBT will no longer allow this after 12/31/2017.

NOTE: If you are Medicare eligible, claims must be submitted to Medicare first. After Medicare has processed your claim, the claim and the Medicare EOB should be submitted to this plan.

ANNUAL ENROLLMENT PERIOD
Each year, a 30-day period will be provided for enrollment. Once you have made elections for the year, your choices cannot be changed until the next annual enrollment period, unless you have a change in status, or request to voluntarily terminate coverage mid-year.

Completed enrollment forms must be received by the plan administrator before the end of the 30 day annual enrollment period. If your completed enrollment form is not received by that time, you will not be able to enter the plan until the next annual enrollment period or change in status.

Enrollment forms will automatically continue each year unless revoked by you in writing each year. Your employer will notify you when the annual enrollment period is each year.

Changes In Status
If you have a change in status, as defined by the IRS, you have 30 days from the date of that change to make new elections under this plan. Any changes in your elections must be consistent with your change in status or they will not be allowed. Change in status means only a change as stated below.

1. Legal Marital Status. Your marriage, divorce, legal separation, annulment or the death of your legal spouse;
2. Number of Dependents. An increase or decrease in the number of dependents you have due to birth, adoption, placement for adoption or the death of a dependent;
Changes in Status - continued

3. **Employment Status.** Any of the following events that change the employment status of you or your dependent, including: termination or commencement of employment, strike or lockout, commencement or return from unpaid leave, change in worksite, and any change in employment status that results in a loss or gain of eligibility under the Section 125 plan or the underlying benefit plan;

4. **Dependent Status.** Your dependent satisfies or ceases to satisfy eligibility requirements for coverage;

5. **Residence.** Any change in residence for you or your dependent;

6. **FMLA Leave Status.** At the time a leave under the FMLA begins the employee may change elections to the extent allowed under the federal Family and Medical Leave Act;

7. **COBRA Continuation.** You or your dependent become eligible for and elect continuation coverage under the employer's group health plan as provided by COBRA or a similar State law;

8. **Judgment, Decree or Court Order.** An order resulting from a divorce, legal separation, annulment, change in legal custody or Qualified Medical Child Support Order as defined by ERISA which requires you or another individual to provide health coverage for your dependent child;

9. **Entitlement to Medicare or Medicaid.** A gain or loss of eligibility under Medicare, Part A or Part B, or Medicaid for you or your dependent;

10. **HIPAA Special Enrollment Rights.** An event which qualifies as a special enrollment right under the Health Insurance Portability and Accountability Act;

11. **Significant Cost Increase.** Election changes are limited to increasing your election to cover the cost increase or changing the election to provide for a similar benefit offered by the employer;

12. **Significant Curtailment of Coverage.** An overall reduction in coverage provided to all participants that results in a general reduction in coverage under the plan;

13. **Addition or Elimination of a Benefit Option.** Election changes are limited to electing the new benefit option in the case of an added benefit option or electing a similar benefit in the case of the elimination of a benefit option;

14. **Changes in a Dependent's Coverage under Another Employer's Plan.** Election changes are limited to changes that result from a change under the plan of your spouse's, ex-spouse's or other dependent's employer. To qualify as a change in status under this plan the change must be permitted under the other employer plan and Section 125 of the Internal Revenue Code or be the result of a differing election period under the other employer plan.

If you have questions regarding whether an event qualifies as a change in status, the claims administrator will answer them.

**SPOUSAL TRANSFER PROVISION**

If both spouses are employees and each has taken single coverage under this plan, this plan permits your spouse to take coverage as your dependent at any time.

In addition, if both spouses are employees and eligible for coverage under this plan and your spouse previously waived coverage as an employee in favor of coverage as your dependent, this plan permits your spouse to take coverage as an employee under the plan and to enroll you and any other eligible dependents as dependents of your spouse when:
Spousal Transfer Provision - continued

1. You and your spouse decide to transfer coverage under the plan from one spouse to the other;

2. Your spouse decides to take coverage as an employee for any reason; or

3. You terminate your coverage under the plan for any reason.

Your spouse must elect coverage under this plan within 30 days of the date your coverage ends to be a timely enrollment. Your spouse's coverage under this plan will be effective on the day your coverage ends.

If your spouse applies more than 30 days after the date your coverage ends, you will not be eligible for coverage until the next annual enrollment period.

BENEFIT CHANGES

Any change in benefits will be effective on the date of change for all employees and dependents. Any change in coverage will be effective on the date of change for all employees and dependents.

SPECIAL PROVISIONS FOR NOT BEING ACTIVELY AT WORK

If you continue to pay the required plan contributions, your coverage will remain in force for no longer than:

1. One year during an approved, non-military leave of absence (including a total disability leave of absence); or

2. Two consecutive years during an approved sabbatical.

Coverage that is required by the Family and Medical Leave Act will reduce any period shown above. The plan must remain in effect for this provision to apply.

At the end of this period, COBRA continuation will be offered.

SURVIVORSHIP CONTINUATION

If you have dependent coverage in force on the date that you die, coverage under this plan will continue for your surviving dependents who were covered under the plan on the day immediately preceding your death. Survivorship Continuation will end on the earliest of the following:

1. The date your surviving dependents become covered under any other group plan;

2. The end of two consecutive years following your death.

This continuation will run concurrently with any continuation of coverage required by COBRA. Any required premium contributions will be waived during this period.

REINSTATEMENT OF COVERAGE

If your coverage ends due to termination of employment and you qualify for eligibility under this plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 26 weeks from the date your coverage ended, your coverage will be reinstated. If your coverage ends due to termination of employment and you do not qualify for eligibility under this plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 26 weeks from the date your coverage ended, and you did not perform any hours of service that were credited within the 26-week period, you will be treated as a new hire and will be required to meet all of the requirements of a new employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact your Personnel office.

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TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date the plan terminates;

2. For any benefit, the date the benefit is removed from the plan;

3. The end of the period for which any required employee or employer contribution was due and not paid;

4. The date you enter the full-time military, naval or air service of any country;

5. The end of the month in which you fail to be in an eligible class of persons according to the eligibility requirements of the employer;

6. For all employees, the end of the month in which termination of employment with the employer occurs or, if earlier, the end of the month in which you are no longer actively at work as defined in this plan;

7. For all employees, the end of the month in which your retirement occurs, unless you are eligible for and elect Retiree Coverage;

8. For your dependents, the date your coverage terminates;

9. For a dependent, the date the dependent enters the full-time military, naval or air service of any country;

10. For a dependent spouse, the end of the month in which that dependent no longer meets this plan’s definition of dependent;

11. For a dependent child, the end of the month in which the dependent child no longer meets the plan’s eligibility requirements as stated in the definition of dependent;

12. The date you request termination of coverage to be effective for yourself and/or your dependents; or

13. The date you die.

Rescission of Coverage

As permitted by the Patient Protection and Affordable Care Act, the plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is not a rescission if:

1. It has only a prospective effect;

2. It is attributable to non-payment of premiums or contributions; or

3. It is initiated by you or your personal representative.

Important Notice for Active Employees and Spouses Age 65 and Over

The plan cannot terminate your coverage due to age or Medicare status. An active employee that is eligible for Medicare due to age (age 65 or over) has the choice to:

1. Maintain coverage under this plan, in which case Medicare benefits would be secondary to this plan; or

2. End coverage under this plan, in which case Medicare would be the only coverage available to you.

An active employee's spouse who is eligible for Medicare due to age (age 65 or over) has the same choice.
FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act is a federal law. This law applies to employers with 50 or more employees. It requires that coverage under this plan be continued during a period of approved FMLA leave. The coverage must be identical to the coverage that would have been provided had FMLA leave not been taken. The coverage must be at the same cost to the employee as it would have been had FMLA leave not been taken.

If this plan is established while you are on FMLA, your coverage will be effective on the same date it would have been had you not taken leave. If the plan is amended while you are on FMLA leave, the changes will be effective for you on the same date as they would have been had you not taken leave.

EMPLOYEE ELIGIBILITY

An employee is eligible to take FMLA leave, if all of the following conditions are met:

1. The employee has been employed with the employer for a total of at least 12 months;
2. The employee has worked at least 1,250 hours during the 12 consecutive months prior to the request for FMLA leave; and
3. The employee is employed at a worksite that employs at least 50 employees.

TYPES OF LEAVE

Coverage under this plan can be continued during a period of FMLA leave. The employee must continue to pay the employee portion of the plan contribution during FMLA leave. If payment is not received, coverage will terminate.

Family and Medical Leave

Up to 12 weeks of coverage is available during a 12 month period, as defined by the employer, for:

1. The birth of the employee's child;
2. The placement of a child with the employee for adoption. The placement of a child with the employee for foster care;
3. The employee taking leave to care for a spouse, son, daughter, or parent that has a serious health condition;
4. The employee taking leave due to a serious health condition, which makes him unable to perform the functions of his position; or
5. Any qualifying necessity that results from the employee's spouse, son, daughter, or parent being called to or serving on active duty in the armed forces in support of a contingency operation.

Military Family Leave

Up to 26 weeks of coverage is available during a 12 month period, as defined by the employer, to care for a member of the armed forces that is the employee's spouse, son, daughter, parent or next of kin. Care must be necessary due to a serious injury or illness incurred by the service member in the line of duty during a period of active duty in the armed forces.
FMLA - continued

Maximum Leave Period
The maximum for each type of FMLA leave will apply separately as stated above. If FMLA leave during a single 12 month period includes both Family and Medical Leave and Military Family Leave, the combined maximum will not exceed 26 weeks.

If the employee and the employee's spouse are both employed by the employer, FMLA leave may be limited to a combined total for both spouses of:

1. 12 weeks when FMLA leave is due to the birth or placement of a son or daughter, or to the care of a parent with a serious health condition;
2. 26 weeks when FMLA leave is due to the care of a member of the armed forces; or
3. 26 weeks combined when both Family and Medical Leave and Military Family Leave are taken.

Termination Before the Maximum Leave Period
If the employee decides not to return to work, coverage under the plan may end at that time.

If the plan contribution is not paid within 30 days of its due date, coverage under the plan may end at that time. Notice of termination must be provided at least 15 days prior to the termination date.

If an employee does not return to work at the end of FMLA leave, COBRA Continuation will be offered at that time.

Recovery of Plan Contributions
The employer has the right to recover the portion of plan contributions it paid to maintain coverage under the plan during an unpaid FMLA leave. If the employee does not return to work at the end of the leave, that right may be exercised. This right will not apply if failure to return is due to circumstances beyond the employee's control.

REINSTATEMENT OF COVERAGE UPON RETURN TO WORK
The law requires that coverage be reinstated upon the employee's return to work. Reinstatement will apply whether coverage under the plan was maintained during the FMLA leave or not.

On reinstatement, all provisions and limits of the plan will apply as they would have applied if FMLA leave had not been taken. The eligibility period will be waived.

DEFINITIONS
For this provision only, the following terms are defined as shown below:

Serious Health Condition is any sickness, injury, impairment or physical or mental condition that involves:

1. Inpatient care in a hospital, hospice or residential medical care facility, including any period of incapacity (i.e. inability to work, attend school or perform other regular daily activities) due to a serious health condition, or treatment of or recovery from a serious health condition;
FMLA - continued

2. Continuing treatment by a *qualified practitioner*, including any period of incapacity:
   
a. for more than three consecutive calendar days, if a *qualified practitioner* is consulted two or more times during the period or a *qualified practitioner* is consulted at least once and a continuing treatment program is provided;
   
b. due to pregnancy or prenatal treatment, even if treatment is not provided or it does not last for more than three days;
   
c. due to a chronic condition (i.e. a condition which requires periodic treatments by a *qualified practitioner* and continues over an extended period of time, whether incapacity is continuous or periodic), even if treatment is not provided or it does not last for more than three days;
   
d. which is permanent or long term due to a condition which requires the supervision of a *qualified practitioner*, but for which treatment is ineffective;
   
e. to receive multiple treatments from a *qualified practitioner* for restorative surgery due to *accident* or *sickness* or for a condition that would likely result in a period of incapacity of more than three days without such treatment.

Serious health condition does not include cosmetic treatments unless inpatient care is required or complications develop, or common ailments such as colds, flu, ear aches, upset stomach, minor ulcers, headaches, other than migraines, routine dental or orthodontic problems.

**Spouse** is *your* lawful husband or wife.

**Son or Daughter** is *your* natural blood related child, adopted child, step-child, foster child, a child placed in *your* legal custody or a child for which *you* are acting as the parent in place of the child's natural blood related parent. The child must be:

1. Under the age of 18; or
2. Over the age of 18, but incapable of self-care due to a mental or physical disability.

**Parent** is *your* natural blood related parent or someone who has acted as *your* parent in place of *your* natural blood related parent.

NOTE: To the extent that State or local law requires an employer to provide greater leave rights than those stated above, this plan will provide that greater right. For complete information regarding *your* rights under the FMLA, contact *your* employer.
UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) is a federal law.

CONTINUATION OF COVERAGE DURING MILITARY LEAVE

The law requires that coverage under this plan be continued during a leave that is covered by the Act. Coverage must be the same as is provided under the plan to similar active employees. This means that when coverage is changed for similar active employees it will also change for the person on leave. The cost of such coverage will be:

1. For leaves of 30 days or less, the same as the employee contribution required for active employees;
2. For leaves of 31 days or more, up to 102% of the full contribution.

This Act only applies to health coverage (i.e. medical, dental, drug, vision). Short and long term disability and life benefits are not subject to the Act.

Coverage provided due to this Act will reduce any coverage required by COBRA.

Maximum Period of Coverage during Military Leave

Continued coverage under this provision will terminate on the earlier of the following events:

1. The date you fail to return to employment with the employer after completion of your leave. Employees must return to employment within:
   a. the first full business day of completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service,
   b. 14 days of completing military service, for leaves of 31 to 180 days,
   c. 90 days of completing military service, for leaves of more than 180 days; or
2. 24 months from the date your leave began.

REINSTATEMENT OF COVERAGE FOLLOWING MILITARY LEAVE

The law requires that coverage be reinstated upon your return to work. Reinstatement will apply whether coverage under the plan was maintained during the leave or not. To be eligible for reinstatement you must be honorably discharged from the military service and return to work within:

1. The first, full business day after your military service ends, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days after your military service ends, for leaves of 31 to 180 days;
3. 90 days after your military service ends, for leaves of more than 180 days.

You may be allowed more time to return to work if your military service: causes a sickness or injury; or worsens a sickness or injury. Your failure to return within the times stated must be due to such a sickness or injury. In that case, you may take up to a period of two years to return to work. If for reasons beyond your control you cannot return to work within two years, you must return as soon as is reasonably possible.
USERRA - continued

On reinstatement, all provisions and limits of the plan will apply to the extent that they would have had you not taken leave. The eligibility period will be waived.

This does not waive the plan's limits on sickness or injury: caused by your military service; or worsened by your military service. The Secretary of Veterans Affairs will determine if your military service caused or worsened a sickness or injury.

NOTE: For complete information regarding your rights under the Uniformed Services Employment and Reemployment Rights Act, contact your employer.
CONTINUATION OF BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

COBRA is a federal law. The law requires employers to offer covered individuals continuation coverage (COBRA) under the plan if coverage is lost or cost increases due to specific events. COBRA must be offered at group rates. The employer cannot require evidence of good health as a condition of COBRA. COBRA must be the same as coverage for similar active employees under the plan. This means that when coverage is changed for similar active employees it will also change for the person on COBRA.

COBRA only applies to health coverage (i.e. medical, dental, drug, vision). Short and long term disability and life benefits are not subject to the COBRA.

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

Employee Rights to COBRA

An employee that is covered by this plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the employee's hours of work; or
2. The termination of the employee's employment. This will not apply if termination is due to gross misconduct on the employee's part.

Spouse Rights to COBRA

The spouse of an employee that is covered by this plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the employee's hours of work;
2. The termination of the employee's employment. This will not apply if termination is due to gross misconduct on the employee's part;
3. The death of the employee;
4. The end of the spouse's marriage to the employee. The marriage must end due to dissolution, annulment, divorce, or legal separation; or
5. The employee becoming entitled to Medicare.

Dependent Child Rights to COBRA

The dependent child of an employee that is covered by this plan has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the employee's hours of work;
2. The termination of the employee's employment. This will not apply if termination is due to gross misconduct on the employee's part;
3. The death of the employee;
COBRA – continued

4. The end of the employee's marriage. The marriage must end due to dissolution, annulment, divorce or legal separation;

5. The employee becoming entitled to Medicare; or

6. The child ceasing to be considered a dependent child as defined in this plan.

Electing COBRA

Each person covered by this plan has an independent right to elect COBRA for himself or herself. A covered employee or spouse may elect COBRA for all family members. A parent or legal guardian may elect coverage for a minor child.

If coverage has been terminated in anticipation of a qualifying event, the right to COBRA will still apply at the time of the event. In this case, COBRA will be effective on the date of the event even though it is after the date coverage was lost or cost increased.

If the employee's dependent child is born during the COBRA coverage period, that child may be added to the coverage. The child will have all of the rights that any other child would have under COBRA. If a child is adopted by or placed for adoption with the employee during the COBRA coverage period, that child may be added to the coverage. The child will have all of the rights that any other child would have under COBRA.

Retiree Coverage (if provided)

If coverage is lost due to the termination of retiree benefits, you have a right to elect COBRA. You also have the right to elect COBRA if retiree benefits are substantially eliminated. Termination or substantial elimination must occur within one year before or after the employer files Chapter 11 bankruptcy.

Notices and Election of Coverage

Under the law, you must inform the plan administrator within 60 days of: a divorce; legal separation; annulment; or dissolution of marriage. You must also inform the plan administrator within 60 days of a child no longer meeting the plan’s definition of dependent. Notice must be provided within the 60-calendar day period that begins on the latest of:

1. The date of the qualifying event; or

2. The date on which there is a loss of coverage (or would be a loss of coverage) due to the original qualifying event; or

3. The date on which the qualified beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The employer must notify the plan administrator of: the employee's death; termination of employment; reduction in hours of work; or Medicare entitlement. The employer must also notify the plan administrator of a termination or substantial elimination of retiree coverage due to Chapter 11 bankruptcy. See Procedures for Providing Notice to the Plan for further information.

Within 14 days of receiving notice that one of the above events has happened, the employer will notify you that you have the right to elect COBRA. If the employer and plan administrator are the same entity, notice of the right to elect will be provided within 44 days. Under the law you must elect COBRA within 60 days from the later of: the date you would lose coverage or cost would increase due to the qualifying event; or the date notice of your right to COBRA and the election form are sent.

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COBRA – continued

The employer/plan administrator must provide you with a quote of the total monthly cost of COBRA. The initial payment is due by the 45th day after coverage is elected. All other payments are due on a monthly basis, subject to a 30 day grace period.

If you elect COBRA within the 60 day period, COBRA will be effective on the date that you would lose coverage. If you do not elect COBRA within this 60 day period, COBRA will not be available. Your coverage under the plan will terminate.

If you elect COBRA, it is your duty to pay all of the monthly payments directly to the employer/plan administrator. The cost of COBRA must be a reasonable estimate of the cost of coverage had it not ended. The plan may add a 2% administration charge to that cost. The plan may charge an additional 50% during the 11 month extension for total disability if the disabled individual is covered. If the disabled individual is not covered, only the 2% administration charge will apply during the extension.

Payments for COBRA may only be increased once during any one 12 month period. The timing of the 12 month period is set by the employer/plan administrator.

Maximum Period of Continuation of Coverage

When coverage is lost or cost increases the law requires that the employer maintain COBRA for up to:

1. 18 months, if due to the employee's termination of employment. Termination must be for reasons other than gross misconduct on the employee's part;

2. 18 months, if due to the employee's reduction in work hours;

3. 36 months, if due to the death of the employee;

4. 36 months, if due to the end of the employee's marriage. The marriage must end due to dissolution, annulment, divorce or legal separation;

5. 36 months, if due to the employee becoming entitled to Medicare. If coverage is not lost or cost does not increase until a later date, COBRA will end at the later of: 36 months from the date of the employee's Medicare entitlement; or the maximum period of COBRA allowed due to the event that caused the loss of coverage or increase in cost;

6. 36 months, if due to your ceasing to be a dependent child as defined in the plan; or

7. The lifetime of the retiree, if due to the termination of retiree benefits. The same period will apply if due to the substantial elimination of retiree benefits. Termination or substantial elimination must occur within one year before or after the employer files Chapter 11 bankruptcy. Upon the retiree's death, any covered dependent may elect COBRA for an additional 36 months from that date.

If you or a dependent are disabled at the time of a qualifying event, an 18 month COBRA period may be extended by 11 months. The 18 month period may also be extended if you or a dependent become disabled during the first 60 days of COBRA. You must be disabled under the terms of Title II or Title XVI of the Social Security Act. The maximum period may extend to 29 months from the original event. You must provide notice to the plan administrator within 60 days of the later of:

1. The date of the Social Security Act disability determination;

2. The date of the Qualifying Event occurs;

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COBRA – continued

3. The date the Qualified Beneficiary loses (or would lose) coverage due to the original Qualifying Event or the date that Plan coverage was lost due to the original Qualifying Event; or

4. The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

This notice must also be prior to the end of the 18 month COBRA period. If notice is not given within these times, you will not be eligible for the extended period. If it is determined that you are no longer disabled, you must notify the plan administrator within 30 days of that final determination. The right to this extended period applies to each individual. It will apply even if the disabled individual does not remain covered. See Procedures for Providing Notice to the Plan for further information.

If a second event occurs during the initial 18 or 29 month period, COBRA may be extended to 36 months. Second events include: the employee's death; the employee's divorce; a child no longer meeting the definition of dependent. A second event will not result in an extension of COBRA, if the event would not result in a loss of coverage for an active employee or dependent. Except in the case of bankruptcy the period will not exceed 36 months from the date of the original event.

The maximum coverage period is measured from the date of the qualifying event. This is true even if the qualifying event does not result in a loss of coverage or increase in cost until a later date.

If COBRA is rejected in favor of an alternate coverage under the plan, COBRA will not be offered at the end of that period. If an alternate coverage is offered, COBRA will be reduced to the extent such coverage satisfies the requirements of COBRA. Alternate coverage includes continuation by: state law; USERRA; or any other plan provision.

OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

Termination Before the End of the Maximum Coverage Period

The law allows COBRA to be terminated prior to the end of the maximum period. Such termination can only be for one of the following reasons:

1. The employer no longer provides a group benefit plan to any of its employees;

2. The payment for COBRA is not paid on time. Monthly payments are subject to a 30 day grace period. If a payment is on time and not significantly less than the amount due, it will be considered full payment unless notice of the amount due is provided to you. You will have 30 days from the date of notice to make the additional payment;

3. You obtain another group plan after the date you elect COBRA;

4. You become entitled to Medicare after the date you elect COBRA;
COBRA – continued

5. There has been a final determination that you are no longer disabled. Such determination must be made under Title II or XVI of the Social Security Act. This will only apply during the 11 month extension of COBRA due to disability. In this case, COBRA will not end until the first day of the month that is more than 30 days after the determination.

Additional Election Period due to The Trade Act of 2002

If you did not elect COBRA during the election period described above, another 60 day period may be presented for you to elect COBRA. If your loss of coverage was due to a Trade Adjustment Assistance (TAA) event and you are determined to be TAA eligible during the six month period following your loss of coverage, you will have an additional period in which to elect COBRA. This election period will begin the first of the month in which you become TAA eligible. The period will end on the earlier of: 60 days from the date it began; or the end of the six month period following your loss of coverage due to a TAA event.

If you elect COBRA during this TAA election period, COBRA will be effective on the first of the month in which you became TAA eligible. COBRA will not be provided for the period of time between your loss of coverage and the first of the month in which you became TAA eligible. In this case, the maximum period of coverage will be counted from the date you lost coverage under the plan, not the date COBRA is effective. If you do not elect COBRA during this period, COBRA will not be available again.

If you elect COBRA, it is your duty to pay all of the monthly payments directly to the plan administrator. The Trade Act of 2002 did create a tax credit for TAA eligible individuals. Under the Act up to 72.5% of the cost of COBRA can be taken as a tax credit. The Act also provides an option for an advance payment of the tax credit toward the cost of COBRA. If you have questions about this tax credit, call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. Additional information about the Trade Act of 2002 can be found at www.doleta.gov/tradeact.

Procedures for Providing Notice to the Plan

In order to maintain your rights under COBRA, you are required to provide the plan with notice of certain events, as described above. The plan will consider your obligation to provide notice satisfied if you provide written notice to the plan administrator that includes:

1. The employee’s name and participant number;
2. The name of the individual(s) to whom the notice applies;
3. The reason for which notice is being provided; and
4. The address and phone number where you can be contacted.

Notice should be addressed to the Human Resources Department, Attn: COBRA Administration. Notice should be mailed to the plan administrator’s address shown in this plan. Your notice will not satisfy your obligation if it is not provided within the time frame stated above for that notice.

Other Information

The plan administrator will answer any questions you may have on COBRA. You can also contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) for answers to your questions. Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA’s website at www.dol.gov/ebsa.
COBRA – continued

To protect your rights under COBRA, you should notify the plan administrator of any changes that affect your coverage. Such changes include a change for you or a family member in marital status; address; or other insurance coverage. When providing any notice to the plan, a copy should be maintained for your own records.

If You Have Questions:
Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

1) The Plan Administrator:

Colorado Employer Benefit Trust
2000 S. Colorado Blvd., Tower II, Suite 900
Denver, CO 80222
(303) 773-1373 or 1-800-332-1168

2) The COBRA Administrator:

Colorado Employer Benefit Trust
2000 S. Colorado Blvd., Tower II, Suite 900
Denver, CO 80222
(303) 773-1373 or 1-800-332-1168
SECTION 4  GENERAL PLAN INFORMATION
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**PLAN DESCRIPTION INFORMATION**

The *employer* sets the benefits under the *plan*. The *employer* sets the rights and privileges of plan participants to those benefits. The *plan* pays benefits directly from the general assets of the *employer*, as needed.

Each *employee* in the *plan* will receive a Summary Plan Description (SPD). This booklet is the SPD and Plan Document for the *plan*. It contains information on: eligibility; termination; benefits provided; and other general *plan* provisions.

The purpose of this SPD is to set forth the provisions of this *plan*. The *plan* provides for the payment or reimbursement of eligible vision expenses.

| PLAN NAME                      | Colorado Employer Benefit Trust  
|                               | Employee Health and Welfare Benefit Plan |
| TYPE OF PLAN                  | A self funded welfare plan that provides vision benefits to covered *employees* and *dependents*. |
|                               | This *plan* is not financed or administered by an insurance company. The *plan's* benefits are not guaranteed by a contract of insurance. |
| PLAN EFFECTIVE DATE           | July 1, 2019 Revision  
|                               | January 1, 1989 Original |
| PLAN YEAR FOR GOVERNMENT REPORTING | July 1 to June 30 |
| PLAN ADMINISTRATOR/PLAN SPONSOR | Colorado Employer Benefit Trust  
|                               | 2000 S. Colorado Blvd., Tower II, Suite 900  
|                               | Denver, CO 80222  
|                               | (303) 773-1373 or 1-800-332-1168 |
| EMPLOYER IDENTIFICATION NUMBER | 74-2141123 |
| CLAIMS ADMINISTRATOR           | UMR, Inc.  
|                               | 2700 Midwest Drive  
|                               | Onalaska, WI 54650-8764  
|                               | (800) 826-9781 (Toll-free) |
| AGENT FOR SERVICE OF LEGAL PROCESS | Colorado Employer Benefit Trust  
|                               | 2000 S. Colorado Blvd., Tower II, Suite 900  
|                               | Denver, CO 80222  
|                               | (303) 773-1373 or 1-800-332-1168 |
COORDINATION OF BENEFITS

Benefits Subject to This Provision
This plan's benefits are coordinated with benefits provided by other plans that cover you. This is done to prevent over insurance, which would result in an increase in the cost of coverage under this plan. This provision will apply whether or not you file a claim under any other plan that covers you.

Effect on Benefits
In certain cases, this plan's benefits will be reduced when you are covered by other plans that provide benefits for the same service. Benefits under this plan and any other plans, as defined below, will be coordinated. The total benefit will not exceed 100% of the total covered expenses incurred under this plan.

Definitions
A plan is any coverage that provides benefits for medical or dental expenses. Benefits may be provided by payment or service. Plan includes any of the following:

1. Group or franchise insurance coverage, whether insured or self-funded;
2. Hospital or medical service organizations on a group basis and other group pre-payment plans;
3. A licensed Health Maintenance Organization (HMO);
4. Any coverage sponsored or provided by or through an educational institution;
5. Any governmental program or a program mandated by state statute;
6. Any coverage sponsored or provided by or through an employer, trustee, union, employee benefit, or other association.

This includes group type contracts not available to the general public. Such contracts may be obtained due to the covered person's membership in or connection with a particular group. This provision will apply whether or not such coverage is designated as franchise, blanket, or in some other fashion.

This does not include group or individual automobile "no fault" or traditional "fault" type contracts. It does not include school or other similar liability type contracts. Nor does it include other types of contracts claiming to be excess or contingent in all cases.

How Coordination of Benefits Works
One of the plans involved will pay benefits first, without considering the benefits available under the other plans. This is called the primary plan. The other plans will then make up the difference, up to the total covered expense. These plans are called secondary plans.

When a plan provides benefits in the form of services rather than cash payments, the customary, usual and reasonable value of each service will be deemed to be the benefit paid. No plan will pay more than it would have paid without this provision.

Order of Benefit Determination
The primary plan will be determined by the following rules. That plan will pay benefits first.

1. The plan that has no coordination provision will be primary.
2. The plan that covers the person as an employee will be primary.
Coordination of Benefits - continued

3. For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the calendar year will be primary. If both parents have the same birthday, the plan covering a parent for the longest period of time will be primary.

4. In the case of a child that is placed in the joint custody and physical placement of divorced, separated or unmarried parents rule 3. will apply, unless one parent has been assigned financial responsibility for the medical expenses of the child. In that case, the plan of the parent with financial responsibility, as ordered by the court, will be primary.

5. In the case of a child of divorced, separated or unmarried parents that is not in the joint custody and physical placement of both parents:
   a. the plan of a parent who has primary physical placement will be primary,
   b. the plan of a step-parent that has primary physical placement will pay benefits next,
   c. the plan of a parent who does not have primary physical placement will pay benefits next, and
   d. the plan of a step-parent that does not have primary physical placement will pay benefits next.

   Unless one parent has been assigned financial responsibility for the medical expenses of the child. In that case, the plan of the parent with financial responsibility, as ordered by the court, will be primary.

6. The plan covering an inactive person: laid off; retired; on COBRA or any other form of continuation; or the dependent of such a person will pay benefits after the plan covering such persons as an active employee or the dependent of an active employee.

7. The plan covering the person under a disability extension of benefits will pay benefits before the plan covering such persons as an active employee or the dependent of an active employee.

When an individual is covered under a spouse’s plan and also under his or her parent’s plan, the primary plan is the plan of the individual’s spouse. The plan of the individual’s parent(s) is the secondary plan.

If the primary plan is not established by the above rules, the plan that has covered the person for the longest period of time will be primary. If a plan other than this plan does not include provision 3., then that provision will be waived in order to determine benefits with the other plan.

Coordination of Benefits between Medical and Vision Plans
In all cases, the vision plan will be secondary. It will only pay benefits after the medical plan pays its benefits as the primary plan.

Coordination of Benefits with Medicare
In all cases, coordination with Medicare will conform to Federal Statutes and Regulations. Each person that is eligible for Medicare will be assumed to have full Medicare coverage. Full Medicare coverage is: Part A hospital insurance; and Part B voluntary medical insurance. Full Medicare coverage will be assumed whether or not it has been taken. Your benefits under this plan are subject to the allowable limiting charges set by Medicare. Benefits will be coordinated to the extent they would have been paid under Medicare as allowed by Federal Statutes and Regulations.
RIGHT OF SUBROGATION, REIMBURSEMENT, AND OFFSET

The plan has a right to subrogation and reimbursement.

Subrogation applies when the plan has paid covered expenses on your behalf for an illness or injury for which a third party is considered responsible. The right to subrogation means that the plan is substituted to and will succeed to any and all legal claims that you may be entitled to pursue against any third party for the covered expenses that the plan has paid that are related to the illness or injury for which a third party is considered responsible.

The right to reimbursement means that if it is alleged that a third party caused or is responsible for an illness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the plan 100% of any covered benefit you received for that illness or injury.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer an illness, injury, or damages, or who is legally responsible for the illness, injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the illness, injury, or damages.
- The Plan Sponsor in a workers’ compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners’, or otherwise), Workers’ Compensation coverage, other insurance carriers, or third party administrators.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the plan in protecting the plan’s legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts that caused covered expenses to be paid or become payable.
  - Providing any relevant information requested by the plan.
  - Signing and/or delivering such documents as the plan or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents’ consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.
Subrogation – continued

Your failure to cooperate with the plan is considered a breach of contract. As such, the plan has the right to terminate your covered benefits, deny future covered benefits, take legal action against you, and/or set off from any future covered benefits the value of covered benefits we have paid relating to any illness or injury alleged to have been caused or caused by any third party to the extent not recovered by the plan due to you or your representative not cooperating with the plan. If the plan incurs attorneys’ fees and costs in order to collect third party settlement funds held by you or your representative, the plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold that should have been returned to the plan.

• The plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

• The plan’s subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys’ fees, will be deducted from our recovery without the plan’s express written consent. No so-called “fund doctrine” or “common-fund doctrine” or “attorney’s fund doctrine” will defeat this right.

• Regardless of whether you have been fully compensated or made whole, the plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any “made-whole doctrine” or “make-whole doctrine,” claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.

• Benefits paid by the plan may also be considered to be benefits advanced.

• If you receive any payment from any party as a result of illness or injury, and the plan alleges some or all of those funds are due and owed to the plan, you will hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the plan has paid.

• The plan’s rights to recovery will not be reduced due to your own negligence.

• Upon our request, you will assign to us all rights of recovery against third parties, to the extent of the covered expenses the plan has paid for the illness or injury.

• The plan may, at its option, take necessary and appropriate action to preserve the plan’s rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer’s legal representative, or other third party; and filing suit in your name, which does not obligate the plan in any way to pay you part of any recovery the plan might obtain.

• You may not accept any settlement that does not fully reimburse the plan, without its written approval.
Subrogation - continued

- The plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.

- No allocation of damages, settlement funds, or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries, or any other person or party will be valid if it does not reimburse the plan for 100% of its interest unless the plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a dependent child who incurs an illness or injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's illness or injury, the terms of this subrogation and reimbursement clause will apply to that claim.

- If a third party causes or is alleged to have caused you to suffer an illness or injury while you are covered under this plan, the provisions of this section continue to apply, even after you are no longer covered.

- The plan and all administrators administering the terms and conditions of the plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the plan.

Workers' Compensation

This plan excludes coverage for any injury or sickness that is eligible for benefits under Workers' Compensation. If benefits are paid by the plan and you receive Workers' Compensation for the same incident, the plan has the right to recover. That right is described in this section. The plan reserves its right to exercise its recovery rights against you even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that the injury or sickness was sustained in the course of or resulted from your employment;

3. The amount of Workers' Compensation due to health care expense is not agreed upon or defined by you or the Workers' Compensation carrier; or

4. The health care expense is specifically excluded from the Workers Compensation settlement or compromise.
GENERAL PROVISIONS

The following provisions are to protect your legal rights and the legal rights of the plan.

ALTERNATE RECIPIENTS

If a court order requires a covered person to provide health care coverage for a dependent child, coverage must be provided to the child. Coverage may not be subject to plan requirements such as: custody; marital status of parent; claimed on taxes; or 50% support. Enrollment periods and other similar limits on the eligibility of dependents are also waived for that child. If a covered person does not enroll the child in the plan, the plan must recognize the child's right to be enrolled. The custodial parent or legal guardian of the child may exercise this right. The Department of Health and Social Services may also exercise this right.

The child will be as an employee under the plan for the purpose of receiving plan information. The custodial parent or legal guardian may have this right on behalf of the child. The Department of Health and Social Services will also have this right. They must receive all information needed to be enrolled in and receive benefits under the plan. They must be provided with a copy of the plan's Summary Plan Description (SPD). Any payments made by the plan must be made to the child or the provider of service. Payment may also be made to the custodial parent, legal guardian or the Department of Health and Social Services. A court order will not entitle the child to any benefits or coverage not already offered by the plan.

AMENDMENTS TO OR TERMINATION OF THE PLAN

The plan's benefits may be amended by the employer at any time. The plan may be terminated by the employer at any time. Any changes to the plan will be communicated immediately by the employer to the persons covered under the plan.

If the plan is terminated, the rights of the covered persons to benefits are limited. Only claims incurred and payable prior to the date of termination will be payable. Plan assets will be allocated to the exclusive benefit of the covered persons. Any taxes and expenses of the plan may be paid from the plan assets.

ASSIGNMENT

Any assignment will only be applied if the provider will refund any payments made in error. The plan does not attest to the legal validity or effect of any assignment.

CONFORMITY WITH APPLICABLE LAWS

If any part of this plan conflicts with any law that applies to the plan, it is hereby amended to comply with that law.

CONTRIBUTIONS TO THE PLAN

The plan is funded by contributions from the employer and the covered employees.

Any funds contributed by the employees are applied to the expenses of the plan as soon as is reasonably possible. Any excess funds are used to pay claims. The employer sets the amount of the employee contribution. The employer reserves the right to modify such contributions. All employee contributions are on a non-discriminatory basis.
DISCRETIONARY AUTHORITY

Benefits under this plan will be paid only if the plan administrator decides in its discretion that the covered person is entitled to the benefits. The plan administrator will have full discretion to interpret plan terms; make decisions regarding eligibility; and resolve factual questions. This discretion will apply with respect to all claim payments and benefits under the plan.

FAILURE TO ENFORCE PLAN PROVISIONS

The plan's failure to enforce any part of the plan will not affect the right, thereafter, to enforce that provision. Such failure will not affect the right to enforce any other provision of the plan.

FRAUD

Fraud is a crime that can be prosecuted. Any covered person who willfully and knowingly engages in an activity intended to defraud the plan is guilty of fraud. The plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a covered person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the plan. In addition, it is a fraudulent act when a covered person willfully and knowingly fails to notify the plan regarding an event that affects eligibility for a covered person. Notification requirements are outlined in this summary plan description and other plan materials. Please read them carefully and refer to all plan materials that you receive (i.e., COBRA notices). A few examples of events that require plan notification would be divorce, dependent child reaching the limiting age, and enrollment in other group health coverage while on COBRA (please note that the examples listed are not all inclusive).

These actions will result in denial of the covered person’s claim or termination from the plan, and are subject to prosecution and punishment to the full extent under state and/or federal law. The plan will pursue all appropriate legal remedies in the event of fraud.

Covered persons must:

1. File accurate claims. If someone else, such as your spouse or another family member, files claims on the covered person’s behalf, the covered person should review the form before signing it;

2. Review your Explanation of Benefits (EOB). Make certain that benefits have been paid correctly based on your knowledge of the covered expense and the services received;

3. Never allow another person to seek medical treatment under your identity. If your plan ID card is lost, report the loss to the plan administrator immediately;

4. Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge; and

5. Notify the plan when an event occurs that effects a covered person’s eligibility.

To maintain the integrity of this plan, covered persons are encouraged to notify the plan whenever a provider:

1. Bills for services or treatment that have never been received; or

2. Asks a covered person to sign a blank claim form; or

3. Asks a covered person to undergo tests that the covered person feels are not needed.

Covered persons concerned about any of the charges that appear on a bill or EOB, or who know of or suspect any illegal activity, should call the toll-free fraud hotline 1-800-356-5803. All calls are strictly confidential.

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FREE CHOICE OF PROVIDER
The covered person has a free choice of any legally licensed provider. The plan will not interfere with the provider/patient relationship.

INTERPRETATION
This plan does not constitute a contract between the employer and any covered person. It will not be considered as an incentive or condition of employment. The plan will not modify the provisions of any collective bargaining agreement that may be made by the employer. A copy of any such agreement is available from the plan administrator upon written request.

LEGAL ACTIONS
You may request the alternate dispute resolution process provided by the plan or bring an action at law or equity against the plan. Such action may not be sought until 60 days after the date you provide written proof of loss to the plan. If an alternative method of dispute resolution has been agreed to, action at law or equity may not be sought until the end of that process. Any such action cannot be sought more than three years after such proof of loss is submitted.

PAYMENT OF CLAIMS
All benefits (except for prescription drugs) will be paid directly to the provider of services, unless you direct otherwise in writing at the time proof of loss is filed.

Benefits payable on behalf of you or your covered dependent, upon death, will be paid at the plan's option to any one or more of the following: your spouse; your dependent children, including legally adopted children; your parents; your brothers and sisters; or your estate.

Any payment made in good faith will fully discharge the plan of its obligations to the extent of such payment.

PHYSICAL EXAMINATION
The plan has the right to have you examined as often as reasonably necessary while a claim is pending. Such examination will be at the plan's expense.

PRIVACY
The employer, who is the sponsor of this plan, will receive protected health information. The information may be identified to the individual in some cases. The employer is limited in how it may use this information. Its uses and disclosures must be necessary to carry out plan functions. The plan functions must relate to payment or health care operations, as defined in 45 CFR Subtitle A, Subchapter C, Part 164 - Security and Privacy. It may also use or disclose the information as required by law.

Prior to receiving any protected health information the employer must certify to the plan that it agrees to:

1. Not use or disclose the information, except as stated above;
2. Require that any agent or subcontractor of the employer agree to the same limits that apply to the employer prior to giving the information to them;
3. Not use or disclose the information for employment related decisions or actions;
4. Not use or disclose the information in connection with other benefit plans the employer may sponsor;
5. Report to the plan any use or disclosure that does not comply with this General Provision;
General Provision for Privacy – continued

6. Make the information available for review by the person that it relates to;

7. Make the information available for amendment and include any amendments with it;

8. Provide the necessary information to give an accounting of disclosures;

9. Make its internal practices, books and records in relation to the information open for review by the Secretary of Health and Human Services;

10. Return or destroy all information when it is no longer needed. If that is not possible, limit any further use or disclosure to the reason it was not possible to return or destroy it;

11. Maintain adequate separation between the plan and itself. Access to the information will be limited to members of the employer's Human Resources and Finance Departments that work with the plan. These individuals will receive the minimum necessary information to carry out the plan functions they perform; and

12. Provide an effective process to address non-compliance by the employer or its agents or subcontractors.

PRONOUNS

All personal pronouns used in the plan include either gender. This will be true unless its use clearly indicates otherwise.

PROTECTION AGAINST CREDITORS

Benefit payments under the plan are not subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind. Any attempt to accomplish these will be void. If the plan finds that such an attempt has been made, it, at its sole discretion, may terminate your interest in the payments. The plan will then apply the amount of the payment to the benefit of an adult child, guardian of a minor child, brother or sister, or other relative of the covered person. Such payment will fully discharge the plan to the extent of the payment.

RIGHT TO NECESSARY INFORMATION

The plan may require certain information in order to apply the provisions of this plan. To get this information the plan may release or obtain information from any party it needs to. The exchange of such information will not require your consent. Any party may include an insurance company, organization or person. Information will only be exchanged to the extent needed to implement the provisions of the plan. You agree to furnish any information needed to apply the plan provisions.

RIGHT TO RECOVER

The plan reserves the right to recover payments made under the plan. Recovery is limited to the amount that exceeds the amount the plan is obligated to pay. This right of recovery applies against:

1. Any person(s) to, for or with respect to whom such payments were made; and

2. Any insurance company or organization. If under the terms of this plan, it owes benefits for the same expense under any other plan.

The plan alone shall determine against whom this right of recovery will be exercised.
Right to Recover – continued

If benefits have been paid by any other plan which should have been paid by this plan, the plan reserves the right to directly reimburse such plan. Reimbursement will be to the extent needed to satisfy the obligations of this plan. Any such payment made in good faith will fully discharge the plan of its obligation to the extent of such payment.

SECURITY

The employer, who is the sponsor of this plan, will receive electronic protected health information. The information may be identified to the individual in some cases. In relation to such electronic protected health information, the employer certifies to the plan that it agrees to.

1. Take appropriate and reasonable safeguards (administrative, physical and technical) to protect the confidentiality, integrity and availability of the information it creates, receives, maintains or transmits;

2. Require that any agent or subcontractor of the employer agrees to the same requirements that apply to the employer under this provision;

3. Report to the plan any security incident that the employer becomes aware of; and

4. Apply reasonable and appropriate security measures to maintain adequate separation between the plan and itself.

STATEMENTS

In the absence of fraud, all statements made by a covered person will be deemed representations and not warranties. A statement will not be used to contest coverage under the plan unless a signed copy of it has been provided to the covered person. If the covered person is deceased, the copy will be provided to their beneficiary.

TIME OF CLAIM DETERMINATION

After receipt of written proof of loss or utilization review request, the plan will notify you of its decision on your claim and issue payment, if any is due, as follows:

Urgent Care

Within 24 hours or as soon as possible if, your condition requires a shorter time frame. If more information is needed to make a decision on the claim, the plan will notify you of the specific information needed within 24 hours. You will then have 48 hours from the receipt of the notice to provide the requested information. Within 48 hours of its receipt of the additional information, the plan will give its decision on the claim. If you fail to provide the information requested by the plan, the plan will provide you with its decision on the claim within 48 hours of the end of the period that you were given to provide the information.

If you fail to follow the plan procedure for a pre-service claim, the plan will notify you within 24 hours of the plan's receipt of the pre-authorization request. The notice will include the reason why the request failed and the proper process for obtaining pre-authorization.

Concurrent Care

Prior to the end of any pre-authorized course of treatment, if benefits are being stopped prior to the number of treatments or time period that was authorized. The notice must provide time for you to make an appeal and receive a decision on that appeal prior to the benefit being stopped. This will not apply if the benefit is being stopped due to a plan amendment. This will not apply if the benefit is being stopped due to the termination of the plan.
Time of Claim Determination – continued

Requests to extend a pre-authorized treatment that involves urgent care must be responded to within 24 hours or as soon as possible if, your condition requires a shorter time frame. Such requests must be made at least 24 hours before the authorized course of treatment ends.

Pre-Service Claims
Within 15 days of receipt of a non-urgent care claim. The plan may extend this period by 15 days if; you are notified of the need for an extension prior to the end of the initial period. The extension must be due to circumstances that are beyond the plan’s control. If an extension is due to the need for additional information, the plan will notify you of the specific information needed. You will then have 45 days from the receipt of the notice to provide the requested information.

If you fail to follow the plan procedure for a non-urgent care pre-service claim, the plan will notify you within five days of the plan’s receipt of the pre-authorization request. The notice will include the reason why the request failed and the proper process for obtaining pre-authorization.

Post-Service Claims
Within 30 days of receipt of the claim. The plan may extend this period by 15 days if; you are notified of the need for an extension prior to the end of the initial period. The extension must be due to circumstances that are beyond the plan’s control. If an extension is due to the need for additional information, the plan will notify you of the specific information needed. You will then have 45 days from the receipt of the notice to provide the requested information.

Upon any adverse benefit determination of a claim, you will be provided with a culturally and linguistically appropriate notice that contains the following:

1. Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable);

2. A statement describing the availability, upon your request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning (this information will be provided as soon as practicable and the request will not be considered an appeal);

3. The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the plan’s standard, if any, that was used in denying the claim;

4. Reference to the specific plan provisions on which the benefit determination is based;

5. A description of any additional material or information necessary for the claimant to perfect the claim or an explanation of why such material or information is necessary;

6. A statement describing any voluntary appeal procedures or external review procedures offered by the plan, including the time limits applicable to such procedures, and the claimant’s right to obtain information about those procedures;

7. A statement regarding the claimant’s right to file a lawsuit, if any;
Time of Claim Determination – continued

8. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

9. If the adverse benefit determination is based on a medical judgment or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

10. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes.

WORKERS' COMPENSATION NOT AFFECTED

This plan is not issued in lieu of Workers' Compensation coverage. It does not affect any requirement for coverage by any Workers' Compensation Law. It does not affect any requirement for coverage by any Occupational Disease Act.
CLAIM APPEAL PROCEDURE

If the employee, dependent or other beneficiary is not satisfied with the payment of claims provided or with a rescission of coverage determination, they must contact the plan administrator. Any informal, verbal inquiries to the plan administrator will not be treated as appeals. If you would like to submit a formal appeal, you may submit a written request to the plan administrator to initiate the appeal process. There are two levels of appeal for vision claims. The first level of appeal will be with the plan administrator and the voluntary second level of appeal will be with the Board of Trustees. See your adverse claim determination (or Explanation of Benefits) or contact the plan administrator for contact information for submitting appeals.

You may appeal the denial of a claim, utilization review decision or a rescission of coverage determination by following the procedures below. You may also appeal the denial of an initial level of an appeal by following the procedures below.

1. File a written request, with the plan administrator, for a full and fair review of the claim or initial level appeal by the plan;
2. Request to review documents pertinent to the administration of the plan, including your claim or appeal file;
3. Submit written comments and issues outlining the basis of your appeal; and
4. Present evidence and testimony regarding your appeal.

Remember, a request for an appeal, whether at the initial or second level, must be in writing, state in clear and concise terms the reason or reasons for disputing the denial, and be accompanied by any pertinent documentary material not already furnished to the plan.

All appeals will be a full and fair review of the claim or appeal. The review will not give weight to the initial claim or initial appeal decision. If the appeal involves a decision of medical judgment, a medical consultant that has appropriate training and experience in the field of medicine at question will be involved. If the appeal involves the experimental status of a service, a medical consultant that has appropriate training and experience in the field of medicine at question will be involved. Any such medical consultant will not have had prior involvement with the claim or initial appeal being appealed. Additionally, the appeal will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Finally, if any new or additional evidence is relied upon or generated during the determination of the appeal, or if a new rationale is expected to be used as the basis of a denial, the plan will provide that information to you free of charge and sufficiently in advance of the due date of the response for the adverse benefit determination.

First Level of Appeal

A request for an initial level appeal must be filed with the plan administrator within 180 days after receipt of the claim denial. If your request for review is not received within 180 days, your right to appeal the claim denial is forfeited.

After the review of the initial level appeal, the plan's decision will be made to you in writing. It will include specific reasons for the decision as well as specific references to the plan provisions on which the decision is based. For each level of appeal, you will be notified of the plan's decision as follows:

1. For urgent care claims, within 72 hours or as soon as possible if your condition requires a shorter time frame (deference will be given to the medical provider as to what is urgent);
2. For pre-service claims, within 15 days or as soon as possible if your condition requires a shorter time frame; or
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3. For post-service claims, within 30 days.

Voluntary Second Level of Appeal

You can proceed to the voluntary second level of appeal if you are not satisfied with the decision at the initial level of appeal by filing a request with the plan administrator or designated prescription drug administrator for an appeal within 60 days after your receipt of an initial level appeal denial. The Board of Trustees will provide the review of the second level of appeal for medical claims and the designated prescription drug administrator will provide the second level of appeal for prescription drug claims. The Board of Trustees or designated prescription drug administrator will respond within 60 days after receipt of the request for the appeal.

Upon good cause shown, the Board of Trustees or the agent appointed by the Board of Trustees shall permit the appeal to be amended or supplemented. The Board of Trustees or the agent appointed by the Board of Trustees shall grant a hearing on the petition to receive and hear any evidence or argument if the claimant requests to present testimony. The failure to file an appeal within such 60-day period, shall constitute a waiver of the claimant’s right to an appeal on the basis of the information and evidence submitted prior to the denial or hearing, as the case may be, provided that the Board of Trustees or the agent appointed by the Board of Trustees may relieve a claimant of any such waiver for good cause if application for such relief is made within one year after the date shown on the notice of denial. Such failure will not, however, preclude the claimant from establishing eligibility for benefits at a later date based on additional information and evidence which was not available to the claimant at the time of the denial or hearing. A decision by the Board of Trustees or the agent appointed by the Board of Trustees shall be made promptly unless special circumstances require an extension of time for processing, in which case a decision shall be returned as soon as possible, but not later than 60 days after receipt of the request for the appeal. You will be advised of the decision in writing.

The decision of the Board of Trustees or the agent appointed by the Board of Trustees with respect to an appeal shall be final and binding upon all parties, including the claimant or any person claiming under the claimant, except if you seek an external review under the Federal External Review Program, discussed below. The provision of this section shall apply to and include any and every claim to benefits from the plan, any claim or right asserted under these Rules and Regulations or against the plan, regardless of when the act or omission upon which the claim is based occurred.

Notices of Decisions on Appeals

Upon any adverse benefit determination at any point in the appeal process, you will be provided with a culturally and linguistically appropriate notice that contains the following:

1. Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable));

2. A statement describing the availability, upon your request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning (this information will be provided as soon as practicable and the request will not be considered an appeal);

3. The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the plan's standard, if any, that was used in denying the claim;

4. Reference to the specific plan provisions on which the benefit determination is based;

5. In the case of a notice of final internal adverse benefit determination, a discussion of the decision;
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6. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits;

7. A statement describing any voluntary appeal procedures or external review procedures offered by the plan, including the time limits applicable to such procedures, and the claimant’s right to obtain information about those procedures;

8. A statement regarding the claimant’s right to file a lawsuit, if any;

9. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

10. If the adverse benefit determination is based on a medical judgment or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

11. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes.