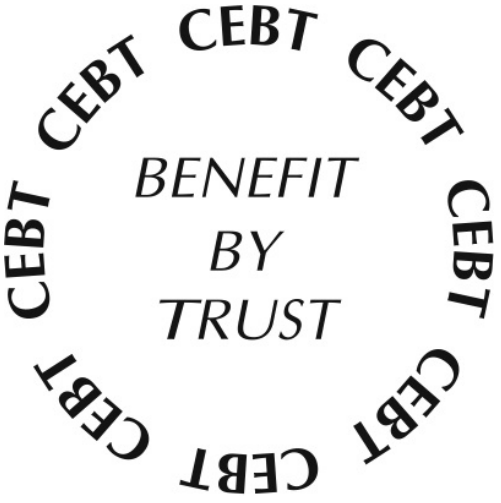
Colorado Employer Benefit Trust

Dental Benefit Plan

Revised: January 1, 2018



SUMMARY PLAN DESCRIPTION

SELF-FUNDED DENTAL PLAN FOR

COLORADO EMPLOYER BENEFIT TRUST

EFFECTIVE DATE: JANUARY 1, 2018

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: Ed Vanderhoek **Date:** 12/19/17

Authorized Representative

Title: CEBT 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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SECTION 1 DENTAL BENEFITS

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NOTE: UMR, Inc. is the *plan's claims administrator*. The *claims administrator* provides clerical and claim processing services to the *plan*. The *claims administrator* is not financially responsible for the funding or payment of claims processed under the *plan*, nor is the *claims administrator* a fiduciary to this *plan*.

SCHEDULE OF BENEFITS

PLAN A DENTAL BENEFITS

CALENDAR YEAR INDIVIDUAL MAXIMUM BENEFIT

Preventive, Basic, Major and Prosthodontic Services: $1,750

PLAN A DENTAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per *Calendar Year* Individual Family	 $0 $0	 $50 $150	The amount *you* must pay each year before the *plan* will begin paying any benefits. Family maximums are calculated on a combined dollar basis for all *covered persons* in the family. No one *covered person* will incur more than the individual maximum shown.	1-7
All *covered expenses* under the *plan* are payable at the *plan's customary, usual and reasonable limits*. The deductible limits shown above apply to all covered expenses unless stated otherwise below.				

PLAN A DENTAL BENEFITS	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Type I - Preventive Services	100%, deductible waived	Oral exams, routine cleanings, bitewing and full mouth x-rays, fluoride treatments and sealants. Refer to text for frequency and age limitations.	1-8
Type II - Basic Services	80%, after deductible	Emergency services, fillings, endodontics, periodontics, oral surgery and extractions.	1-8
Type III - Major and Prosthodontic Services	50%, after deductible	Onlays, crowns, bridges, dentures and implants. Refer to text for frequency limitations.	1-9

PLAN A DENTAL BENEFITS	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Type IV - Orthodontic Services	50%, deductible waived	Orthodontic diagnosis, treatment and appliances. *Lifetime* Maximum: $2,000 For *dependent* children under the age of 19 only.	1-10
Limitations and Exclusions	Not Payable	List of exclusions that apply to all covered expenses. A service that is normally covered or *dentally necessary* may be excluded when provided with an excluded item.	1-12

Schedule of Benefits – continued

PLAN B DENTAL BENEFITS

CALENDAR YEAR INDIVIDUAL MAXIMUM BENEFIT

Preventive, Basic, Major and Prosthodontic Services: $1,500

PLAN B DENTAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per *Calendar Year* Individual Family	 $0 $0	 $50 $150	The amount *you* must pay each year before the *plan* will begin paying any benefits. Family maximums are calculated on a combined dollar basis for all *covered persons* in the family. No one *covered person* will incur more than the individual maximum shown.	1-7
All *covered expenses* under the *plan* are payable at the *plan's customary, usual and reasonable limits.* The deductible limits shown above apply to all covered expenses unless stated otherwise below. **NOTE:** If *you* are a *late applicant* as defined in the *plan* or voluntarily drop coverage, *you* must wait at least 24 months to enroll or re-enroll. *You* will be able to enroll or re-enroll at the next annual enrollment period following completion of the 24-month waiting period.				

PLAN B DENTAL BENEFITS	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Type I - Preventive Services	100%, deductible waived	Oral exams, routine cleanings, bitewing and full mouth x-rays, fluoride treatments and sealants. Refer to text for frequency and age limitations.	1-8
Type II - Basic Services	80%, after deductible	Emergency services, fillings, endodontics, periodontics, oral surgery and extractions.	1-8
Type III - Major and Prosthodontic Services	50%, after deductible	Onlays, crowns, bridges, dentures and implants. Refer to text for frequency limitations.	1-9

PLAN B DENTAL BENEFITS	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Type IV - Orthodontic Services	50%, deductible waived	**Note: Orthodontic benefits are only available if elected by *your employer*.** Orthodontic diagnosis, treatment and appliances. *Lifetime* Maximum: $1,500 For *dependent* children under the age of 19 only.	1-10
Limitations and Exclusions	Not Payable	List of exclusions that apply to all covered expenses. A service that is normally covered or *dentally necessary* may be excluded when provided with an excluded item.	1-12

Schedule of Benefits – continued

PLAN C DENTAL BENEFITS

CALENDAR YEAR INDIVIDUAL MAXIMUM BENEFIT

Preventive, Basic, Major and Prosthodontic Services: $1,500

PLAN C DENTAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per *Calendar Year* Individual Family	 $0 $0	 $50 $150	The amount *you* must pay each year before the *plan* will begin paying any benefits. Family maximums are calculated on a combined dollar basis for all *covered persons* in the family. No one *covered person* will incur more than the individual maximum shown.	1-7
All *covered expenses* under the *plan* are payable at the *plan's customary, usual and reasonable limits.* The deductible limits shown above apply to all covered expenses unless stated otherwise below. **NOTE:** If *you* are a *late applicant* as defined in the *plan* or voluntarily drop coverage, *you* must wait at least 24 months to enroll or re-enroll. *You* will be able to enroll or re-enroll at the next annual enrollment period following completion of the 24-month waiting period.				

PLAN C DENTAL BENEFITS	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
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Type III - Major and Prosthodontic Services	50%, after deductible	Onlays, crowns, bridges, dentures and implants. Refer to text for frequency limitations.	1-9
Limitations and Exclusions	Not Payable	List of exclusions that apply to all covered expenses. A service that is normally covered or *dentally necessary* may be excluded when provided with an excluded item.	1-12

HOW TO FILE A DENTAL 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.

DENTAL BENEFITS

DEDUCTIBLE AND COINSURANCE INFORMATION

Deductible

The deductible applies to each *covered person*, each *calendar year*. Only charges that are a *covered expense* will be used to satisfy the deductible. The amount of the deductible is shown on the Schedule of Benefits.

Maximum Family Deductible

The maximum deductible per family is shown on the Schedule of Benefits. No further deductibles will be taken during a *calendar year* once this maximum has been met.

Coinsurance

The deductible must be satisfied each *calendar year*. Benefits are then payable at the percentage rate shown on the Schedule of Benefits. Benefits are payable up to any *plan* maximums on a *customary, usual and reasonable* basis.

PREDETERMINATION

If a dental service is expected to cost **$300** or more, *you* should submit it for *predetermination*. The same should be done for a series of services that is expected to cost $300 or more. The *plan* will advise *you* what expenses will be covered. It will take into account alternate procedures and courses of treatment that are available. All decisions will be based on professionally endorsed standards of dental care.

Predetermination is only valid for 180 days. If treatment begins more than 180 days after the date of *predetermination*, *you* should submit another treatment plan. *Predetermination* is not a guarantee of payment. Payment of covered expenses is subject to all *plan* provisions. To be a covered expense the work must be done while coverage is in effect.

OPTIONAL TREATMENT

The *plan* will only pay up to the amount that is *dentally necessary*. In all cases where a more expensive service is selected than what is *dentally necessary*, the difference in cost will not be covered. The *plan* will only pay for the amount that is needed to restore the tooth or dental arch to contour and function.

DENTAL COVERED EXPENSES

TYPE I - PREVENTIVE SERVICES

1. Oral exams. Limited to two exams per *calendar year*.

2. Full mouth or panorex x-rays. Limited to once in a three *calendar year* period, unless necessary due to an *injury*. Complete series radiographs include bitewings and will count as one occurrence for that *calendar year*. Nine or more radiographs in any combination of periapical and bitewing radiographs will be considered a complete series. Benefits are not provided for periapical x-rays when performed on the same date as a complete series or a panoramic film.

3. Bitewing x-rays. Limited to once per *calendar year* (must be received on the same date of service).

4. Cleanings (routine prophylaxis). Limited to twice per *calendar year*.

5. Topical fluoride treatments. Covered for *dependent* children up to age 16 only. Limited to twice per *calendar year*. A cleaning performed with a fluoride treatment is a separate dental service.

6. Space maintainers. Covered for *dependent* children up to age 12 only. Limited to once per *lifetime*. Recementing of space maintainers will be allowed once per *lifetime*. Fixed appliances to maintain a space created by the premature loss of a primary tooth or teeth.

7. Sealants. Covered for *dependent* children up to age 16 only. Limited to molar teeth only and not more than one per tooth, per *calendar year*, up to two applications per tooth per *lifetime*. Not covered for primary teeth.

8. X-rays. Dental x-rays when *dentally necessary* as part of the treatment of a *covered expense*.

TYPE II - BASIC SERVICES

1. Ancillary. Emergency oral exams and palliative treatment for relief of dental pain. Limited to two visits per *calendar year*.

2. Office visits for consultations. Limited to twice per *calendar year*. Not covered if *you* receive other services during the office visit.

3. Restorative Fillings. Amalgam, acrylic, synthetic porcelain, composite and silicate fillings.

4. Pin retention, limited to once per tooth in any *calendar year* (regardless of the number of pins per tooth). Pin retention must be performed on the same date of service and in conjunction with a covered amalgam or composite restoration.

5. Preformed Stainless Steel Crowns. Covered for *dependent* children up to age 16, with deciduous primary teeth only.

6. Endodontics. Root canal treatments, root canal fillings, pulp vitality tests and other related procedures.

7. Osseous surgery and grafts.

8. Periodontics. Periodontal maintenance, debridement and exams, and other related procedures necessary to treat a disease of the supporting tissues of the teeth. Periodontal splinting is **not** a covered expense.

9. Oral Surgery. Extractions and other oral surgery including pre- and post-operative care. A biopsy report must be submitted with claims for the removal of tumors, cysts or neoplasms.

Revised 1/1/18

Type II Services - continued

10. Local Anesthesia and Analgesia. Local anesthesia and analgesia will be considered as part of the *covered expense* for the purpose of determining *customary, usual and reasonable*.

11. General Anesthesia when administered by a *dentist* due to oral or dental surgery. When necessary due to a medical condition that presents a high risk to the patient.

12. Injections of antibiotic drugs by the attending *dentist*.

13. Cone Beam x-rays, limited to once in a three *calendar year* period.

14. Occlusal guards, limited to once per five *calendar year* period. Occlusal adjustments, limited to once per 24 months.

TYPE III - MAJOR AND PROSTHODONTIC SERVICES

Major Services

1. Onlays.

2. Crowns. Crowns to restore occlusion or incisal edge due to bruxism or harmful habits is not a *covered expense*.

3. Maintenance of onlays and crowns, limited as follows:

    a. recementing of crowns/onlays, limited to once per *lifetime*,
    b. crown build-up is limited to once per five *calendar year* period. Amalgam and/or composite restorations submitted in conjunction with crown buildups or post and core procedures will be considered as part of those procedures. Crown buildups performed in conjunction with post and core procedures will be considered part of those procedures. Crown buildups on the same tooth as an amalgam or composite restoration done within the same benefit year will not be covered,
    c. post and core buildups, limited to once per tooth in any five *calendar year* period (documentation must be supplied to verify completion of root canal therapy),
    d. crown or onlay repairs, limited to once per crown or onlay in any five *calendar year* period;

4. Dental implantology techniques, including prosthetic devices related to such techniques.

Limitations for Major Restorative Services

Replacement of an onlay or crown will only be covered if it was installed at least five years prior to its replacement. This provision will be waived when replacement is due to an *accidental injury* that occurred while *you* are covered under this *plan*. This provision will be waived when replacement is required due to the involvement of an additional tooth surface. Replacement of an appliance that can be made serviceable will not be covered.

Expense incurred for major services performed on other than permanent teeth is not covered.

Prosthodontic Services

1. Installation of removable or fixed bridgework. *Covered expenses* are limited as follows:

    a. repair, limited to once per five *calendar year* period,
    b. recementing, limited to once per *lifetime* per bridge,
    c. post and core build-up, limited to once per tooth per five *calendar year* period;

Type III Services - continued

2. Installation of partial and complete dentures, including six month post-installation care. Covered expenses are limited as follows:

    a. adjustments, limited to once per appliance per *calendar year*,
    b. repairs, limited to once per appliance per five *calendar year* period,
    c. addition of tooth clasp (unless additions are completed on the same date as replacement partials/dentures), limited to once per *lifetime* per tooth,
    d. reline/rebase, limited to once per *calendar year* chair side or once per three *calendar years* laboratory,
    e. connector bar, limited to once per five *calendar years*.

Limitations for Prosthodontic Services

Replacement of a bridge or denture will only be covered if it was installed at least five years prior to its replacement. This provision will be waived if:

1. Replacement is *dentally necessary* due to the placement of an initial opposing full denture;

2. Replacement is *dentally necessary* due to the extraction of additional natural teeth. Such extraction must leave the bridge or partial denture unserviceable;

3. The bridge or denture is damaged beyond repair while in the oral cavity. The *injury* must occur while *you* are covered under this *plan*; or

4. The existing denture is a temporary denture, placed while *you* were covered under this *plan*. Replacement by a permanent denture must be required and performed within 12 months of the date the temporary denture was placed.

Expense incurred for prosthodontic services performed on other than permanent teeth is not covered.

Expense incurred to replace at any time a bridge or denture that meets, or can be made to meet, commonly held dental standards of functional acceptability is not covered.

TYPE IV - ORTHODONTIC SERVICES

Orthodontic benefits are not covered for Plan C.

1. Orthodontic diagnosis.

2. Interceptive and corrective treatment.

3. Orthodontic appliances, limited to one appliance per *lifetime*.

4. Diagnostic orthodontic records, limited to a *lifetime* maximum of once per covered *dependent*.

5. Related services, including extractions, x-rays, space maintainers and regainers.

Limitations for Orthodontic Services

Orthodontic services are only covered for *dependent* children under the age of 19.

If the plan of orthodontic treatment is terminated prior to completion, benefits will end on the date treatment ends. If a patient becomes ineligible for the orthodontic benefit, that benefit will end on that date.

LIMITATIONS AND EXCLUSIONS

The *plan* does not provide benefits for:

APPLIANCE AND SERVICE SPECIFIC

1. Replacement of **lost, missing, broken or stolen appliances** or duplicate appliances;

2. **Preventive control programs** including: oral hygiene instruction; plaque control; carries susceptibility tests; dietary planning; lab tests; anaerobic culture, except in connection with periodontal disease; sensitivity testing; and bite registrations;

3. Surgical and non-surgical treatment of any jaw joint problem, including but not limited to appliances and therapy. Jaw joint problems include: **temporomandibular joint disorder (TMJ)**; craniomaxillary or craniomandibular disorders; other conditions of the joint linking the jawbone and skull; conditions of the facial muscles used in expression or mastication; and symptoms thereof including headaches;

4. Appliances or restorations for: **increasing vertical dimension**; restoring occlusion; replacing tooth structure lost by attrition; correction of congenital or developmental malformations;

5. **Study models**;

6. **Gold foil fillings** or their maintenance;

7. **Inlays** or their maintenance;

8. **Athletic mouth guards**;

9. **Pulp capping** (direct or indirect); pulpotomy on permanent teeth;

10. Replacement of restorations due to **mercury or other possible allergies**;

11. For **resin crowns or onlays**, whether for single restorations, bridge retainers or pontics; or

12. **Tissue conditioning** procedures.

EXPERIMENTAL OR UNPROVEN SERVICES

1. Dental services that do not have **uniform professional endorsement;** or

2. Any **procedure or drug that does not have scientific evidence that permits conclusions as to its effect** on health outcomes. Scientific evidence is only evidence that is obtained from well designed and soundly conducted studies. Such studies must have been published in recognized peer review journals. The study must show a measurable effect on health outcomes that can be duplicated outside of the study's setting.

PHYSICAL APPEARANCE

1. *Cosmetic dentistry*, including personalization or characterization of dentures and crown facings, abutments or pontics posterior to the second bicuspid; or labial veneer laminates; or

2. **Precision or semi-precision attachments**.

PROVIDERS

1. Fees for **treatment by other than a** *dentist*. The following services when performed by a licensed dental hygienist will be covered: scaling or cleaning of teeth; and topical application of fluoride. These services must be done under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards;

2. Any service or supply:

   a. **not authorized or prescribed by a** *dentist*,
   b. authorized or prescribed by a *dentist*, but **excluded under this** *plan***;**

3. Services provided by a **person who ordinarily resides in** *your* **home** or who is a *family member*;

4. **Telephone, computer or Internet consultations** between *you* and any provider. Completion of forms. Any appointment *you* did not attend; or

5. **After hour charges in relation to a service performed during normal operating hours** for the provider.

SERVICES UNDER ANOTHER PLAN

1. 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;

2. 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;

3. Any service or supply provided by or **payable under any plan or law of any government** or any political subdivision (this does not include *Medicare* or Medicaid);

4. Any service or supply provided in the care of any service related *injury* or *sickness* (past or present) **if** *you* **are in a** *hospital* **or facility owned or operated by the United States Government** or any of its agencies; or

5. Any charges covered under **the** *employer's* **medical benefit plan**. Such charges include but are not limited to hospital charges, services of an anesthesiologist and prescription drugs.

OTHER

1. Charges **in excess of the** *customary, usual and reasonable* **charge** for the service or supply;

2. That portion of any fee that is in excess of the fee for the *dentally necessary* treatment. That portion of any fee that is in excess of the services needed to restore the tooth or dental arch to contour and function;

3. Any expense incurred **after the date** *your* **coverage under the** *plan* **terminates**, except as specifically described;

4. Any dental expense due to commission or attempt to commit a **civil or criminal battery or felony**;

Limitations and Exclusions – continued

5. Any loss caused or contributed to by:

    a. **war or any act of war**, whether declared or not, or
    b. any act of international armed conflict, or any conflict involving armed forces of any international authority;

6. Any dental expense unless specifically indicated; or

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

SECTION 2 DEFINITIONS

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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*.

Accident
A happening by chance and without intention or design. A happening which is unforeseen, unexpected and unusual at the time it occurs.

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*.

Cosmetic Dentistry
Those services provided solely to improve appearance. Correction of form and function are not needed and no pathological condition exists.

Covered Expense
Expense not excluded by the *plan* that is incurred by *you* or *your* covered *dependents* due to an *injury* or *sickness*. Expenses must be incurred while *you* are covered for that benefit under this *plan*.

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.

Dentally Necessary
The extent of care needed to correct form and function or treat *sickness* or *injury*. Such care must be generally accepted, proven and established practice by most *dentists* with similar experience.

Definitions - continued

Dentist
An individual licensed to practice dentistry or perform oral surgery. Such individual must be operating within the scope of that license.

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.

    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*.

Definitions - continued

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
For dental expenses, the *customary, usual and reasonable* fee charged for services and supplies. The *expense incurred* date is: the date the service is completed; or the date that the teeth are prepared for fixed bridges, crowns, or onlays; or the date the final impression is made for dentures or partials.

Family Member
Your lawful spouse. *Your* child. *Your* parent. *Your* grandparent. *Your* brother or sister. Any person related in the same way to *your* covered *dependent*.

Injury
Physical damage to *your* body caused by an external force. Damage must be due directly and independently of all other causes to an *accident*. Muscle tiredness or soreness is a *sickness* under the *plan*. Overexertion in an athletic or physical activity is a *sickness* under the *plan*.

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*.

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.

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

Predetermination
A review by the *plan* of a *dentist's* planned treatment and expected charges. The review will include diagnostic charges performed prior to the actual 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.

Definitions - continued

Sickness
A disease or disturbance in function or structure of *your* body. It must cause physical signs and/or symptoms and if left untreated, will result in a deterioration of the health state of the structure or systems of *your* body.

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.

SECTION 3 ELIGIBILITY

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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. Y*our* 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. For Plans B and C, please refer to the Schedule of Benefits for certain exceptions to this provision.

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;

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.

For Plan A, *you* will be allowed to voluntarily terminate *dependent* coverage mid-year. However, for Plans B and C, *you* will not be allowed to change *your* elections unless *you* have a change in status event.

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.
Revised 1/1/18

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. For the employer-paid plan only, 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.

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;

COBRA – continued

3. The death of the employee;

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.

COBRA – continued

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.

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;

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;

COBRA – continued

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

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

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 within 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.

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 dental expenses.

PLAN NAME	Colorado Employer Benefit Trust Employee Health and Welfare Benefit Plan
TYPE OF PLAN	A self funded welfare plan that provides dental 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	January 1, 2018 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.

Coordination of Benefits - continued

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.

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.

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 Dental Plans

In all cases, the dental 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.

If the primary payer cannot be determined due to coverage under more than one plan and Medicare, the plan that is primary to Medicare by Federal Statute will pay benefits first. This will apply whether the plan covers the person as an employee, dependent or other.

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.

COVERAGE OUTSIDE OF THE UNITED STATES

A *covered person* who receives services in a country other than the United States, and it's territories, is responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the *plan*, the *covered person* will need to pay the claim up front and then submit the claim to the *plan* for reimbursement. The *plan* will reimburse the *covered person* for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the *covered person* paid the claim, or on the date of service if the paid date is not known.

Please refer to the exclusions section for specific information on treatment outside of the United States that will not be covered by the *plan*.

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 effects 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.

Fraud – continued

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.

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: y*our* spouse; y*our dependent* children, including legally adopted children; y*our* parents; y*our* brothers and sisters; or y*our* 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.

Revised 1/1/18

General Provision for Privacy – continued

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;

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.

If benefits have been paid by any other plan that 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.

Time of Claim Determination – continued

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*.

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;

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 dental claims. The first level of appeal will be with the *plan administrator* and the 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*);

Claim Appeal - continued

2. For *pre-service claims*, within 15 days or as soon as possible if *your* condition requires a shorter time frame; or

3. For *post-service claims*, within 30 days.

Second Level of Appeal

You can proceed to the 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 the same time frames that apply at the initial level of 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, or the failure to appear and participate in such hearing, 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 30 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;

Claim Appeal - continued

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;

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.

AMENDMENT #1 **Colorado Employer Benefit Trust (Dental Plan)**
Employer Identification Number: 74-2141123

BENEFIT PLAN AMENDMENT
IT IS UNDERSTOOD AND AGREED THAT:

On pages 4-15 – 4-17, the Claim Appeal Procedure section is amended to read as follows:

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 dental 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

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;

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;

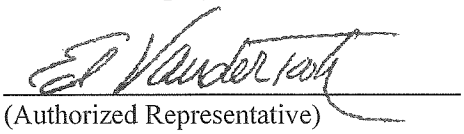
9. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making 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.

IN WITNESS WHEREOF, the undersigned has caused this amendment to be duly adopted and effective as of July 17, 2018.

Colorado Employer Benefit Trust



(Authorized Representative)

8/16/18

(Date)