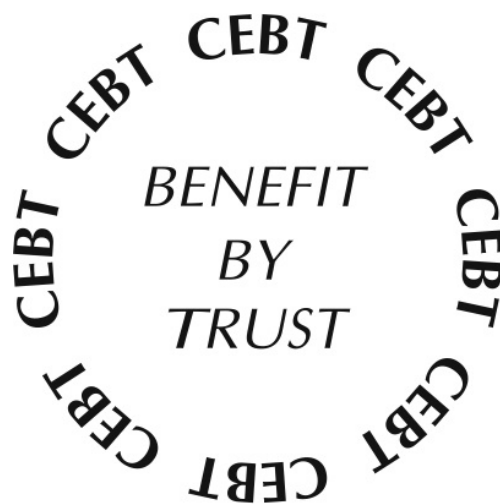


Colorado Employer Benefit Trust

EPO Medical Benefit Plan

Revised: July 1, 2018



SUMMARY PLAN DESCRIPTION




SELF-FUNDED EPO PLAN FOR

COLORADO EMPLOYER BENEFIT TRUST

EFFECTIVE DATE: JULY 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:		Date:	
	Authorized Representative		
Title:			

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CHANGES IN ELIGIBILITY

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 MEDICAL 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

PRIOR AUTHORIZATION REQUIREMENTS

The Utilization Management company (UM) shown on *your* ID card will handle the *prior authorization* requirements of *your plan*. *You* should call the UM as soon as possible to receive proper *prior authorization*. However, *you* must call within the time frames shown below. The UM toll-free number is shown on the back of *your* ID card.

PRIOR AUTHORIZATION	NON-COMPLIANCE PENALTY	SUMMARY	TEXT PAGE
Inpatient Hospital	None	<i>You</i> must call UM at least five days in advance of any non- <i>emergency</i> inpatient admission. All inpatient admissions, except maternity admissions that do not exceed 48 hours for a normal vaginal delivery or 96 hours for a cesarean section delivery, should be authorized. If admission is on an <i>emergency</i> basis, UM should be notified within 48 hours or the second business day following <i>your</i> admission.	1-23
Extended Care Facility/Inpatient Rehabilitation Center	None	<i>You</i> should call UM at least five days in advance of any non- <i>emergency</i> admission. If admission is on an <i>emergency</i> basis, UM should be notified within 48 hours or the second business day following <i>your</i> admission.	1-23
Organ Transplant	None	<i>You</i> should call UM as soon as <i>you</i> become aware of the potential need for an organ transplant. In all cases, <i>prior authorization</i> should be provided prior to the initial evaluation for a transplant.	1-23
Outpatient Surgical Procedures Does Not Include: <ul style="list-style-type: none"> • Endoscopic Surgeries (i.e. colonoscopy, sigmoidoscopy etc.) 	None	<i>You</i> should call UM at least five days in advance of any outpatient surgical procedures. If <i>your</i> outpatient surgery is on an <i>emergency</i> basis, UM should be notified within 48 hours or the second business day following <i>your</i> admission. Please note that outpatient biopsies do not require prior authorization.	1-23

PRIOR AUTHORIZATION	NON-COMPLIANCE PENALTY	SUMMARY	TEXT PAGE
Radiology Services	None	<p><i>You should call UM at least five days in advance of any of the following radiology tests:</i></p> <ul style="list-style-type: none"> • CT • MRA • MRI Nuclear Medicine • PET • Proton Beam • SPECT 	1-23
Other Services and Treatment	None	<p><i>You should call UM at least five days in advance of receiving any of the following services:</i></p> <ul style="list-style-type: none"> • Capsule endoscopy • Cardiac rehabilitation • Physical, occupational, speech and aquatic therapy • Dental anesthesia • Durable medical equipment (purchase costing \$1500 or more/rental costing \$500 or more) • EECF (a type of heart treatment) • Home health care • Hyperbaric chamber • Injectable medications and home infusion therapy • Liquid oxygen • Orthotics costing \$500 or more • Pain management programs • Pulmonary rehabilitation • Sleep studies • Defibrillators • Any new service that may be considered experimental 	1-23
Air Ambulance	None	<p><i>You should call UM at least five days in advance of any scheduled transport by air ambulance. If air ambulance transport is on an <i>emergency</i> basis, UM should be notified within 48 hours or the second business day following <i>your</i> air ambulance transport.</i></p>	1-23

PRIOR AUTHORIZATION	NON-COMPLIANCE PENALTY	SUMMARY	TEXT PAGE
Qualifying Clinical Trials	None	<i>You</i> should call UM for authorization at least 24 hours in advance of starting a qualifying clinical trial.	1-23
Hospital Bill Review	None	If <i>you</i> discover a <i>hospital</i> billing error, report it to the <i>plan</i> . As a reward, <i>you</i> will receive 50% of the error amount, but not more than \$1,250.	1-24

Schedule of Benefits - continued

MEDICAL BENEFITS

Plan Lifetime Maximum (applies to all *plan* options): Unlimited

EPO PLAN 3 MEDICAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per <i>Calendar Year</i>			The <i>EPO</i> plan does not have a deductible. Certain <i>covered expenses</i> are subject to a copay. The copay applies per service. Please refer to the Covered Expenses section of the Schedule of Benefits for copay information.	
Individual Coinsurance per <i>Calendar Year</i>	100%	0%	After any applicable copay, the coinsurance applies.	
Out-of-Pocket Limit per <i>Calendar Year</i> Individual Family		\$5,000 \$10,000	Represents the total paid for copays and pharmacy expenses. After which the <i>plan</i> pays 100% of <i>covered expenses</i> subject to any maximums. The family maximum is calculated on a combined dollar basis for all <i>covered persons</i> in the family. No one <i>covered person</i> will incur more than the individual maximum shown.	1-22
All <i>covered expenses</i> under the <i>plan</i> are payable at the <i>plan's customary, usual and reasonable limits</i> .				

Schedule of Benefits – continued

EPO PLAN 4 MEDICAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per <i>Calendar Year</i>			The <i>EPO</i> plan does not have a deductible. Certain <i>covered expenses</i> are subject to a copay. The copay applies per service. Please refer to the Covered Expenses section of the Schedule of Benefits for copay information.	
Individual Coinsurance per <i>Calendar Year</i>	100%	0%	After any applicable copay, the coinsurance applies.	
Out-of-Pocket Limit per <i>Calendar Year</i> Individual Family		\$5,500 \$11,000	Represents the total paid for copays and pharmacy expenses. After which the <i>plan</i> pays 100% of <i>covered expenses</i> subject to any maximums. The family maximum is calculated on a combined dollar basis for all <i>covered persons</i> in the family. No one <i>covered person</i> will incur more than the individual maximum shown.	1-22
All <i>covered expenses</i> under the <i>plan</i> are payable at the <i>plan's customary, usual and reasonable limits</i> .				

Schedule of Benefits – continued

EPO PLAN 5 MEDICAL BENEFITS	PLAN PAYS	YOU PAY	BENEFIT SUMMARY	TEXT PAGE
Deductible per <i>Calendar Year</i>			The <i>EPO</i> plan does not have a deductible. Certain <i>covered expenses</i> are subject to a copay. The copay applies per service. Please refer to the Covered Expenses section of the Schedule of Benefits for copay information.	
Individual Coinsurance per <i>Calendar Year</i>	100%	0%	After any applicable copay, the coinsurance applies.	
Out-of-Pocket Limit per <i>Calendar Year</i> Individual Family		\$6,000 \$12,000	Represents the total paid for copays and pharmacy expenses. After which the <i>plan</i> pays 100% of <i>covered expenses</i> subject to any maximums. The family maximum is calculated on a combined dollar basis for all <i>covered persons</i> in the family. No one <i>covered person</i> will incur more than the individual maximum shown.	1-22
All <i>covered expenses</i> under the <i>plan</i> are payable at the <i>plan's customary, usual and reasonable limits</i> .				

Schedule of Benefits – continued

EPO Provisions (applicable to all plan options)

Expenses must be received from an *EPO* provider to be considered a *covered expense* under this *plan*. Expenses received from a Non-*EPO* provider will not be covered, **except**:

1. For ambulance care;
2. If *you* require *emergency* medical care, including transport by ambulance relating to *your emergency* treatment;
3. *You* receive treatment that is a *covered expense* from an *EPO* provider and as a result of that treatment, a *covered expense* is incurred from a Non-*EPO* provider. This includes a facility based physician whose office is located in the *outpatient* department of a Non-*EPO hospital*;
4. *You* do not have access to an *EPO* provider within a 50 mile radius of *your* primary place of residence. Services received outside of the United States, as allowed by the *plan*, are not included in this provision;
5. Laboratory tests (when received in an office visit setting or *outpatient* hospital setting);
6. Flu shots;
7. Routine vision exams, including related refraction charge;
8. Wellness benefit expenses, as stated on page 1-26 of this *plan*; or
9. Hearing aids for *covered persons* age 18 and older.

Please note that even though claims will be payable at the *EPO* benefit level, *you* will be responsible for any amounts over the *customary, usual and reasonable* charge.

Primary Care Physician (PCP)/Specialist (applicable to all plan options)

Primary Care Physician includes family practice, general practice, internal medicine, nurse practitioner, pediatrician, OB/GYN, physician assistant, chiropractic care, physical therapist, occupational therapist, speech therapist, respiratory therapist, D.O. (doctor of osteopathy) and mental health/substance abuse providers. All other types of *qualified practitioners* will be considered a specialist.

Copays

Only one copay will apply per provider on the same date of service. If multiple copays could apply, the highest copay will be applied.

Schedule of Benefits – continued

COVERED EXPENSES FOR ALL PLAN OPTIONS	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
<p>Inpatient Hospital Benefit</p> <p>EPO Plan 3</p> <p>EPO Plan 4</p> <p>EPO Plan 5</p>	<p>\$1,000 copay per <i>confinement</i>, then 100%</p> <p>\$1,500 copay per <i>confinement</i>, then 100%</p> <p>\$2,500 copay per <i>confinement</i>, then 100%</p>	<p>Semi-private room and board, intensive care or coronary care and miscellaneous charges.</p> <p><i>Prior authorization</i> is required. Please refer to pages 1-1 and 1-2 for information.</p>	<p>1-25</p>
<p>Qualified Practitioner Office Services Benefit</p> <p>EPO Plan 3</p> <p>EPO Plan 4</p> <p>EPO Plan 5</p>	<p>Primary Care Physician (PCP): \$40 copay per visit/100%</p> <p>Specialist: \$55 copay per visit/100%</p> <p>Primary Care Physician (PCP): \$45 copay per visit/100%</p> <p>Specialist: \$60 copay per visit/100%</p> <p>Primary Care Physician (PCP): \$50 copay per visit/100%</p> <p>Specialist: \$65 copay per visit/100%</p>	<p>The copay includes office visits and other <i>covered expenses</i> performed in the office, except as specifically stated otherwise for certain x-rays (refer to x-ray benefit). The copay will only apply if <i>you</i> are charged for an office visit. If <i>you</i> receive a service without an office visit charge (i.e. lab test only), the copay will be waived.</p> <p>This copay will apply to all <i>covered expenses</i> listed on the Schedule of Benefits, if performed in an office, unless the benefit specifically states that it does not apply.</p>	<p>1-25</p>
<p>Qualified Practitioner Benefits</p>	<p>100% (no copay) for all plans</p>	<p>Inpatient and outpatient <i>hospital</i> visits, surgery and anesthesia.</p>	<p>1-25</p>

COVERED EXPENSES FOR ALL PLAN OPTIONS	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Oral Surgery	Payable based on services received	Refer to list of covered oral surgeries in text. Treatment of a dental <i>injury</i> will be payable as stated in the Qualified Practitioner Office Services Benefit.	1-25
Wellness Benefit EPO Plan 3 EPO Plan 4 EPO Plan 5	Primary Care Physician (PCP): 100% (no copay) Specialist: 100%, (no copay) Primary Care Physician (PCP): 100% (no copay) Specialist: 100%, (no copay) Primary Care Physician (PCP): 100% (no copay) Specialist: 100%, (no copay)	Benefits include routine physical exams, well child exams; routine x-ray and laboratory tests, including routine mammograms and routine PSA tests; routine endoscopic surgeries (i.e. colonoscopy); and immunizations. Please refer to the text for frequency limitations.	1-26
Outpatient Hospital Benefit EPO Plan 3 EPO Plan 4 EPO Plan 5	\$750 copay per visit, then 100% \$1,000 copay per visit, then 100% \$1,750 copay per visit, then 100%	<i>Prior authorization</i> is required for outpatient surgeries. Please refer to pages 1-1 and 1-2 for information.	1-27

COVERED EXPENSES FOR ALL PLAN OPTIONS	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Emergency Room Benefit	\$250 copay per visit, then 100% for all plans and all providers	<p>The copay is waived if <i>you</i> are admitted to the <i>hospital</i> directly from the <i>emergency</i> room.</p> <p>The copay applies to the facility charge and any other <i>covered expenses</i> received during <i>your emergency</i> room visit.</p> <p>Per healthcare reform, non-grandfathered plans must provide <i>emergency</i> services at the same benefit level for all <i>PPO</i> and Non-<i>PPO</i> providers.</p>	1-27
Urgent Care Center Benefits	\$50 copay per visit, then 100% for all plans	Services provided by an Urgent Care Center or Walk-In Clinic. Benefits include all <i>covered expenses</i> performed during the visit.	1-28
Ambulatory Surgical Center EPO Plan 3 EPO Plan 4 EPO Plan 5	\$750 copay per visit, then 100% \$1,000 copay per visit, then 100% \$1,750 copay per visit, then 100%		1-28
X-ray Benefit MRI/MRA/CT with or without contrast, PET and SPECT Scans EPO 3 EPO 4 EPO 5	\$500 copay per visit, then 100% \$750 copay per visit, then 100% \$1,250 copay per visit, then 100%	<p>If <i>your</i> procedure is billed with a surgical code instead of a radiology code, the outpatient <i>hospital</i> copay will apply instead of the applicable x-ray copay.</p> <p>Dental x-rays limited to covered oral surgery or <i>injury</i>.</p> <p>Mammograms are payable as stated at the end of the Schedule of Benefits.</p> <p><i>Prior authorization</i> is required for certain services. Please refer to pages 1-1 and 1-2 for information.</p>	1-28

COVERED EXPENSES FOR ALL PLAN OPTIONS	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
<p>X-ray Benefit</p> <p>All Other X-Rays</p>	<p>\$50 copay per provider per date of service/100%</p>	<p>If <i>your</i> procedure is billed with a surgical code instead of a radiology code, the outpatient <i>hospital</i> copay will apply instead of the applicable x-ray copay.</p> <p>Dental x-rays limited to covered oral surgery or <i>injury</i>.</p> <p>Mammograms are payable as stated at the end of the Schedule of Benefits.</p> <p><i>Prior authorization</i> is required for certain services. Please refer to pages 1-1 and 1-2 for information.</p>	<p>1-28</p>
<p>Laboratory Test Benefit (applies to all providers)</p> <p>EPO Plan 3</p> <p>EPO Plan 4</p> <p>EPO Plan 5</p>	<p>\$40 copay per provider per date of service/100%</p> <p>\$45 copay per provider per date of service/100%</p> <p>\$50 copay per provider per date of service/100%</p>	<p>Lab tests performed in a <i>qualified practitioner's</i> office are payable as shown above in the <i>Qualified Practitioner Office Services</i> benefit.</p>	<p>1-28</p>
<p>Ambulance Service Benefit</p>	<p>\$250 copay per one-way trip, then 100%</p>	<p>Limited to medically appropriate transport to and from the nearest facility equipped to treat the <i>sickness</i> or <i>injury</i>.</p> <p><i>Prior authorization</i> is required for air ambulance. Please refer to pages 1-1 and 1-2 for information.</p>	<p>1-28</p>

COVERED EXPENSES FOR ALL PLAN OPTIONS	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Pregnancy Benefit EPO Plan 3 EPO Plan 4 EPO Plan 5	\$1,000 copay per <i>confinement</i> , then 100% \$1,500 copay per <i>confinement</i> , then 100% \$2,500 copay per <i>confinement</i> , then 100%	Covered for <i>employee</i> , spouse and <i>dependent</i> daughter. The first office visit to determine pregnancy will be payable as stated in the <i>Qualified Practitioner</i> Office Services benefit. Charges for routine pre-natal care and routine screening for gestational diabetes are payable as shown under the Wellness Benefit. (This also applies to <i>dependent</i> daughter maternity, even if the <i>plan</i> does not cover <i>dependent</i> daughter maternity. This does not apply to high risk pregnancy or complications of pregnancy.) Laboratory Tests Any laboratory tests performed during the course of a pregnancy and billed separate of the delivery charge are payable at 100%, copay waived.	1-28
Newborn Benefits EPO Plan 3 EPO Plan 4 EPO Plan 5	\$1,000 copay per <i>confinement</i> , then 100% \$1,500 copay per <i>confinement</i> , then 100% \$2,500 copay per <i>confinement</i> , then 100%	The copay is waived if the newborn is discharged at the same time as the mother. See "Section 3 – Eligibility" for important information on <i>Dependent</i> Coverage.	1-28

COVERED EXPENSES FOR ALL PLAN OPTIONS	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Birthing Center Benefit EPO Plan 3 EPO Plan 4 EPO Plan 5	\$1,000 copay per <i>confinement</i> , then 100% \$1,500 copay per <i>confinement</i> , then 100% \$2,500 copay per <i>confinement</i> , then 100%		1-29
Extended Care Facility Benefit	100% (no copay) for all plans	Limited to 45 days per <i>calendar year</i> . <i>Prior authorization</i> is required. Please refer to pages 1-1 and 1-2 for information.	1-29
Home Health Care Benefit	100% (no copay) for all plans	Limited to 100 visits per <i>calendar year</i> . Home Health Care must be in lieu of a covered <i>confinement</i> in a <i>hospital</i> or <i>extended care facility</i> . <i>Prior authorization</i> is required. Please refer to pages 1-1 and 1-2 for information.	1-29
Hospice Care Benefit	100% (no copay) for all plans	Bereavement counseling is limited to \$1,150 paid in the 12-month period following the hospice patient's death. <i>Hospice care</i> must be in lieu of a covered <i>confinement</i> in a <i>hospital</i> or <i>extended care facility</i> .	1-30
Psychological Disorders, Chemical Dependence and Alcoholism Benefit	Payable based on services received	For office visits and therapy received in an office visit setting, <i>covered expenses</i> will be payable at the PCP benefit level.	1-31
Other Covered Expenses		<i>Covered expenses</i> included this section are generally payable at 100%, no copay, except for those <i>covered expenses</i> specifically stated otherwise as follows.	1-32

COVERED EXPENSES FOR ALL PLAN OPTIONS	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Outpatient Private Duty Nursing EPO Plan 3 EPO Plan 4 EPO Plan 5	\$55 copay per visit/100% \$60 copay per visit/100% \$65 copay per visit/100%		1-32
Prosthetic Appliances and Durable Medical Equipment	100% (no copay) for all plans	<i>Prior authorization</i> is required for durable medical equipment. Please refer to pages 1- 1 and 1-2 for information.	1-32
Chiropractic Care EPO Plan 3 EPO Plan 4 EPO Plan 5	\$40 copay per visit/100% \$45 copay per visit/100% \$50 copay per visit/100%	For all plans: <ul style="list-style-type: none"> • limited to 20 visits per <i>calendar year</i> • routine or maintenance care is covered Chiropractic x-rays are payable as stated in the X-ray benefit and are not subject to the <i>calendar year</i> visit maximum.	1-32

COVERED EXPENSES FOR ALL PLAN OPTIONS	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Diabetic Self-Management Education Classes EPO Plan 3 EPO Plan 4 EPO Plan 5	Primary Care Physician (PCP): \$40 copay per visit/100% Specialist: \$55 copay per visit/100% Primary Care Physician (PCP): \$45 copay per visit/100% Specialist: \$60 copay per visit/100% Primary Care Physician (PCP): \$50 copay per visit/100% Specialist: \$65 copay per visit/100%		1-32
Physical, Speech, Occupational and Aquatic Therapy EPO Plan 3 EPO Plan 4 EPO Plan 5	\$40 copay per visit/100% \$45 copay per visit/100% \$50 copay per visit/100%	Therapy services are limited to a combined maximum of 20 visits per <i>sickness</i> or <i>injury</i> . Additional visits may be available if approved by the <i>plan</i> . Specific to speech therapy: <ul style="list-style-type: none"> • the 20 visit maximum is not applied to speech therapy for autistic children • coverage will be allowed for covered <i>dependent</i> children up to age five, without regard to diagnosis <i>Prior authorization</i> is required. Please refer to pages 1-1 and 1-2 for information.	1-32

COVERED EXPENSES FOR ALL PLAN OPTIONS	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Respiratory Therapy EPO Plan 3 EPO Plan 4 EPO Plan 5	\$40 copay per visit/100% \$45 copay per visit/100% \$50 copay per visit/100%	<i>Prior authorization</i> is required. Please refer to pages 1-1 and 1-2 for information.	1-32
Outpatient Cardiac Rehabilitation Therapy EPO Plan 3 EPO Plan 4 EPO Plan 5	\$40 copay per visit/100% \$45 copay per visit/100% \$50 copay per visit/100%	<i>Prior authorization</i> is required. Please refer to pages 1-1 and 1-2 for information.	1-33
Radiation and Chemo Therapy	100% (no copay) for all plans		1-33
Dialysis	100% (no copay) for all plans		1-33
Pre-Admission Testing	Payable based on services received	Includes any related x-ray or laboratory tests.	1-33
Organ Transplants	Payable based on services received	Services must be received at a Designated Transplant Benefit facility or there is no benefit. <i>Prior authorization</i> is required. Please refer to pages 1-1 and 1-2 for information Refer to list of covered transplants in text.	1-33
Mammograms	100% (no copay) for all plans	When necessary to treat a <i>sickness</i> .	1-34
PKU Benefit	100% (no copay) for all plans	Please refer to the text for additional information.	1-34

COVERED EXPENSES FOR ALL PLAN OPTIONS	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Sleep Study Benefit EPO Plan 3 EPO Plan 4 EPO Plan 5	\$750 copay per visit, then 100% \$1,000 copay per visit, then 100% \$1,750 copay per visit, then 100%	<i>Prior authorization</i> is required. Please refer to pages 1-1 and 1-2 for information.	1-34
Eyeglasses or Contacts Following Cataract Surgery	100% (no copay) for all plans	One pair of glasses or contacts will be allowed per surgery, up to a maximum benefit paid of \$300 paid per pair of glasses or contacts. Two pairs of glasses or contacts will be allowed per <i>lifetime</i> . Either glasses or contacts will be allowed but not both.	1-34
Cochlear Implants	100% (no copay) for all plans		1-34
Allergy Injections	\$10 copay per visit/100%		1-35
Wigs Following Cancer Treatment	100% (no copay) for all plans	Limited to \$3,000 paid per <i>lifetime</i> . This benefit is not subject to the <i>customary, usual and reasonable charge plan</i> provision.	1-35
Hearing Aids Under Age 18 All Plans Age 18 and Older All Plans	Payable based on services received 100% (no copay) for all providers	Please refer to the Other Covered Expenses section for additional information regarding benefit coverage. For all plans, limited to \$3,500 paid per 36 month period.	1-35

COVERED EXPENSES FOR ALL PLAN OPTIONS	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Diagnostic Colonoscopy and Sigmoidoscopy <ul style="list-style-type: none"> • Under Age 50 • Age 50 and Older 	Payable based on services received 100% (no copay) for all plans	Includes all related ancillary charges.	1-35
<i>Applied Behavior Analysis (ABA Therapy)</i>	Payable as any other <i>sickness or injury</i>	<i>ABA therapy</i> is subject to the following maximums: <ul style="list-style-type: none"> • For covered <i>dependent</i> children through age 8, \$34,000 paid per <i>calendar year</i> • For covered <i>dependent</i> children age 9 through age 18, \$12,000 paid per <i>calendar year</i> 	1-37
Teladoc Services	100% (no copay) for all plans		1-38
Smoking Cessation	Payable based on services received	Includes <i>qualified practitioner</i> office visits and any related x-ray/ lab charges.	1-38
Vision Therapy EPO Plans 3, 4 & 5	Payable based on services received	Vision therapy is a <i>covered expense</i> when considered to be <i>medically necessary</i> for specific conditions. Limited to 20 visits per episode of care.	1-38
Limitations and Exclusions	Not Payable	List of exclusions that apply to all <i>covered expenses</i> . A service that is normally covered may be excluded when provided with an excluded item.	1-39

COVERED EXPENSES FOR ALL PLAN OPTIONS	PAYABLE AT	BENEFIT SUMMARY	TEXT PAGE
Prescription Drug Card	<p>100%, after copay</p> <p>Note: Prescription drug copays are applied to the medical Out-of-Pocket Limit</p>	<p>Retail \$20 copay per generic drug/refill; \$40 copay per formulary brand name drug/refill; \$60 copay per non-formulary brand name product. Limited to a 30-day supply.</p> <p>Mail Order \$40 copay per generic drug/refill; \$80 copay per formulary brand name drug/refill; \$120 copay per non-formulary brand name product. Limited to a 90-day supply.</p> <p>Generic Substitution Program (applies to all plan options) If <i>you</i> receive a brand name drug when a generic substitute is available, <i>you</i> will have to pay the difference between the cost of the brand name drug and the cost of the generic substitute in addition to the applicable copayment.</p> <p>Generic Step Therapy Program (applies to all plan options) Step therapy provisions may apply to certain therapeutic drug categories. The program establishes a hierarchy of medications and requires members to try the generic drug, before moving on to a brand name drug.</p> <p>Specialty Pharmacy Program Specialty pharmacy drugs must be purchased through the Specialty Pharmacy Program. There is a one-time courtesy fill allowed under the medical <i>plan</i>. After this one-time exception, specialty pharmacy drugs must be purchased thru the Specialty Pharmacy Program and will not be a <i>covered expense</i> under the medical <i>plan</i>. Please call CEBT at (303) 773-1373 or 1-800-332-1168 for additional details.</p>	1-44

EPO NETWORK INFORMATION

EPO networks negotiate contracts with health care providers to provide services at a discounted price. In return, the provider receives a higher volume of patients due to the *plan's* incentives to use *EPO* providers. These contracts establish a fair market value for health care services, which in most cases will reduce *your* costs.

The *trust* has contracted one or more *EPO's* to provide services to this *plan* in the areas it has *members*. Each *EPO* network consists of physicians, *hospitals* and other medical care providers. The *EPO* that is applicable to *you* is shown on *your* ID card.

Any *plan* limits on access to specialist or emergency care, use of primary care physicians, or pre-authorization of benefits are shown on the Schedule of Benefits.

HOW TO FILE A MEDICAL 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.

MISCELLANEOUS MEDICAL CHARGES

Bills for medical items *you* purchased yourself should be sent to the *claims administrator* at least once every three months (quarterly). Make sure each receipt includes: the group number, participant number, *employee* name, patient name, name of prescribing *qualified practitioner* and date purchased.

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 its participation with the *trust*, claims may be subject to different filing limitations, as found in the Employee Participation Agreement.

MEDICAL BENEFITS

COPAY INFORMATION

The copay for a *covered expense* will apply each time that expense is received. The amount of each copay varies by the type of service provided. All copays are shown on the Schedule of Benefits.

Out-of-Pocket Limit

The amount *you* must pay is the out-of-pocket limit. The out-of-pocket limit is shown on the Schedule of Benefits. The out-of-pocket limit is made up of copays and pharmacy copays. When the out-of-pocket limit has been met for a *covered person* or family, the *plan* will pay 100% of covered *expenses* for the rest of the *calendar year*.

This limit does not apply to penalties for failure to comply with the Notice Requirements.

PRIOR AUTHORIZATION REQUIREMENTS

HOW THE PROGRAM WORKS

When *you* call UM, *you* will be asked the following questions:

1. Group name and number
2. Name of *employee*
3. *Employee's* participant #
4. Name of patient
5. Patient's birthday
6. Patient's address
7. Admitting facility and phone number, if applicable
8. Physician's name and phone number
9. Reason for admission or treatment
10. Admission or treatment date

Once *prior authorization* is provided, it is valid for 30 days (excluding pregnancies) from the scheduled date of treatment. A new notice must be made if: *you* do not receive the treatment within 30 days of the scheduled date; *you* use a different facility or physician; or *you* are admitted for a different reason.

PRIOR AUTHORIZATION REQUIREMENTS

You are required to call UM prior to receiving certain types of health care. The services that require *prior authorization* are listed on the Schedule of Benefits. **If *you* fail to provide *prior authorization* as required, benefits may be reduced or denied.**

PRIOR AUTHORIZATION DOES NOT GUARANTEE BENEFIT PAYMENT. BENEFITS ARE SUBJECT TO ALL *PLAN* PROVISIONS.

NOTICE SECONDARY COVERAGE WAIVER

If this *plan* is secondary to another medical plan that also covers *you*, notice will not be required.

SECOND OPINION

UM may determine, at its discretion, the need for a second opinion. Benefits for the second opinion will be paid at 100%, after any applicable copay. *You* may go to a *qualified practitioner* of *your* choice. The *qualified practitioner* may not be in practice with the practitioner who gave the initial opinion and may not perform the procedure.

CASE MANAGEMENT

Case management services are designed to identify catastrophic and complex illnesses, transplants and trauma cases. UMR Care Management's nurse case managers identify, coordinate and negotiate rates for out-of-network services (where appropriate and allowed under the *plan*) and help manage related costs by finding alternatives to costly inpatient stays. Opportunities are identified by using a system-integrated, automated diagnosis-based trigger list during the *prior authorization* review process. Other case management trigger points include the following criteria: length of stay, level of care, readmission and utilization, as well as employer or self-referrals. UMR Care Management works directly with the patient, the patient's family members, the treating physician and the facility to mobilize appropriate resources for the *covered person's* care. Our philosophy is that quality care from the beginning of the serious illness helps avoid major complications in the future. The *covered person* may request that the *plan* provide services and the *plan* may also contact the *covered person* if the *plan* believes case management services may be beneficial.

MATERNITY MANAGEMENT

Maternity management provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full-term deliveries and decreases the cost of long-term *hospital* stays for both mothers and babies. Program members are contacted via telephone at least once each trimester and once postpartum. A comprehensive assessment is performed at that time to determine the risk level and educational needs. UMR's pre-pregnancy coaching program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, not only face risks to their babies, but also to themselves while they are pregnant. *You* can self-enroll in the pre-pregnancy coaching program by calling our toll-free number. *You* will then be contacted by nurse case managers who have extensive clinical backgrounds in obstetrics/gynecology. The nurses complete pre-pregnancy assessments to determine risk levels, if any, and provide *you* with education and materials based on *your* needs.

HOSPITAL BILL REVIEW

You should carefully review *your hospital* bill, both inpatient and outpatient. If *you* find any errors such as:

1. Treatment that is billed, but was not received;
2. Incorrect arithmetic;
3. Drugs or supplies that were not received;

you should report them to the provider of service and request a corrected itemized billing. *You* should then submit copies of the original bill, with the errors to the *claim administrator*. This serves as proof that the provider of service agreed to the corrections. **If *you* are correct, *you* will receive 50% of the errors in the bill, but not more than \$1,250 per bill** (the minimum reward is \$25).

MEDICAL COVERED EXPENSES

INPATIENT HOSPITAL BENEFITS

Charges made for these services furnished during *your hospital confinement* are payable as shown on the Schedule of Benefits:

1. Room and board charges for: average daily semi-private; ward; intensive care; isolation or coronary care. General nursing services for each day of *confinement*. *Hospital* admission kits. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the *hospital*, unless necessary due to *your sickness or injury*.
2. Services and supplies provided for the treatment of *your sickness or injury*. Benefits include services of a radiologist, pathologist and anesthesiologist, when billed directly by the *hospital* or separately.

Observation in a *hospital* room will be considered inpatient treatment if the duration of the observation status exceeds 72 hours. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether *you* will require further treatment as an inpatient or can be discharged from the *hospital* setting.

QUALIFIED PRACTITIONER BENEFITS

Charges for these services of a *qualified practitioner* are payable as shown on the Schedule of Benefits:

1. Home and office visits;
2. Inpatient and outpatient *hospital* visits;
3. Administration of anesthesia;
4. Surgical procedures, including post-operative care.

Benefits are not payable for incidental procedures done during a covered surgery (e.g. the removal of a healthy appendix during abdominal surgery).

Oral Surgery

Charges made for these oral surgeries are payable as shown on the Schedule of Benefits. Benefits include directly related charges for lab tests and x-rays. *Hospital* or *ambulatory surgical center* services are also covered.

1. Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required;
2. Surgeries required to correct *accidental* injuries to the jaw, cheeks, lips, tongue, roof and floor of the mouth;
3. Reduction of fractures and dislocations of the jaw;
4. External incision and drainage of cellulitis;
5. Incision of accessory sinuses, salivary glands or ducts; and

Oral Surgery Benefit - continued

6. Repair of or initial replacement of natural teeth damaged due to *injury*, including dental implants (dental implants including prosthetic devices related to dental implants when the result of an *accident* to a sound natural tooth). To be a *covered expense* under the *plan*, the replacement expense must begin within 6 months and be completed within 24 months of the *injury*. Damage resulting from biting or chewing will not be considered an *injury*.

WELLNESS BENEFIT

Charges for preventive medical services are payable as shown on the Schedule of Benefits. Wellness benefits include treatment provided as a result of a family history of a specific *sickness*. *Covered expenses* relating to family history will be treated as any other *sickness*. *Covered expenses* include the following as well as any other services as required by the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Centers for Disease Control and Prevention (CDC) that are listed on this website:

<http://www.healthcare.gov/law/about/provisions/services/lists.html>.

All Covered Persons

1. Preventive medicine visits (wellness exams). For covered *dependent* children, includes school and sport exams;
2. All standard immunizations recommended by the American Committee on Immunization Practices, including those required for travel. Zoster (shingles) vaccine is covered beginning at age 60;
3. Routine vision exams. If *you* have elected Vision Coverage, benefits will be payable under the Vision Benefit first. If *your* vision benefit has been exhausted, charges for a routine vision exam will be payable through the Wellness Benefit.

Screening/Services For All Covered Persons at Appropriate Ages

1. Elevated cholesterol and lipids;
2. Certain sexually transmitted diseases and HIV (includes counseling);
3. Alcohol and substance abuse, tobacco use, obesity, diet and nutrition counseling;
4. High blood pressure;
5. Diabetes;
6. Depression;
7. Screening/counseling for obesity (adults and children);
8. Routine endoscopic surgery (i.e. colonoscopy), including computed tomographic colonography (virtual colonoscopy), beginning at age 50.

For Women

1. Gynecological exams;
2. Routine mammograms for any *covered person*, including 3D mammograms. For *covered persons* age 35-49, benefits are subject to the following frequency limitations (no frequency limitations for age 50 and older):
 - a. a baseline age 35-39,
 - b. one every *calendar year* age 40-49;
2. Screening for cervical cancer including pap smears;
3. Routine pre-natal care;
4. Routine gestational diabetes screening;
5. Human papillomavirus (HPV) DNA testing for all covered women 30 years and older;
6. Counseling for sexually transmitted infections (provided annually);
7. Screening and counseling for human immune-deficiency virus (HIV) (provided annually);

Wellness Benefit - continued

8. Breastfeeding support, supplies and counseling in conjunction with each birth. Benefits include comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the post-partum period and charges for the rental or purchase of breastfeeding equipment, including breastfeeding equipment purchased from a retail provider;
9. Screening and counseling for interpersonal and domestic violence (provided annually);
10. Contraceptive methods and counseling approved by the Food and Drug Administration (FDA), such as insertable vaginal devices, injections and administration, devices (e.g. IUD, implants) including insertion and removal, sterilizations (for any covered female person), patient education and related office services. Birth control pills and patches are not covered under the medical plan. They may be covered under the prescription drug card;
11. Coverage of BRCA Testing. The *plan* must provide BRCA (breast cancer genetic marker) genetic testing and counseling without cost sharing to women who do not have a family history of the specified cancers, but who themselves have had breast, ovarian, or other cancer that was not diagnosed as BRCA-related;
12. Screening for gonorrhea, chlamydia, syphilis;
13. Screening for pregnant women for anemia and iron deficiency, bacteriuria, hepatitis B virus; Rh incompatibility;
14. Instructions to promote and help with breast feeding;
15. Screening for osteoporosis for those age 60 and older;
16. Counseling for those at high risk for breast cancer for chemoprevention.

Please visit the following links for additional information:

<https://www.healthcare.gov/preventive-care-benefits/>

<https://www.healthcare.gov/preventive-care-benefits/children/>

<https://www.healthcare.gov/preventive-care-benefits/women/>

For Men

1. Screening for abdominal aortic aneurysm for men aged 65-79 who have smoked (one time screening).
2. Prostate cancer screening, to include a PSA test and digital rectal exam, for any male *covered person*.

For Children

1. Screening newborns for hearing, thyroid disease, phenylketonuria, sickle cell anemia;
2. Standard metabolic screening panel for inherited enzyme deficiency diseases;
3. Screening for major depressive disorders;
4. Screening for developmental delay/autism;
5. Screening for lead and tuberculosis;
6. Screening for anemia;
7. Preventive/routine oral fluoride supplements prescribed for *dependent* children ages six months to five years old whose primary water source is deficient in fluoride.

OUTPATIENT HOSPITAL BENEFIT

Charges for these outpatient *hospital* services are payable as shown on the Schedule of Benefits:

1. Services and supplies provided for the treatment of *your sickness* or *injury*;
2. Regularly scheduled medical treatments (e.g. kidney dialysis, chemotherapy, inhalation therapy, physical therapy and radiation therapy) when ordered by *your attending qualified practitioner*; and
3. *Emergency* room charges.

Outpatient Hospital Benefit – continued

Observation in a *hospital* room will be considered inpatient treatment if the duration of the observation status exceeds 72 hours. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether *you* will require further treatment as an inpatient or can be discharged from the *hospital* setting.

URGENT CARE CENTER BENEFIT

Charges for *covered expenses* provided by an *Urgent Care Center* are payable as shown on the Schedule of Benefits.

AMBULATORY SURGICAL CENTER/FREE STANDING SURGICAL FACILITY

Charges made by an *ambulatory surgical center* for use of the facility in performing a covered surgery are payable as shown on the Schedule of Benefits. *Hospital* miscellaneous services provided in the facility are also covered.

X-RAY AND LABORATORY TESTS

Charges for diagnostic x-ray and lab tests are payable as shown on the Schedule of Benefits. A *qualified practitioner* must perform the tests. Tests covered under the Inpatient Hospital Benefit are not covered under this benefit. Dental x-rays are not covered, unless related to a covered *injury* or oral surgery. *Covered expenses* include lab tests when used to identify ineffective drug therapies due to certain genetic markers.

AMBULANCE SERVICE BENEFIT

Charges for ground ambulance service to and from a local *hospital* are payable as shown on the Schedule of Benefits. If *you* need care that is not available in a local *hospital*, transport to the nearest *hospital* that can provide the care is covered. If *you* require care that is not available by ground ambulance, air ambulance service to the nearest *hospital* that can provide the care is covered.

PREGNANCY BENEFIT

Charges for pregnancy are payable as shown on the Schedule of Benefits for any covered female person. *Complications of pregnancy* are payable as a *sickness* at the point the complication sets in.

In general, Federal law prohibits group health plans and health insurance issuers from limiting benefits for any *hospital* stay in connection with childbirth to less than 48 hours after a normal vaginal delivery or less than 96 hours after a cesarean section. This law applies equally to the stay of the mother and the stay of the newborn. This law does not generally prohibit the attending provider of the mother or newborn from discharging them, after consulting the mother, at an earlier time than the 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length stay that is not in excess of 48 hours (or 96 hours).

NEWBORN BENEFITS

Please refer to the "Eligibility" section of this booklet for more information on enrolling *your* newborn.

Well-Newborn

Charges for these services for a well-newborn are payable as shown on the Schedule of Benefits: hospital nursery services; circumcision of a male child; routine examination of the newborn child before release from the *hospital*.

Sick-Newborn

Charges for these services for a sick-newborn are payable as shown on the Schedule of Benefits: treatment of *injury* or *sickness*; care and treatment for premature birth; treatment of medically diagnosed birth defects and abnormalities; and surgery to repair or restore normal body functioning. *Covered expenses* do **not** include plastic or cosmetic surgery, **except** surgery for:

1. Reconstruction due to *injury*, infection or other disease of the involved part; or
2. Congenital disease or anomaly that resulted in a functional defect.

BIRTHING CENTER BENEFIT

Charges made by a *birthing center* for services and supplies provided for: prenatal care; delivery of children; and immediate postpartum care are payable as shown on the Schedule of Benefits.

EXTENDED CARE FACILITY

Charges for room and board and nursing care are payable as shown on the Schedule of Benefits. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the facility.

HOME HEALTH CARE BENEFIT

Home health care services are provided for patients when determined *medically necessary*. *Covered expenses* may include:

1. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge for the same service in a provider's office.
2. Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
3. Nutrition counseling provided by or under the supervision of a qualified dietician, or other *qualified practitioner*, if applicable.
4. Physical, occupational, respiratory and speech therapy provided by or under the supervision of a qualified therapist, or other qualified practitioner, if applicable.
5. Medical supplies, drugs, or medication prescribed by a physician and laboratory services to the extent that the *plan* would have covered them under this *plan* if the *covered person* had been in a *hospital*.

A *home health care* visit is defined as: A visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if medically necessary) or a single visit by a qualified therapist, qualified dietician, or other *qualified practitioner*, if applicable.

EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

1. Homemaker or housekeeping services;
2. Supportive environment materials such as handrails, ramps, air conditioners and telephones;
3. Services performed by family members or volunteer workers;
4. "Meals on Wheels" or similar food service;
5. Separate charges for records, reports or transportation;
6. Expenses for the normal necessities of living such as food, clothing and household supplies;
7. Legal and financial counseling services, unless otherwise covered under this *plan*.

HOSPICE CARE BENEFIT

Charges for these *hospice care* services are payable as shown on the Schedule of Benefits. *Hospice care* must be in lieu of a covered *hospital* or *extended care facility confinement*.

1. Room and board;
2. Part-time nursing care by or supervised by a registered nurse (R.N.);
3. Counseling by a licensed clinical social worker. Counseling by a pastoral counselor. Benefits are provided for the hospice patient and immediate family;
4. Bereavement counseling by a licensed clinical social worker. Bereavement counseling by a pastoral counselor. Benefits are payable up to the maximum state on the Schedule of Benefits in the 12-month period following the hospice patient's death;
5. Medical social services provided to *you* or *your* immediate family. Services include:
 - a. assessment of social, emotional and medical needs, and the home and family situation, and
 - b. identification of the community resources available and assisting in obtaining those resources;
6. Dietary counseling;
7. Consultation and case management services;
8. Physical or occupational therapy;
9. Part-time home health aide service; and
10. Medical supplies, drugs and medicines prescribed by a *qualified practitioner*.

Limitations

Hospice care must be furnished in a *hospice facility* or by a *hospice care agency* in *your* home. A *qualified practitioner* must certify that *you* are terminally ill with a life expectancy of six months or less. For *hospice care* only, *your* immediate family is *your* parent, spouse and *dependent* children.

Hospice care benefits do **not** include: private or special nursing services; a *confinement* not required for pain control or other acute chronic symptom management; funeral arrangements; or financial or legal counseling including estate planning or drafting of a will.

Hospice care benefits do **not** include homemaker or caretaker services; sitter or companion services; house cleaning or household maintenance; services by volunteers or persons who do not regularly charge for their services; or services by a licensed pastoral counselor to a member of his congregation.

PSYCHOLOGICAL DISORDERS, CHEMICAL DEPENDENCE AND ALCOHOLISM BENEFIT

Inpatient and Transitional Treatment Benefits

Charges for inpatient treatment are payable as shown on the Schedule of Benefits. Charges for a transitional treatment program are payable as shown on the Schedule of Benefits.

Transitional treatment means treatment that is provided in a less restrictive manner than inpatient treatment, but in a more intensive manner than outpatient treatment.

Transitional treatment includes the following services or programs when approved by the Department of Health and Social Services: adult day treatment programs; child and adolescent day treatment programs; services for the chronically psychologically ill provided by a community support program; services provided by a residential treatment program; and services provided in a day treatment program. Transitional treatment also includes services in intensive outpatient programs provided in accordance with the Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders of the American Society of Addiction Medicine.

Outpatient Benefits

Charges for outpatient treatment are payable as shown on the Schedule of Benefits. Outpatient Benefits include related expenses for diagnostic lab tests and psychological testing. Prescription drugs are payable under the Prescription Drug Benefit.

Limitations

Benefits do **not** include: 1. Treatment of nicotine habit or addiction; 2. Treatment of being overweight or obese; 3. Marriage counseling; or 4. Court ordered examinations or counseling.

Covered expenses are applied to the out-of-pocket limit shown on the Schedule of Benefits.

OTHER COVERED EXPENSES

These other *covered expenses* are payable as shown on the Schedule of Benefits:

1. Private duty services of a registered nurse (R.N.) for outpatient nursing care. Private duty services of a licensed practical nurse (L.P.N.) for outpatient nursing care. Care must be ordered by *your* attending *qualified practitioner*.
2. Blood and blood plasma that is **not** replaced by donation. Blood and blood products including blood extracts or derivatives.
3. Prosthetic devices to replace lost natural limbs and eyes. Replacement devices and repair expenses are covered. Maintenance expenses are not covered. *Covered expenses* are subject to the combined maximum for prosthetic devices and durable medical equipment as stated on the Schedule of Benefits.
4. Special supplies when prescribed by *your* attending *qualified practitioner* and necessary for the continuing treatment of a *sickness* or *injury*:
 - a. catheters,
 - b. flotation pads,
 - c. needles and syringes,
 - d. custom molded orthotic devices,
 - e. casts, splints, surgical dressings, trusses, braces and crutches,
 - f. oxygen and other gases.
5. Rental of durable medical equipment or purchase of such equipment when approved by the *plan* (e.g. wheelchair, *hospital* bed). The equipment must be needed for therapeutic treatment and not be mainly hygienic, custodial or educational in nature. It must be able to withstand repeated use. It must be primarily and normally used to serve a medical purpose. It must not be generally useful to a person except for the treatment of an *injury* or *sickness*. Repair expenses are not covered, unless the equipment has been purchased. Maintenance expenses are not covered. Convenience items, as determined by the *plan*, are not covered. Unless approved by the *plan* benefits for the rental of durable medical equipment will not exceed the cost to purchase the item.
6. Mechanical medical devices placed in the body to aid the function of a body organ (e.g. pacemaker, artificial larynx, artificial hip).
7. Chiropractic care for the treatment of an *injury* or *sickness*. Routine or maintenance chiropractic care is *covered expense*.
8. Installation and use of an insulin infusion pump. Other equipment and supplies used in the treatment of diabetes, when not covered by the Prescription Drug Card. Diabetic self-management education classes.
9. Elective sterilization and vasectomy. Note: Sterilization services for any covered female person are covered under the Wellness Benefit. Refer to the "For Women" list under the Wellness Benefit for more information.
10. Treatment including manipulations by a licensed: physical therapist; speech therapist; respiratory therapist; occupational therapist or aquatic therapist. All treatment must be to restore loss or correct impairment due to an *injury* or *sickness*, except as specifically stated otherwise on the Schedule of Benefits. Speech therapy for stuttering, lispings or delayed speech is not covered.

Other Covered Expenses - continued

11. Outpatient cardiac rehabilitation, following myocardial infraction or cardiac revascularization procedure. This benefit is an extension of the treatment for an *inpatient* episode and must begin within two months of discharge from the acute care facility.
12. Radiation therapy and chemotherapy.
13. Dialysis.
14. Pre-admission testing.
15. Tissue transplants (e.g. arteries or veins, corneas, heart valves, skin) placed in the body to aid the function of a body organ or replace tissue lost due to *sickness* or *injury*.
16. These human organ or tissue transplants. The transplant must be provided from a human donor to a living human recipient:
 - a. bone marrow, stem cell (allogeneic and autologous) or cellular therapy chimerica antigen receptor T-Cell Therapy (CART-T) for certain conditions;
 - b. heart transplants;
 - c. heart lung transplants (combined procedures);
 - d. kidney transplants;
 - e. liver transplants;
 - f. lung transplants;
 - g. pancreas transplants;
 - h. pancreas kidney transplants (combined procedures);
 - i. small bowel transplants; and
 - j. small bowel liver transplants (combined procedures).

When both the recipient and donor are covered by this *plan*, each is entitled to benefits.

When only the recipient is covered by the *plan*, both the donor and the recipient are entitled to benefits. The donor's benefits are limited to those not available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any government program. Benefits for the donor are charged against the recipient's coverage under the *plan*.

When only the donor is covered by the *plan*, the donor is entitled to benefits. The benefits are limited to only those not available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any governmental program. No benefits are provided to the non-covered transplant recipient.

If any organ or tissue is sold rather than donated, no benefits are payable for the purchase or removal of such organ or tissue. Other costs related to the evaluation and procurement are covered for a recipient who is covered under this *plan*.

17. When reconstructive surgery is elected after a mastectomy, the following services will also be covered:
 - a. reconstruction of the breast that was removed,
 - b. surgery and reconstruction of the other breast to produce a symmetrical appearance,
 - c. prostheses to replace the breast that was removed, and
 - d. any physical complications resulting from all stages of the mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Other Covered Expenses - continued

Benefits must have been payable for the mastectomy and these services must be part of the ongoing treatment of that mastectomy to be covered under the *plan*.

18. 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); 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. *Covered expenses* do not include orthodontic services or treatment. Benefits will be payable based on services received.
19. Mammograms for any *covered person*, when necessary to treat a *sickness*. Routine mammograms are payable as stated in the Wellness Benefit.
20. Routine endoscopic surgery (i.e. colonoscopy) beginning at age 50.
21. Phenylketonuria (PKU) testing and treatment (including food). Testing for Phenylketonuria (PKU) is covered to prevent the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU enzyme deficiency. Medical foods, for the purpose of this benefit, refer exclusively to prescription metabolic formulas and their modular counterparts, obtained through a pharmacy. Medical foods are specifically designated and manufactured for the treatment of Inherited Enzymatic Disorders caused by Single Gene Defects. Coverage for Inherited Enzymatic Disorders caused by Single Gene Defects include, but are not limited to the following diagnosed conditions: Phenylketonuria, Maternal Phenylketonuria, Maple Syrup Urine Disease, Tyrosinemia, Homocystinuria, Histidinemia, Urea Cycle Disorders, Hyperlysinemia, Glutaric Acidemias, Methylmalonic Acidemia and Propionic Acidemia. Covered care and treatment of such conditions shall include, to the extent *medically necessary*, medical foods for home use for which a *qualified practitioner* has issued a written, oral or electronic prescription.
The maximum age to receive this benefit for Phenylketonuria is 21 years of age; except that the maximum age to receive this benefit for Phenylketonuria for women who are child-bearing age is 35 years of age.
22. Sleep studies.
23. Initial contact lenses or eyeglasses following cataract surgery.
24. Cochlear implants, for profoundly hearing impaired *covered persons* who are not benefited from conventional amplification (hearing aids). Coverage is provided for *covered persons* who are at least 18 months of age, who have profound bilateral sensory hearing loss or for prelingual *covered persons* with minimal speech perception under the best hearing aided condition. Includes services needed to support the mapping and functional assessment of the cochlear device.
25. Anesthesia and associated *qualified treatment facility* charges for covered *dependent* children, when necessary because the *dependent* child:
 - a. has a physical, mental or medically compromising condition,
 - b. has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations or allergy,
 - c. is an extremely uncooperative, unmanageable, anxious or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred,
 - d. has sustained extensive oral-facial and dental trauma.

Benefits will be payable based on services received.

Other Covered Expenses - continued

26. Allergy injections, when the only service received during the visit is the administration of an allergy injection. Allergy testing will be payable as stated in the Qualified Practitioner Office Services benefit as stated on the Schedule of Benefits.
27. Charges for services and supplies for infertility evaluation and surgical procedures to correct documented physiological abnormalities of the reproductive system.
28. Wigs, following cancer treatment. Limited to one per *lifetime*.
29. *Hearing aids*:
 - a. for covered *dependents* under 18 years of age. *Covered expenses* must meet the *medically necessary* criteria as stated on page 2-6. The hearing loss must be verified by *your qualified practitioner* or licensed audiologist. Benefits are subject to the deductible and coinsurance as stated on the Schedule of Benefits and include the following:
 - the initial *hearing aid* and replacements once per five *calendar year* period,
 - a new *hearing aid* when alternations to the existing *hearing aid* cannot adequately meet the *dependent child's* needs,
 - services and supplies, including but not limited to, the initial assessment, fitting, adjustments and auditory training that is provided according to accepted professional standards.
 - b. for *covered persons* age 18 and older, payable as stated on the Schedule of Benefits. The benefit maximum includes related expenses for hearing aid fitting and repair.
30. Diagnostic colonoscopy and sigmoidoscopy, including all related ancillary charges.

31. Qualifying clinical trials as defined below, including routine patient care costs as defined below incurred during participation in a qualifying clinical trial for the treatment of:

Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the *covered person* is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials may include:

1. Covered health services (i.e., physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;
2. Covered health services required solely for the administration of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
3. Covered health services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Other Covered Expenses - continued

Routine costs for clinical trials do not include:

1. The experimental or investigational service or item as it is typically provided to the patient through the clinical trial;
2. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
4. Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and that meets any of the following criteria in the bulleted list below.

1. Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - National Institutes of Health (NIH), including the National Cancer Institute (NCI);
 - Centers for Disease Control and Prevention (CDC);
 - Agency for Healthcare Research and Quality (AHRQ);
 - Centers for Medicare and Medicaid Services (CMS);
 - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veteran's Administration (VA);
 - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
 - The Department of Veterans Affairs, the Department of Defense, or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
 - It is comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
 - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
2. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;

Other Covered Expenses - continued

3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application;
 4. The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (IRBs) before participants are enrolled in the trial. The plan sponsor may, at any time, request documentation about the trial; or
 5. The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the *plan*.
32. *Applied behavior analysis (ABA therapy)* for the treatment of autism, subject to the maximum stated on the Schedule of Benefits. Please note that other types of treatment for autism are payable as any other *sickness or injury* subject to all *plan* provisions, including but not limited to *medical necessity*, experimental, developmental delay, etc.
33. Teladoc Services. This *plan* has a special benefit allowing *covered persons* of all ages to receive telephone or web-based video consultations with *qualified practitioners* for routine primary medical diagnoses.

Teladoc may be used:

- When immediate care is needed.
- When considering the ER or urgent care center for non-Emergency issues.
- When You are on vacation or on a business trip.

Teladoc can provide care for the following types of conditions:

- General medicine, including, but not limited to:
 - Sinusitis
 - Colds and flu
 - Sore throats
 - Ear infections
 - Allergies
 - Urinary tract infections
- A refill of a recurring Prescription
- Pediatric care
- Non-Emergency medical assistance

In order to obtain this benefit, *you* must complete a medical history disclosure form that will serve as an electronic medical record for consulting *qualified practitioner*. This form can be completed via the Teladoc website, via the call center, or via the Teladoc mobile app. Once enrolled, *you* may phone 1-800-TELADOC (1-800-835-2362) and request a consultation with a *qualified practitioner*. A *qualified practitioner* will then return *your* phone call. If *you* request a web-based video consultation, the consultation will be scheduled and an appointment reminder notification will be sent prior to the appointed time. If necessary, the *qualified practitioner* will write a Prescription. The Prescription will be called in to a pharmacy of *your* choice. Benefits for this service are shown in the Schedule of Benefits.

Other Covered Expenses - continued

Teladoc may not be used for:

- Drug Enforcement Agency-controlled Prescriptions
- Charges for telephone or online consultations with *qualified practitioners* and/or other providers who are not contracted through Teladoc
- Telephone consultations provided in Idaho
- Web-based video consultations provided in Texas
- Telephone and web-based video consultations provided in Arkansas

34. *Qualified practitioner* office visits and related x-ray/laboratory charges for the purpose of prescribing smoking cessation products. Related prescription drug expenses will be payable through the *plan's* Prescription Drug Card.

35. Diagnostic 3D mammograms, payable as any other *sickness* or *injury*.

36. Nutritional counseling, payable as any other *sickness* or *injury*. Nutritional counseling is only allowed for the following conditions:

- a. HIV/AIDS
- b. cancer
- c. premature infant
- d. diabetes
- e. eating disorders
- f. hyperlipidemia
- g. hypertension

The *plan* will cover a maximum of four visits per *lifetime* per condition. To be a *covered expense*, the nutritional counseling must be prescribed by a *qualified practitioner* and received from a licensed dietician or nutritionist under the supervision of a *qualified practitioner*.

37. Vision therapy, when considered to be *medically necessary* for specific conditions. Limited to 20 visits per episode of care.

LIMITATIONS AND EXCLUSIONS

This *plan* does **not** provide benefits for:

ALTERNATIVE TREATMENTS

1. Any charge for **alternative medical treatments**. Treatments include but are not limited to: holistic medicine, ayurveda and ayurvedic nutrition, craniosacral therapy, yoga, homeopathy, movement therapy, naturopathy, tai chi chuan, visualization sessions and other programs with an objective to provide complete personal fulfillment or harmony, chelation (metallic ion therapy) except in the treatment of heavy metal poisoning, rolfing, reiki, reflexology, therapeutic touch, colon therapy, massage therapy, herbal therapy, vitamin therapy, and hypnotherapy;
2. **Acupuncture**;
3. **Mechanotherapy** or other forms of passive motion therapy, unless specifically approved by the *plan*;
4. **Athletic training**; or
5. **Vertebral Axial Decompression (VAX-D)**.

DENTAL

1. **Dental care** or treatment to the teeth, nerves and roots of the teeth, gums or other gingival tissues, or the supporting structures of the teeth (alveolar processes), except as stated; or
2. **Dental implantology** techniques, including prosthetic devices related to such techniques, except as specifically stated otherwise; (please refer to the Dental Booklet for benefit information).

DRUGS

1. **Birth control drugs**, biologicals and patches. Benefits may be available through the Prescription Drug Card;
2. Drugs, food or nutritional supplements, or medical or other supplies that are **available without the written prescription of a qualified practitioner (OTC - over the counter)**. OTC items specifically stated in this plan as a *covered expense* will be covered. When OTC items are provided as a necessary part of a covered expense incurred in a *qualified practitioner's* office, *hospital* or other facility it will be covered. This exclusion does not apply to the extent any of these is the only available source of nutrition; or
3. Charges for **prescription drugs**, unless provided during a covered *qualified practitioner* office visit or covered *hospital* stay and not excluded under any other provision of this *plan*. Please note that if *your* prescription drug is excluded by the Prescription Drug Card, it is not eligible for reimbursement through the medical *plan*.

EXPERIMENTAL OR UNPROVEN SERVICES

1. Experimental, investigational or unproven services, which means any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

Limitations and Exclusions – continued

- a. items within the research, investigational or experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- b. items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;
- c. items based on anecdotal and unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- d. items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered experimental, investigational or unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

PHYSICAL APPEARANCE

1. **Plastic or cosmetic surgery**, including any services or supplies related to, resulting from complications of or for reversal of cosmetic surgery. Reconstructive surgery due to *injury*, infection or other disease of the involved part is a *covered expense* when the need for such surgery is not the result of or a complication of a prior cosmetic procedure;
2. Treatment, drugs, medicines, services and supplies for, or leading to, **gender transition surgery**;
3. Treatment of a **congenital disease or anomaly**, except to correct a functional defect;
4. Any treatment or services for **weight control or reduction**. Treatment includes, but is not limited to: nutritional supplements (except as specifically stated otherwise); dietary or nutritional counseling; individual or behavior modification therapy; body composition or underwater weighing procedures; exercise therapy; weight control or reduction programs; except as specifically stated for preventive counseling;
5. Any treatment of **obesity** or **morbid obesity** including, but not limited to surgery (e.g. stomach stapling, gastric bubble, intestinal or stomach bypass or suction lipectomy);
6. **Wigs** or artificial hairpieces, except as specifically stated otherwise;

Limitations and Exclusions - continued

7. Any treatment of **gynecomastia** (enlargement of the breast tissue in males); or
8. Any treatment of **hyperhidrosis** (excessive sweating).

PROVIDERS

1. Any service or supply:
 - a. provided while *you* are **not under the regular care of a qualified practitioner**,
 - b. **not authorized or prescribed by a qualified practitioner**,
 - c. authorized or prescribed by a *qualified practitioner*, but **excluded under this plan**;
2. Services provided by a **person who ordinarily resides in your home** or who is a *family member*;
3. **Completion of claim forms** or forms necessary for *your* return to work or school. Any appointment *you* did not attend;
4. **Private duty nursing** while in a *hospital* or other *qualified treatment facility*;
5. Charges for a **standby surgical team**, unless surgery is actually performed; or
6. **After hour charges in relation to a service performed during normal operating hours** for the provider.

REPRODUCTION

1. Charges for **donor semen for artificial insemination, in vitro fertilization, in vivo fertilization**, embryo transport procedures, injectable substances, medications used to correct physiological abnormalities or to stimulate the individual's natural reproductive system, supplies, procedures **and all other associated expenses related to infertility**;
2. Treatment, services or supplies for a **surrogate mother** or any pregnancy resulting from *your* service as a surrogate mother only if the surrogate mother is not a *covered person* under this *plan*;
3. **Genetic testing or counseling**, unless used to treat the *sickness* or *injury* of a *covered person*, used in the treatment of a high risk pregnancy or unless specifically stated otherwise as a *covered expense*;
4. The **reversal of voluntary sterilization** procedures;
5. **Elective abortions** performed by any means including surgical and pharmaceutical methods; or
6. Treatment of a **sexual dysfunction**, including, but not limited to sexual counseling or therapy, implants and hormonal therapy. Benefits for prescription drugs may be available through the Prescription Drug Card.

ROUTINE AND GENERAL HEALTH

1. **Corneal refractive therapy**, radial keratotomy or keratoplasty to correct refractive disorders, eyeglasses or the fitting or repair of eyeglasses. The initial purchase of eyeglasses or contact lenses after a cataract surgery is a *covered expense*; or
2. **Health check-ups or routine exams and immunizations**; prophylactic surgery to prevent a *sickness* that has not occurred yet; or third party exams, including, but not limited to premarital tests or examinations; exams directed or requested by a court of law; routine physical exams for occupation, employment or the purchase of insurance; unless specifically stated as a *covered expense*.

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 charges that **would have been paid by your primary plan** had *you* complied with all of the pre-certification requirements of that plan;
4. 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); or
5. 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.

OTHER

1. Charges **in excess of the customary, usual and reasonable charge** for the service or supply;
2. Services **not medically necessary** for diagnosis and treatment of an *injury* or *sickness*;
3. *Custodial care*;
4. Any medical expense incurred **after the date your coverage under the plan terminates**, except as specifically described;
5. Charges incurred **outside the United States** if *you* traveled to such location to obtain the service, drug or supply;
6. Any medical expense due to commission or attempt to commit a **civil or criminal battery or felony** except if due to domestic violence;

Limitations and Exclusions - continued

7. 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;
8. **Educational testing or training or recreational therapy;**
9. Services or treatment for **behavioral problems, learning disabilities, developmental delays**, or other *medical conditions* that do not constitute a distinct medical diagnosis, except as specifically stated otherwise for speech therapy or *ABA therapy*;
10. Any human organ or tissue transplant except as stated. Any **non-human organ transplant**. Any artificial organ transplant;
11. Any treatment that is provided to **enhance the life style of a person without treating** a *sickness* or *injury*;
12. Any service or supply that is provided in connection with or to comply with: **a court order; an involuntary commitment; a police detention**; or other similar arrangement;
13. **Total parenteral nutrition (TPN)** except when administered in lieu of *hospitalization*;
14. Any service or supply provided in connection with or **as a result of any service or supply that is not a covered expense**, except as specifically stated otherwise; or
15. Additional costs and/or care related to **wrong surgeries**. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, etc.

PRESCRIPTION DRUG CARD

A directory of participating pharmacies is available on the Drug Card's web site. *You* can also find a participating pharmacy by calling the Drug Card's customer service number on *your* ID card.

Covered Drugs

Your Drug Card provides coverage for most commonly used drugs that are Federal Legend Drugs. Federal Legend Drugs are drugs that require a label stating, "Caution: Federal law prohibits dispensing without a prescription." *You, your* pharmacist or the prescribing physician can verify coverage for a drug by contacting the Drug Card service at the number on *your* ID card or on their website. If *you* are unable to access the Drug Card's web site, *you* can determine if a drug is covered by contacting the Drug Card's customer service.

How To Use The Prescription Drug Card

Present the ID Card and the prescription to a participating pharmacy. Then sign the pharmacist's voucher and pay the pharmacist the copay shown on the Schedule of Benefits.

If *you* are without *your* ID Card or at a non-participating pharmacy, *you* may be required to pay for the prescription and submit a claim to the Drug Card service. Claim forms are available from *your employer*, online at the Drug Card's website, or by contacting the Drug Card's customer service.

Mail Order Drug Service

If *you* are using an ongoing prescription drug, *you* may purchase that drug from the Drug Card's mail service pharmacy. Most drugs covered by the Drug Card may also be purchased by mail order. The mail order drug service is most often used to purchase drugs that treat an ongoing medical condition and are taken on a regular basis.

The copay for mail order prescriptions is shown on the Schedule of Benefits.

Mail order prescriptions should be sent to the Drug Card mail service pharmacy. Order forms are available at the Drug Card's web site, from the Drug Card's customer service, or from *your employer*. All prescriptions will be mailed directly to *your* home or chosen delivery address.

Formulary Program

This *plan* uses a formulary program to help reduce drug costs and ensure quality. The formulary is a list of preferred brand name drugs. The list of preferred brand name drugs is available at the Drug Card's website or from the Drug Card's customer service. Please present it to *your qualified practitioner* when drugs are being prescribed for *you*. The *plan* encourages *you* to use the formulary whenever possible.

Use of the formulary is on a voluntary basis. However, drugs that are not on the formulary may have higher copays or be excluded, as shown on the Schedule of Benefits.

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*.

ABA/IBI/Autism Spectrum Disorder therapy

Intensive behavioral therapy programs used to treat autism spectrum disorder are often referred to as Intensive Behavioral Intervention (IBI), Early Intensive Behavioral Intervention (EIBI), or Applied Behavior Analysis (ABA). These interventions aim to reduce problem behaviors and develop alternative behaviors and skills in those with Autism Spectrum Disorder. In a typical therapy session, the child is directed to perform an action. Successful performance of the task is rewarded with a positive reinforcer, while noncompliance or no response receives a neutral reaction from the therapist. For children with maladaptive behaviors, plans are created to utilize the use of reinforcers to decrease problem behavior and increase more appropriate responses. Although once a component of the original Lovaas methodology, aversive consequences are no longer used. Parental involvement is considered essential to long-term treatment success; parents are taught to continue behavioral modification training when the child is at home, and may sometimes act as the primary therapist.

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.

Ambulatory Surgical Center

A distinct facility whose business purpose is to provide surgical services on an outpatient basis. The facility must be duly licensed by the state in which it is located. It may not provide accommodations for patients to stay overnight.

Amendment

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

Birthing Center

A licensed facility which: 1. Provides prenatal care, delivery and immediate postpartum care, and care of a child born at the *birthing center*; 2. Is directed by a *qualified practitioner* specializing in obstetrics and gynecology; 3. Has a *qualified practitioner* or certified nurse midwife present at all births and during the immediate postpartum period; 4. Extends staff privileges to *qualified practitioners* who practice obstetrics and gynecology in the area; 5. Has at least two beds or birthing rooms for use by patients during labor and delivery; 6. Provides full-time skilled nursing services (directed by a R.N. or certified nurse midwife) in the delivery and recovery rooms; 7. Provides diagnostic x-ray and laboratory services for the mother and newborn; 8. Has the capacity to administer a local anesthetic and perform minor surgery (including episiotomy and repair of perineal tear); 9. Is equipped and staffed to handle medical emergencies and provide immediate life support measures; 10. Accepts only patients with low risk pregnancies; 11. Has a written agreement with an area *hospital* for *emergency* transfer of patients and ensures its staff is aware of the procedure; 12. Provides an ongoing quality assurance program; and 13. Keeps a medical record for each patient.

Board of Trustees

The *Board of Trustees* established by the *Trust Agreement*.

Definitions - continued

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*.

Complications of Pregnancy

1. *Medical conditions* that are distinct from pregnancy, but adversely affected by pregnancy or caused by pregnancy. Such conditions include acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;
2. A non-elective cesarean section surgical procedure;
3. A terminated ectopic pregnancy; or
4. A spontaneous termination of pregnancy that occurs during a gestation in which a viable birth is not possible.

Complications of pregnancy does not mean: false labor; occasional spotting; prescribed rest during the pregnancy; or similar conditions associated with the management of a difficult pregnancy, but not constituting a distinct medical diagnosis.

Confinement

Being a resident patient in a *hospital* for at least 15 consecutive hours per day. Being a resident bed patient in an *extended care facility* or other *qualified treatment facility* 24 hours a day. Successive *confinements* are considered one if:

1. Due to the same *injury* or *sickness*; and
2. Separated by fewer than 30 consecutive days when *you* are not confined.

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*.

Custodial Care

Care to assist in the activities of daily living. Care that is not likely to improve *your sickness* or *injury*.

Customary, Usual and Reasonable

For Non-EPO Providers, 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.

1. If more than one surgery is performed during an operative session, the *covered expense* will be limited. The *customary, usual and reasonable* (CU&R) fee for the primary surgical procedure will be payable. 50% of the CU&R fee for the secondary procedure will be payable. 50% of the CU&R fee for the third and following procedures will be payable.

EPO Plan - Revised 7/1/18

Definitions - continued

2. The CU&R fee for an assistant surgeon or physician's assistant is based on the CU&R fee for the primary surgeon as follows: 16% for an assistant surgeon; and 14% for a physician's assistant.

In the case of an *EPO* Provider, it will mean the negotiated *EPO* discount rate for the service or procedure.

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.

EPO

Exclusive Provider Organization. If a provider has contracted with the *EPO* Network, they are an *EPO* Provider. *EPO* providers furnish services at a discounted rate to the *plan*. If a provider has not contracted with the *EPO* Network, they are a Non-*EPO* provider.

Definitions – continued

Emergency

Any *injury* or *sickness* that would jeopardize or impair the health of the *covered person* if not treated immediately. An *emergency* may or may not be life threatening. A condition is considered to be an *emergency* care situation when a sudden and serious condition such that a *prudent layperson* could reasonably expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of bodily functions would result unless immediate medical care is rendered. Examples of an *emergency* care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

Employee

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

Employer

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

Enrollment Date

The first day of *your* eligibility period or if earlier, *your* effective date of coverage under this *plan*. If *you* are a *late applicant*, *your enrollment date* is the effective date of *your* coverage under this *plan*.

Expense Incurred

For medical expenses, the *customary, usual and reasonable* fee charged for services and supplies needed to treat the *injury* or *sickness*. The date a supply or service is provided is the *expense incurred* date.

Extended Care Facility

A facility, or distinct part thereof, that is duly licensed where it is located. It must maintain and provide:

1. Full-time bed care facilities for resident patients;
2. A *qualified practitioner's* services available at all times;
3. A registered nurse (R.N.) or *qualified practitioner* in charge and on full-time duty. With one or more registered nurses (R.N.'s) or licensed vocational or practical nurses on full-time duty;
4. A daily record for each patient; and
5. Continuous skilled nursing care during convalescence from *sickness* or *injury*.

An *extended care facility* is not, except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of drug addicts or alcoholics.

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*.

Hearing Aids

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

Definitions – continued

Home Health Care

A formal program of care and intermittent treatment that is: Performed in the home; prescribed by a physician; intermittent care and treatment for the recovery of health or physical strength under an established plan of care; prescribed in place of a *hospital* or an *extended care facility* stay or results in a shorter *hospital* or *extended care facility* stay; organized, administered, and supervised by a *hospital* or qualified licensed providers under the medical direction of a physician; and appropriate when it is not reasonable to expect the *covered person* to obtain medically indicated services or supplies outside the home.

For purposes of *home health care*, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Agency

An agency or organization that specializes in providing medical care in the home. Such a provider must meet all of the following conditions:

1. Its primary purpose is to provide skilled nursing and other medical services. Is duly licensed in the location where services are provided;
2. Has policies set by a professional group. This professional group must have at least one registered nurse (R.N.) to govern the services provided. It must provide for full-time supervision of such services by a *qualified practitioner* or registered nurse;
3. Maintains a complete medical record on each patient;
4. Has a full-time administrator; and
5. Is approved by *Medicare*.

Home Health Care Plan

A formal, written plan made by the *covered person's qualified practitioner* that is evaluated on a regular basis. It must state the diagnosis, certify that the *home health care* is in place of *hospital* confinement, and specify the type and extent of *home health care* required for the treatment of the *covered person*.

Hospice Care Agency

An agency whose primary purpose is providing hospice services. It must be licensed and operated according to the laws of the state in which it is located. It must meet all of the following requirements: has obtained any required certificate of need; provides 24 hour a day, seven day a week service; is supervised by a *qualified practitioner*; has a full-time coordinator; keeps written records of services provided to each patient; has a nurse coordinator who is a registered nurse (R.N.) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients; and has a licensed social service coordinator.

A *hospice care agency* will establish policies for the provision of *hospice care*. It will assess the patient's medical and social needs and develop a program to meet those needs. It will provide an ongoing quality assurance program. It will permit area medical personnel to use its services for their patients. It will use volunteers trained in care of and services for non-medical needs.

Hospice Care

Palliative and supportive care to hospice patients. It offers supportive care to the families of the hospice patients. It offers an assessment of the hospice patient's medical and social needs and a description of the care necessary to meet those needs. *Hospice care* must be provided under a written plan of *hospice care*. The plan must be established and reviewed by the *qualified practitioner* attending the person and the *hospice care agency*.

Definitions – continued

Hospice Facility

A licensed facility or part thereof that principally provides *hospice care*. It has 24 hour a day nursing services provided under the direction of a registered nurse (R.N.). It has a full-time administrator. It keeps medical records of each patient. It has an ongoing quality assurance program, and has a *qualified practitioner* on call at all times.

Hospital

Hospital means a facility that:

1. Is a licensed institution authorized to operate as a *hospital* by the state in which it is operating; and
2. Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
3. Has a staff of licensed Physicians available at all times; and
4. Is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency; or, if outside of the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
5. Continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
6. Is not a place primarily for maintenance or Custodial Care.

For purposes of this *plan*, the term "*hospital*" also includes Surgical Centers and Birthing Centers licensed by the state in which they operate. The term "*hospital*" does not include services provided in facilities operating as residential treatment centers.

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.

Medical Condition

A syndrome or group of symptoms that are not attributable to a specific disease or a distinct medical diagnosis.

Medically Necessary

Means health care services provided for the purpose of preventing, evaluating, diagnosing or treating a *sickness*, *injury*, psychological disorder, chemical dependence disorder, alcoholism disorder or its symptoms, that are all of the following, as determined by the *plan* or *our* designee, within our sole discretion:

1. In accordance with Generally Accepted Standards of Medical Practice; and
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for *your sickness*, *injury*, psychological disorder, chemical dependence disorder, alcoholism disorder or its symptoms; and

Definitions – continued

3. Not mainly for *your* convenience or that of *your qualified practitioner*; and
4. Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of *your sickness, injury* or symptoms.

The fact that a physician or *qualified practitioner* has performed, prescribed, recommended, ordered or approved a service, treatment plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility *medically necessary*.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are *medically necessary*. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to *you* by calling UMR at the telephone number shown on *your* ID card, and to *qualified practitioners*, physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare

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

Morbid Obesity

A condition in which the presence of excess weight causes physical trauma; where pulmonary and circulatory insufficiencies are present; where complications related to the treatment of conditions such as atherosclerosis, diabetes, coronary disease, etc., exist; and where the *covered person* is at least one hundred pounds overweight.

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*.

Outpatient

A period of time during which *you* are not confined as a resident bed patient in a: *hospital; extended care facility; or other qualified treatment facility*.

Pediatric Services

Services provided to a *covered person* under the age of 19.

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*.

Definitions – continued

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.

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.

Prior Authorization

The process of determining benefit coverage prior to service being rendered to a *covered person*. A determination is made based on medical necessity (*medically necessary*) criteria for services, tests or procedures that are appropriate and cost-effective for the *covered person*. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

Prudent Layperson

A person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

Qualified Practitioner

A provider duly licensed, registered, and/or certified by the state in which he or she is practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this *plan*. A *qualified practitioner's* services are not covered if the practitioner resides in *your* home or is a *family member*.

Qualified Treatment Facility

A facility that is duly licensed and operating within the scope of its license.

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. *Sickness* includes treatment provided as a result of a family history of a specific *sickness*.

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.

Definitions – continued

Urgent Care Center (Walk-In Clinic)

A facility that provides outpatient medical care on a walk-in or unscheduled basis. Such care may be offered during extended hours that include evenings, weekends and holidays. *Urgent Care Center* does not include a *hospital* or emergency room.

You and Your

You as the covered *employee*. Any of *your dependents*, unless otherwise indicated.

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

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

DEPENDENT COVERAGE

Dependent Eligibility

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

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

Dependent Eligibility - continued

5. The date a child is legally adopted;
6. The date a valid court order is issued which, by federal law or *plan* provision, requires the *plan* to provide coverage; or
7. For a Civil Union partner, the date *you* meet the definition of *dependent* as stated in the *plan*.

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

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

Dependent Effective Date

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

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

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

Newborn and Adopted Children

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

HIPAA SPECIAL ENROLLMENT RIGHTS

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

Loss of Other Coverage

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

1. Due to *your* exhaustion of the maximum COBRA period;
2. Due to *your* loss of eligibility, for any reason; or
3. Employer contributions cease toward the cost of the other coverage;

HIPAA Special Enrollment Rights – continued

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

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

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

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

Marriage

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

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

Birth, Adoption or Placement for Adoption

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

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

MEDICAID/STATE CHILD HEALTH PLAN

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

You must request coverage under this *plan* within 60 days after the date of termination of such coverage. Coverage under this *plan* will be effective on the date the other coverage ends. If *you* apply for coverage more than 60 days after the date the Medicaid or State child health plan coverage ends, *you* will be considered a *late applicant* under this *plan*.

Premium Assistance

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

RETIREE COVERAGE

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

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

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

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

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

ANNUAL ENROLLMENT PERIOD

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

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

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

Changes In Status

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

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

Changes in Status - continued

3. **Employment Status.** Any of the following events that change the employment status of *you* or *your dependent*, including: termination or commencement of employment, strike or lockout, commencement or return from unpaid leave, change in worksite, and any change in employment status that results in a loss or gain of eligibility under the Section 125 plan or the underlying benefit plan;
4. **Dependent Status.** *Your dependent* satisfies or ceases to satisfy eligibility requirements for coverage;
5. **Residence.** Any change in residence for *you* or *your dependent*;
6. **FMLA Leave Status.** At the time a leave under the FMLA begins the *employee* may change elections to the extent allowed under the federal *Family and Medical Leave Act*;
7. **COBRA Continuation.** *You* or *your dependent* become eligible for and elect continuation coverage under the employer's group health plan as provided by *COBRA* or a similar State law;
8. **Judgment, Decree or Court Order.** An order resulting from a divorce, legal separation, annulment, change in legal custody or Qualified Medical Child Support Order as defined by ERISA which requires *you* or another individual to provide health coverage for *your dependent* child;
9. **Entitlement to Medicare or Medicaid.** A gain or loss of eligibility under Medicare, Part A or Part B, or Medicaid for *you* or *your dependent*;
10. **HIPAA Special Enrollment Rights.** An event which qualifies as a special enrollment right under the *Health Insurance Portability and Accountability Act*;
11. **Significant Cost Increase.** Election changes are limited to increasing *your* election to cover the cost increase or changing the election to provide for a similar benefit offered by the employer;
12. **Significant Curtailment of Coverage.** An overall reduction in coverage provided to all participants that results in a general reduction in coverage under the plan;
13. **Addition or Elimination of a Benefit Option.** Election changes are limited to electing the new benefit option in the case of an added benefit option or electing a similar benefit in the case of the elimination of a benefit option;
14. **Changes in a Dependent's Coverage under Another Employer's Plan.** Election changes are limited to changes that result from a change under the plan of *your spouse's*, *ex-spouse's* or other *dependent's* employer. To qualify as a change in status under this plan the change must be permitted under the other employer plan and Section 125 of the Internal Revenue Code or be the result of a differing election period under the other employer plan.

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

SPOUSAL TRANSFER PROVISION

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

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

Spousal Transfer Provision – continued

1. *You* and *your* spouse decide to transfer coverage under the *plan* from one spouse to the other;
2. *Your* spouse decides to take coverage as an *employee* for any reason; or
3. *You* terminate *your* coverage under the *plan* for any reason.

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

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

BENEFIT CHANGES

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

SPECIAL PROVISIONS FOR NOT BEING ACTIVELY AT WORK

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

1. One year during an approved, non-military leave of absence (including a *total disability* leave of absence); or
2. Two consecutive years during an approved sabbatical.

Coverage that is required by the Family and Medical Leave Act will reduce any period shown above. The *plan* must remain in effect for this provision to apply. At the end of this period, COBRA continuation will be offered.

SURVIVORSHIP CONTINUATION

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

1. The date *your* surviving *dependents* become covered under any other group plan;
2. The end of two consecutive years following *your* death.

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

REINSTATEMENT OF COVERAGE

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

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date the *plan* terminates;
2. For any benefit, the date the benefit is removed from the *plan*;
3. The end of the period for which any required *employee* or *employer* contribution was due and not paid;
4. The date *you* enter the full-time military, naval or air service of any country;
5. The end of the month in which *you* fail to be in an eligible class of persons according to the eligibility requirements of the *employer*;
6. For all *employees*, the end of the month in which termination of employment with the *employer* occurs or, if earlier, the end of the month in which *you* are no longer *actively at work* as defined in this *plan*;
7. For all *employees*, the end of the month in which *your* retirement occurs, unless *you* are eligible for and elect Retiree Coverage;
8. For *your dependents*, the date *your* coverage terminates;
9. For a *dependent*, the date the *dependent* enters the full-time military, naval or air service of any country;
10. For a *dependent* spouse, the end of the month in which that *dependent* no longer meets this *plan's* definition of *dependent*;
11. For a *dependent* child, the end of the month in which the *dependent* child no longer meets the *plan's* eligibility requirements as stated in the definition of *dependent*;
12. The date *you* request termination of coverage to be effective for yourself and/or *your dependents*; or
13. The date *you* die.

Rescission of Coverage

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

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

1. It has only a prospective effect;
2. It is attributable to non-payment of premiums or contributions; or

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

Important Notice for Active Employees and Spouses Age 65 and Over

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

1. Maintain coverage under this *plan*, in which case *Medicare* benefits would be secondary to this *plan*; or
2. End coverage under this *plan*, in which case *Medicare* would be the only coverage available to *you*.

An active *employee's* spouse who is eligible for *Medicare* due to age (age 65 or over) has the same choice.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

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

EMPLOYEE ELIGIBILITY

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

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

TYPES OF LEAVE

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

Family and Medical Leave

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

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

Military Family Leave

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

FMLA - continued

Maximum Leave Period

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

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

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

Termination Before the Maximum Leave Period

If the *employee* decides not to return to work, coverage under the *plan* may end at that time.

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

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

Recovery of Plan Contributions

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

REINSTATEMENT OF COVERAGE UPON RETURN TO WORK

The law requires that coverage be reinstated upon the *employee's* return to work. Reinstatement will apply whether coverage under the *plan* was maintained during the FMLA leave or not.

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

DEFINITIONS

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

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

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

FMLA - continued

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

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

Spouse is *your* lawful husband or wife.

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

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

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

NOTE: To the extent that State or local law requires an *employer* to provide greater leave rights than those stated above, this *plan* will provide that greater right. For complete information regarding *your* rights under the FMLA, contact *your employer*.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

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

CONTINUATION OF COVERAGE DURING MILITARY LEAVE

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

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

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

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

Maximum Period of Coverage during Military Leave

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

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

REINSTATEMENT OF COVERAGE FOLLOWING MILITARY LEAVE

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

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

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

USERRA - continued

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

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

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

CONTINUATION OF BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

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

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

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

Employee Rights to COBRA

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

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

Spouse Rights to COBRA

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

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

Dependent Child Rights to COBRA

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

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

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

COBRA – continued

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

COBRA – continued

(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 medical expenses.

PLAN NAME	Colorado Employer Benefit Trust Employee Health and Welfare Benefit Plan
TYPE OF PLAN	A self-funded welfare plan that provides medical benefits to covered <i>employees</i> and <i>dependents</i> . This <i>plan</i> is not financed or administered by an insurance company. The <i>plan's</i> benefits are not guaranteed by a contract of insurance.
PLAN EFFECTIVE DATE	July 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.

Order of Benefit Determination

The primary plan will be determined by the following rules. That plan will pay benefits first.

1. The plan that has no coordination provision will be primary.
2. The plan that covers the person as an *employee* will be primary.

Coordination of Benefits - continued

3. For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the *calendar year* will be primary. If both parents have the same birthday, the plan covering a parent for the longest period of time will be primary.
4. In the case of a child that is placed in the joint custody and physical placement of divorced, separated or unmarried parents rule 3. will apply, unless one parent has been assigned financial responsibility for the medical expenses of the child. In that case, the plan of the parent with financial responsibility, as ordered by the court, will be primary.
5. In the case of a child of divorced, separated or unmarried parents that is not in the joint custody and physical placement of both parents:
 - a. the plan of a parent who has primary physical placement will be primary,
 - b. the plan of a step-parent that has primary physical placement will pay benefits next,
 - c. the plan of a parent who does not have primary physical placement will pay benefits next, and
 - d. the plan of a step-parent that does not have primary physical placement will pay benefits next.

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

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

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

If the primary plan is not established by the above rules, the plan that has covered the person for the longest period of time will be primary. If all plans have covered the person for the same period of time, the plans will share equally in the allowable expenses. In no event, will any plan pay more than it would have paid as 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.

TRICARE

If an eligible *employee* is on active military duty, TRICARE is the only coverage available to that *employee*. Benefits are not coordinated with the *employee's* health insurance plan.

In all instances where an eligible *employee* is also a TRICARE beneficiary, TRICARE will pay secondary to this *plan*.

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 its 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. *Covered expenses* allowed by the *plan* will be payable as stated on the Schedule of Benefits.

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 affects eligibility for a *covered person*. Notification requirements are outlined in this summary plan description and other *plan* materials. Please read them carefully and refer to all *plan* materials that you receive (i.e., COBRA notices). A few examples of events that require *plan* notification would be divorce, dependent child reaching the limiting age, and enrollment in other group health coverage while on COBRA (please note that the examples listed are not all inclusive).

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

Covered persons must:

1. File accurate claims. If someone else, such as *your* spouse or another family member, files claims on the *covered person's* behalf, the *covered person* should review the form before signing it;
2. Review your Explanation of Benefits (EOB). Make certain that benefits have been paid correctly based on *your* knowledge of the *covered expense* and the services received;
3. Never allow another person to seek medical treatment under *your* identity. If *your plan* ID card is lost, report the loss to the *plan administrator* immediately;
4. Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of *your* knowledge; and

Fraud – continued

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

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

1. Bills for services or treatment that have never been received; or
2. Asks a *covered person* to sign a blank claim form; or
3. Asks a *covered person* to undergo tests that the *covered person* feels are not needed.

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

FREE CHOICE OF PROVIDER

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

INTERPRETATION

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

LEGAL ACTIONS

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

PAYMENT OF CLAIMS

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

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

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

PHYSICAL EXAMINATION

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

PRIVACY

The *employer*, who is the sponsor of this *plan*, will receive protected health information. The information may be identified to the individual in some cases. The *employer* is limited in how it may use this information. Its uses and disclosures must be necessary to carry out *plan* functions. The *plan* functions must relate to payment

Privacy – continued

or health care operations, as defined in 45 CFR Subtitle A, Subchapter C, Part 164 - Security and Privacy. It may also use or disclose the information as required by law.

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

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

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);

Time of Claim Determination – continued

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 that, if the claimant is not satisfied with the determination of the Claim appeal Procedure, the claimant may call the relevant member assistance phone number or, if there is no applicable office of health insurance consumer assistance or ombudsman for which to provide contact information under item 10, the Department of Health and Human Services Health Insurance Assistance Team (HIAT) at 1-888-393-2789;
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 both medical and prescription drug claims. For medical 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*. For prescription drug claims, both levels of appeal will be with the designated prescription drug administrator. 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* or designated prescription drug 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 Procedure - 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 Procedure - 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 that, if the claimant is not satisfied with the determination of the Claim appeal Procedure, the claimant may call the relevant member assistance phone number or, if there is no applicable office of health insurance consumer assistance or ombudsman for which to provide contact information under item 11, the Department of Health and Human Services Health Insurance Assistance Team (HIAT) at 1-888-393-2789;
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.

FEDERAL EXTERNAL REVIEW PROGRAM

If, after exhausting *your* internal appeals, *you* are not satisfied with the final determination, *you* may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

1. Clinical reasons;
2. The exclusion for experimental or investigational services or unproven services; or
3. As otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a predetermination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to *you* after exhausting the appeals process identified above and *you* receive a decision that is unfavorable, or if UMR, Inc. or *your employer* fail to respond to *your* appeal within the time lines stated above.

You may request an independent review of the adverse benefit determination. Neither *you* nor UMR, Inc. or *your employer* will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If *you* wish to pursue an external review, please send a written request to the following address:

EPO Plan - Revised 7/1/18

Federal External Review – continued

UMR, INC.
EXTERNAL REVIEW
APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include:

1. *Your* specific request for an external review;
2. The *employee's* name, address, and member ID number;
3. *Your* designated representative's name and address, when applicable;
4. The service that was denied; and
5. Any new, relevant information that was not provided during the internal appeal.

You will be provided more information about the external review process at the time we receive *your* request.

All requests for an independent review must be made within four (4) months of the date *you* receive the adverse benefit determination. *You* or an authorized designated representative may request an independent review by contacting the toll-free number on *your* ID card or by sending a written request to the address on *your* ID card.

The independent review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested service or procedure is a *covered expense* by the *plan*. The Independent Review Organization (IRO) has been contracted by UMR, Inc. and has no material affiliation or interest with UMR, Inc. or *your employer*. UMR, Inc. will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

1. All relevant medical records;
2. All other documents relied upon by UMR, Inc. and/or *your employer* in making a decision on the case; and
3. All other information or evidence that *you* or *your* physician has already submitted to UMR, Inc. or *your employer*.

If there is any information or evidence *you* or *your* physician wish to submit in support of the request that was not previously provided, *you* may include this information with the request for an independent review, and UMR, Inc. will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if *you* meet the criteria for an expedited external review as defined by applicable law.

Federal External Review – continued

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide *you* and UMR, Inc. and/or *your employer* with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the *plan* will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the *plan*. If the final independent review decision is that payment or referral will not be made, the *plan* will not be obligated to provide benefits for the service or procedure.

You may contact the *claims administrator* at the toll-free number on *your* ID card for more information regarding *your* external appeal rights and the independent review process.

**BENEFIT PLAN AMENDMENT
IT IS UNDERSTOOD AND AGREED THAT:**

On pages 4-15 through 4-19, 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 both medical and prescription drug claims and an external review process as outlined below. For medical 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*. For prescription drug claims, both levels of appeal will be with the designated prescription drug administrator. 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* or designated prescription drug 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 that, if the claimant is not satisfied with the determination of the Claim appeal Procedure, the claimant may call the relevant member assistance phone number or, if there is no applicable office of health insurance consumer assistance or ombudsman for which to provide contact information under item 11, the Department of Health and Human Services Health Insurance Assistance Team (HIAT) at 1-888-393-2789;
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.

FEDERAL EXTERNAL REVIEW PROGRAM

If, after exhausting *your* internal appeals (either at initial appeal or voluntary second level appeal if elected), *you* are not satisfied with the final determination, *you* may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

1. Clinical reasons;
2. The exclusion for experimental or investigational services or unproven services; or

3. As otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a predetermination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to *you* after exhausting the appeals process identified above and *you* receive a decision that is unfavorable, or if UMR, Inc. or *your employer* fail to respond to *your* appeal within the time lines stated above.

You may request an independent review of the adverse benefit determination. Neither *you* nor UMR, Inc. or *your employer* will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If *you* wish to pursue an external review, please send a written request to the following address:

UMR, INC.
EXTERNAL REVIEW
APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include:

1. *Your* specific request for an external review;
2. The *employee's* name, address, and member ID number;
3. *Your* designated representative's name and address, when applicable;
4. The service that was denied; and
5. Any new, relevant information that was not provided during the internal appeal.

You will be provided more information about the external review process at the time we receive *your* request.

All requests for an independent review must be made within four (4) months of the date *you* receive the adverse benefit determination. *You* or an authorized designated representative may request an independent review by contacting the toll-free number on *your* ID card or by sending a written request to the address on *your* ID card.

The independent review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested service or procedure is a *covered expense* by the *plan*. The Independent Review Organization (IRO) has been contracted by UMR, Inc. and has no material affiliation or interest with UMR, Inc. or *your employer*. UMR, Inc. will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

1. All relevant medical records;
2. All other documents relied upon by UMR, Inc. and/or *your employer* in making a decision on the case; and
3. All other information or evidence that *you* or *your* physician has already submitted to UMR, Inc. or *your employer*.

If there is any information or evidence *you* or *your* physician wish to submit in support of the request that was not previously provided, *you* may include this information with the request for an independent review, and UMR, Inc. will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if *you* meet the criteria for an expedited external review as defined by applicable law.


The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide *you* and UMR, Inc. and/or *your employer* with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the *plan* will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the *plan*. If the final independent review decision is that payment or referral will not be made, the *plan* will not be obligated to provide benefits for the service or procedure.


You may contact the *claims administrator* at the toll-free number on *your* ID card for more information regarding *your* external appeal rights and the independent review process.

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)



(Date)