CONTRACTORS HEALTH TRUST (CHT)
Medical, Dental, Vision
Plan Document/Summary Plan Description

Amended, restated and effective January 1, 2020

NO VESTED RIGHTS

No Participant, the Spouse or Civil Union Partner of a deceased Participant or any other person shall have any vested right to any benefit(s) provided by the Plan (except for a Health Savings Account that is set up for use with a qualified High Deductible Health Plan).

NO AGENT MAY INTERPRET PLAN

Individual Trustees are not authorized to furnish any information respecting the Plan's benefits or eligibility requirements. Any questions regarding eligibility or benefits should be sent to the Administrative Office or to the attention of the full Board of Trustees.

As applicable to certain insured benefits described in this document, nothing in this document is meant to interpret or extend or change in any way the provisions expressed in the insurance policies.

In the event of inconsistencies, between this document and any applicable insurance policies, the insurance policies shall prevail.

The Board of Trustees reserves the right to amend, modify or discontinue all or part of this Plan, for any or all Participants, whenever in its judgment conditions so warrant.

TABLE OF CONTENTS

INTRODUCTION

What this Document Tells You

This Plan Document/Summary Plan Description describes the medical, dental, vision, life insurance (including dependent life) and the accidental death and dismemberment benefits of Contractors Health Trust (hereafter referred to as "CHT" or "Plan" or "Trust"). The Plan described in this document is effective January 1, 2020, as amended, except for those provisions that specifically indicate other effective dates, and replaces all other plan documents, summary plan descriptions, and applicable amendments to those documents previously provided to Plan Participants.

The provisions of the Restated Plan Document/Summary Plan Description are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of the Restated Plan Document/Summary Plan Description and the provisions of the Trust Agreement, the provisions of the Trust Agreement will prevail.

To determine if you are in a class of individuals who are eligible for benefits under this Plan, refer to the Eligibility chapter in this document. Note that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment.

This document will help you understand and use the benefits provided by CHT. You should review it and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverage provided, the procedures to follow in submitting claims, and your responsibilities to provide necessary information to the Plan. Be sure to read the Exclusions and Definitions chapters. **Remember, not every expense you incur for health care is covered by the Plan.**

All provisions of this document contain important information. If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information. A Quick Reference Chart to sources of help or information about the Plan appears in this chapter.

IMPORTANT INFORMATION

CHT is committed to maintaining health care coverage for Employees and their families at an affordable cost, however, because future conditions cannot be predicted, the Board of Trustees reserves the right to amend or terminate coverage at any time and for any reason. As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

This Plan is established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. The medical benefits of the Plan are self-funded with contributions from the Contributing Employers and are held in a Trust. An independent Claims Administrator pays benefits out of Trust assets. The Davis Vision plan, Delta Dental plan, and life and Accidental Death and Dismemberment Insurance and the Dependent life insurance are fully insured with insurance companies whose names are listed on the Quick Reference Chart in this document.

Suggestions for Using this Document

This document provides detail about your Plan. We suggest that you pay particular attention to the following:

- Read through this **Introduction** and look at the **Table of Contents** that immediately precedes it. If you don't understand a term, look it up in the Definitions chapter. The **Table of Contents** provides you with an outline of the chapters. The **Definitions** chapter explains many technical, medical and legal terms that appear in the text.
- This document contains a **Quick Reference Chart** following this introductory text**.** This is a handy resource for the names, addresses, and phone numbers of the key contacts for your benefits such as the Claims Administrator.
- Review the **Schedule of Medical Benefits and Medical Plan Exclusions chapter.** These describe your benefits in more detail. There are examples, charts, and tables to help clarify key provisions and more technical details of the coverage.

- Review the **Medical Networks and Utilization Management chapters**. They describe how you can maximize Plan benefits by following the provisions explained in these chapters.
- Refer to the **General Provisions chapter** for information regarding your rights and information about ERISA. While the **Claim Filing and Appeal Information chapter** tells you what you must do to file a claim and how to seek review (appeal) if you are dissatisfied with a claims decision.
- The chapter on **Coordination of Benefits** discusses situations where you have coverage under more than one group health care plan, Medicare, another government plan, automobile and/or motorcycle insurance coverage, workers' compensation, or where you can recover expenses from any other source.
- The **Eligibility chapter** outlines who is eligible for coverage and when coverage ends while the **COBRA chapter** discusses your options if coverage ends for you or a covered Spouse, Civil Union Partner or Dependent Child.
- The **Vision Plan** and **Dental Benefits** chapters outline those benefits when offered by your Employer.

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the Administrative Office information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in status of a Dependent Child, Medicare enrollment or disenrollment or the existence of other coverage.

Notify the Plan preferably within 31 days, but no later than 60 days, after any of the above noted events.

Failure to do so may cause you or your Dependents to lose certain rights under the Plan or may result in your liability to the Plan if any benefits are paid to an ineligible person.

FOREIGN LANGUAGE SUPPORT

This booklet contains a summary in English of your Plan rights and benefits under the Contractors Health Trust. If you have difficulty understanding any part of this booklet, contact the Administrative Office at 2380 S. Tejon Street, Englewood, Colorado 80100. Office hours are from 8:00 A.M. to 4:30 P.M. Monday through Friday. You may also call the General Trust Office/Plan Administrative Office at (303) 935-2475 or the toll free number (833) 935-2475.

Este folleto contiene un resumen en el inglés de sus derechos del plan y beneficios bajo la Confianza de Contratistas de Colorado. Si usted tiene la comprensión de dificultad cualquier parte de este folleto, avise al Administrador del Plan en 2380 S. Tejon Street, Englewood, Colorado 80100. Las horas de la oficina son de 8:00 DE LA MAÑANA a 4:30 DE LA TARDE. El lunes por viernes. Usted puede llamar también el Plan la Oficina Administrativa en (303) 935-2475 0 el peaje liberta el número (833) 935-2475.para la ayuda.

SELF-AUDIT REWARD PROGRAM

The **Self-Audit Reward Program** pays an Employee 50% of the savings realized from discrepancies found in Hospital or Health Care Practitioner bills, such as billing for services not rendered. Such services include but are not limited to:

- Oxygen;
- Drugs;
- Supplies;
- Durable medical equipment; and
- Charges for more days than actually Hospital-confined.

In order to qualify for reimbursement, the error must be substantiated by documentation and found by the Participant after payment has been made by the Administrative Office. The reimbursement amounts are a:

- Minimum of $25 (for a $50 payment error); and
- Maximum of $500 (for a $1,000 or more payment error).

Please contact the General Trust/Administrative Office at the telephone number on the Quick Reference Chart if you would like more information on this benefit.

FOR HELP OR INFORMATION

When you need information, please check this document first. If you need further help, call the people listed in the following Quick Reference Chart:

QUICK REFERENCE CHART

Information Needed	Whom to Contact
General Trust Office/Administration Office • General Contractors Health Trust Administration • Employer Payment • Administration Accounting • Marketing • Eligibility for Coverage • Summary of Benefits and Coverage (SBC) • Medicare Part D Notice of Creditable Coverage • COBRA coverage and administration of COBRA • Second Qualifying Event and Disability Notification • Level 2 Voluntary Claim Appeals • EPIC Hearing Care Benefit • HIPAA Privacy and Security Officer • HIPAA Notice of Privacy Practices	**Contractors Health Trust** **Administrative Office** **Physical/Mailing Address** 2380 S. Tejon St. Englewood, CO 80110 Telephone: (303) 935-2475 or (833) 935-2475 www.contractorshealthtrust.org
Claims Administration and PPO Network • Medical and Behavioral Health Network Provider Directory • Additions/Deletions of Network Providers (Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price) • Behavioral Health Program – Mental Health and Substance Abuse • Claim Forms (Medical) • Level 1 Medical Claim Appeals	**Anthem Blue Cross and Blue Shield** **For PPO Network assistance, go to www.anthem.com or call Anthem at 1-800-810-2583.** **CAUTION:** Use of a **non**-PPO provider could result in you having to pay a substantial balance on the provider's billing (see definition of "Balance Billing" in the Definition chapter of this document). Your lowest out of pocket costs will occur when you use In-Network PPO providers.
Utilization Management (UM) Program • Precertification of Admissions (including Residential Treatment Programs and certain medical services • Case Management • Appeals of UM decisions • Review of Medical Necessity and Precertification of organ and tissue Transplants	**Anthem Blue Cross and Blue Shield** Claims Submittal Address: P.O. Box 5747 Denver, Colorado 80217-5747 Telephone (for Precertification): 1-800-832-7850

QUICK REFERENCE CHART

Information Needed	Whom to Contact
Prescription Drugs (PBM) • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Formulary of Preferred Drugs • Precertification of Certain Drugs • Specialty Drug Program: Precertification and Ordering	**Express Scripts, Inc.** **Participant Customer Service and Mail order set up:** 1-877-551-8811 **Website:** www.express-scripts.com **Mail Order Address:** Express Scripts PO Box 52123 Phoenix, AZ 85072-2123 Members **cannot** fax in their own prescriptions. However, your Physician can fax your **Mail Order prescription** to: Fax: 1-800-763-5502 or 1-800-396-2171
Employee Assistance Program (EAP) • Professional, confidential information, support and referral to help individuals cope with personal problems that impact their home and work life. EAP counselors can help you with stress, marriage/family/work-related problems, Substance Abuse, financial and legal problems.	**Mines and Associates, P.C.** 1-800-873-7138 or (303) 832-1068 www.minesandassociates.com
Delta Dental Plan (Optional by Employer) • Dental Network Provider Directory • Dental Claims and Appeals	**Delta Dental of Colorado** P.O. Box 173803 Denver, CO 80217-3803 Telephone: (303) 741-9305 or 1-800-610-0201 www.deltadentalco.com **Integrated Voice Response (IVR):** Delta Dental's IVR allows you to call and request a listing of Dentists in your area and receive it by mail or fax. Call 1-800-610-0201 and follow the prompts
Alpha Dental Plan (Optional by Employer) • Dental Network Provider Directory • Dental Claims and Appeals	**Alpha Dental plan through Beta Health Association, Inc.** Carrara Place 6200 South Syracuse Way Suite 460 Greenwood Village, CO 80111 (303) 744-3007 or 1-800-807-0706 https://www.betadental.com/Alpha19/
Vision Plan (Optional by Employer Through DavisVision) • Vision Network and Provider Directory • Vision Claims and Appeals	**For information on this benefit call DavisVision at (877) 923-2347 (Client Code 8975)**
Life Insurance and AD&D • Employee Life Insurance • Dependent Life Insurance • Accidental Death and Dismemberment Insurance • Life Insurance and AD&D Claims and Appeals	**UnitedHealthcare Specialty Benefits (UHC)** 6300 Olson Memorial Hwy. Golden Valley, MN 55427 Phone Number for questions: (866) 615-8727 Fax: (866) 837-7478 website: www.myuhcspecialtybenefits.com

ELIGIBILITY RULES FOR HOUR BANK EMPLOYEES

Hour Bank Employees

Hour Bank Employees include:

- All field or shop personnel paid solely for the hours worked and not covered by a collective bargaining agreement and the Contributing Employer elects to provide Hour Bank coverage; or
- Superintendents and Foremen regardless of how they are paid.

If you are an Hour Bank Employee, your eligibility for benefits provided will be established under an "Hour Bank" system. The Hour Bank system is a plan in which the hours you work for an Associated Organization are accumulated for credit in an Hour Bank account. The Associated Organization must make sufficient contributions on your behalf before coverage will become effective. Under the Hour Bank system, you may accumulate additional hours of eligibility to be used during periods of unemployment.

Eligibility for Hour Bank Employees

Eligibility for benefits for Hour Bank Employees is established under an "Hour Bank" system. The hours worked for an Associated Organization are accumulated for credit in an Employee's Hour Bank account. Under this system, an Employee can accumulate additional hours of eligibility to be used during periods of unemployment. There is no opportunity for an Hour Bank Employee to decline coverage.

In order that there will be sufficient time for the Associated Organization reports to be received and processed by the Administrative Office, a lag month will be used in determining an Employee's monthly eligibility. The lag month is the month between the report period and the month of actual coverage.

Hour Bank Employees will attain Initial Eligibility <u>ON THE EARLIER OF</u> the following dates:

- The first (1st) day of the second (2nd) calendar month next following any period of not more than four (4) consecutive calendar months during which the Employee works a total of at least three hundred (300) hours with one (1) or more Associated Organizations. All Hour Bank Employees must make a written request to the Contributing Employer on an approved enrollment card within thirty-one (31) days of becoming eligible for coverage and the Employees must make an authorized payroll deduction if applicable. The Contributing Employer will forward the document to the Administrative Office. Benefits are not considered for payment until the enrollment card is received by the Administrative Office.
- For Employees for whom the Trust cannot determine if the Employee is a full-time Employee averaging 130 Hours of Service or more per month, the Trust uses the Affordable Care Act "Look Back Measurement Method". Under this method, the Trust determines the status of a new Employee or an ongoing Employee as full-time or not for a future period (called a stability period) based on the number of Hours of Service the Employee attained in a prior period (called a measurement period)
    1) The new variable hour, part-time or seasonal Employee is considered to be a full-time Employee when they average 130 Hours of Service or more in the Initial Measurement Period (the 12-month period commencing the first day of the month following date-of-hire).
    2) The ongoing Employee is considered to be a full-time Employee when they average 130 Hours of Service or more in the standard measurement period (12-month period).
    3) The Look Back Measurement Method for new and ongoing Employees are managed by the Administrative Office.
    4) This Plan uses a 12-month initial and standard measurement period, one-month administrative period and a 12-month stability period.
    5) A new Employee is one who has been employed for less than one Standard Measurement Period.
    6) An ongoing Employee is one who has been employed by an Employer for at least one Standard Measurement Period.
    7) Hours include all hours for which the Employee is paid by a Participating Employer (including hours reported by a Participating Employer for unpaid leave subject to FMLA, USERRA or jury duty. These unpaid hours are counted by calculating the average total hours paid by a Participating Employer during

the weeks in the stability period when the Employee is not on unpaid leave and using this average as the weekly unpaid hours during the unpaid leave.

Please note that if you do not work any hours in any consecutive 4-month period, you will be treated as a new Employee for purposes of the above rules and the Fund will perform a fresh 12-month look back measurement starting with the month in which you first return to work and begin to accrue hours. However, if you terminate employment with a Participating Employer and you are subsequently re-hired (or hired by another Participating Employer) with a break in service of less than 4 calendar months, you will still be considered as an Ongoing Variable Hour Employee for purposes of Supplemental Coverage Months.

New Employees will not be eligible for Supplemental Coverage Months until at least the first day of the month following a 12-month Initial Measurement Period plus a 1-month Administrative Period. This 13-month period begins on the first of the month coincident with or following the Employee's initial employment date.

Continued Eligibility for Hour Bank Employees

Hours worked for Associated Organizations by an Hour Bank Employee will be credited to the Employee's Hour Bank. One hundred fifty (150) hours will be deducted from the Employee's Hour Bank for each month of coverage. An Employee will continue to remain covered as long as:

- His/her Hour Bank contains at least one hundred fifty (150) hours of credit; OR
- He/she meets the safe harbor rules for measuring fulltime status using a 12 month look back measurement period with a one-month administrative period and a 12-month stability period during the subsequent year.

Whenever an Employee is credited with more than one -hundred fifty (150) hours during a month (which is required to furnish one (1) month's coverage), the excess hours will be added to the Employee's Hour Bank accumulation. The Employee will be allowed to accumulate excess hours in his/her Hour Bank up to maximum of four hundred fifty (450) hours after deduction for the current month's coverage.

PLEASE NOTE: THE HOUR BANK REQUIREMENTS FOR INITIAL AND ONGOING ELIGIBILITY HAVE NOT CHANGED. THE FUND HAS JUST ADDED A "SAFETY NET" FOR THOSE PARTICIPANTS WHO MAY NOT OBTAIN INITIAL ELIGIBILITY OR MAINTAIN ONGOING ELIGIBILITY USING THE 150 HOUR STANDARD. THESE EMPLOYEES WILL HAVE THEIR HOURS OF SERVICE MEASURED UNDER THE ACA LOOK BACK MEASUREMENT RULES FOR THE PURPOSES OF DETERMINING IF THEY HAVE EARNED SUPPLEMENTAL COVERAGE MONTHS.

The following chart outlines how the **Look-back Measurement method** is utilized as a "safety net".

Employee Category	Definition of Category	For a NEW Employee, When Will Plan Benefits Become Effective?	For an ONGOING Employee, When Are Plan Benefits Effective?
Full-time	A "full-time employee" is an Employee who is expected to work on average 30 or more hours per week during each calendar month.	• The first (1st) day of the second (2nd) calendar month next following any period of not more than four (4) consecutive calendar months during which the Employee works a total of at least three hundred (300) hours with one (1) or more Associated Organizations; or • The Trust determines the status of a new Employee as full-time or not for a future period (called a stability period) based on the number of Hours of Service the Employee attained in a prior period (called a measurement period).	• His/her Hour Bank contains at least one hundred fifty (150) hours of credit; or • He/she meets the safe harbor rules for measuring fulltime status using a 12 month look back measurement period with a one-month administrative period and a 12-month stability period during the subsequent year.

Employee Category	Definition of Category	For a NEW Employee, When Will Plan Benefits Become Effective?	For an ONGOING Employee, When Are Plan Benefits Effective?
Variable Hour Employee	A "variable hour employee" is an Employee for whom the Participating Employer cannot determine that the Employee is reasonably expected to be employed on average at least 30 Hours of Service per week during their "Initial Measurement Period" (i.e., the 12-month period commencing the first day of the month following date-of-hire) because the Employee's hours are variable or otherwise uncertain.	The earlier of: • The first (1st) day of the second (2nd) calendar month next following any period of not more than four (4) consecutive calendar months during which the Employee works a total of at least three hundred (300) hours with one (1) or more Associated Organizations; or • The Employee must first complete a 12-month Initial measurement period (that starts on the first day of the month following the date of hire) during which Employee is not eligible for benefits. • At the completion of the Initial Measurement Period, an Employee who has worked on average at least 130 Hours of Service per month during that period will be eligible for Supplemental Coverage Months as long as they remain employed during the 12-month Stability Period irrespective of their hours, provided they remain employed. • An Employee who fails to work on average at least 130 hours per month during their Initial Measurement Period is generally not eligible for coverage during the corresponding initial Stability Period. However, the Employee will also be measured under the first Standard measurement period following their date of hire to determine eligibility for future stability periods.	• His/her Hour Bank contains at least one hundred fifty (150) hours of credit; or • Once an Employee has worked a full 12-month Standard measurement period, the Employee is classified as an "Ongoing Variable Hour Employee." An Ongoing Variable Hour Employee is measured each year during a12-month Standard Measurement Period. The one month period between the end of one Standard Measurement Period and the start of the next Standard Measurement Period is called the Administrative Period during which benefits are offered to ongoing Employees who are determined to be eligible for coverage. • An ongoing Employee who works on average at least 130 Hours of Service per month during any 12-month Standard Measurement Period will qualify for coverage during a 12-month Stability Period. • An ongoing Employee who fails to work on average at least 130 Hours of Service per month during any 12-month Standard Measurement Period is not eligible for coverage during the corresponding 12-month Stability Period.
Seasonal Employee	A "seasonal employee" is an Employee who is hired into a position for which the customary annual employment is six (6) months or less.		

Termination of Eligibility

An Employee's coverage will terminate on the last day of the calendar month in which:

- The work credits in his/her Hour Bank fall below one hundred fifty (150) hours after deduction of one hundred fifty (150) hours for the current month's coverage; OR
- He or she is not determined to be full-time in accordance with the Look Back Measurement method.

The Administrative Office will notify the Employee of the loss of eligibility and will inform him/her that he or she may elect COBRA coverage.[1]

[1] See "COBRA: Temporary Continuation of Coverage" in this SPD for Alternatives to COBRA.

Please note that Supplemental Coverage Months for a new Variable Hour Employee who terminates during the 12-month Initial Stability Period will cease on the last day of the month of termination.

Reinstatement of Eligibility

An Employee whose coverage has terminated may again become eligible if:

- His/her accumulated hours total at least one hundred fifty (150) hours within a four (4) consecutive calendar month period; OR
- He/she meets the safe harbor rules for measuring fulltime status as outlined above.

Such reinstatement will be effective on the first day of the second month which follows the month in which this requirement is met.

If the Employee is not reinstated within a four (4) calendar month period, any reserve hours in his/her account will be forfeited and he/she will need to complete the initial eligibility requirements outlined above in order to become eligible for coverage again.

Dependents of a Deceased Employee

The eligible Dependents of a deceased Employee may exhaust the deceased Employee's Hour Bank. Coverage under the Hour Bank terminates the last day of the month in which there are fewer than one hundred fifty (150) hours remaining in the deceased Employee's Hour Bank account. After the exhaustion of the Employee's Hour Bank, the Dependents of a deceased Employee may continue the coverage in force under COBRA Continuation for the allowable continuation period (up to 36 months) as described in "COBRA: Temporary Continuation of Coverage".

ELIGIBILITY RULES FOR MONTHLY CONTRIBUTION EMPLOYEES

Office, Administrative and other Employees

In order to be a Monthly Contribution Employee, you must be employed by an Associated Organization on a full-time basis and be scheduled for an average of thirty (30) Hours of Service per week at a regularly scheduled place of employment as determined by the Board of Trustees. Monthly Contribution Employees include the following:

- An Employee who is receiving constant weekly or monthly salary, regardless of hours worked; or
- All office workers of all Contributing Employers, regardless of the basis on which they are paid; or
- All Owner-Employees of an Associated Organization (as defined in the Definition's section of this document); or
- Subject to Board approval, non-seasonal hourly Employees performing substantial regular services at the Associated Organization's principal place of business; or
- All field or shop personnel paid solely by the hours worked (and superintendents and foremen regardless of how they are paid) if the Contributing Employer has not elected to provide Hour Bank coverage.

Eligibility and Waiting Period for Monthly Contribution Employees

The Contributing Employer must decide if it wants to impose a waiting period in accordance with the terms of the Participation Agreement. An Employee will become eligible in accordance with the written statement of the Contributing Employer which includes one (1) of the following available options: On the first (1st) day of the month following:

- The date of employment; or
- One (1) month of continuous full-time permanent employment; or
- Two (2) months of continuous full-time permanent employment.

General Risk Questionnaire

Contributing Employers will be required to complete a general risk questionnaire prior to their initial participation date. Employees may also be required to complete a questionnaire. Please note that this information will not be used to determine individual eligibility for coverage or individual premiums for coverage. The information may be used to determine an appropriate aggregate group rate for providing coverage to the group health plan as a whole or to determine acceptance into the Trust for the group as a whole.

Effective Date

The effective date of coverage will be the first of the month following approval by the Board of Trustees, but not earlier than the date specified above as selected by the Contributing Employer. Employees not employed on the effective date of Employer participation will become eligible on the date selected by the Contributing Employer.

Enrollment/Waiver Requirements

All Monthly Contribution Employees must make a written request to the Contributing Employer on an approved enrollment card within thirty-one (31) days of becoming eligible and must authorize payroll deductions, if required, for the amount of monthly payment due. The Contributing Employer will forward that information to the Administrative Office.

If the Employee's written request for coverage is received more than thirty-one (31) days after the effective date, the Employee will be not be eligible to enroll until the next Open Enrollment period or any Special Enrollment period.

Monthly Contribution Employees may waive coverage under the Trust if the Employee (and any family member for whom the Employee reasonably expects to claim a personal exemption deduction for the relevant taxable year) provides proof that they are covered by other minimum essential coverage that is group insurance. The Monthly Contribution Employee must sign a waiver of benefit coverage card on an annual basis and place it on

file with the Contributing Employer. The Contributing Employer must send it to the Administrative Office and an Employee is eligible for benefits under the Plan only if an enrollment card is filed with the Administrative Office in accordance with the above requirements.

Monthly Contribution Employees who waive coverage will be waiving all coverage for which they are eligible (medical, dental, vision, life and AD&D).

Termination of a Monthly Contribution Employee's Coverage

The coverage of a Monthly Contribution Employee will be terminated on the last day of the month coinciding with or next following the earliest of the following dates:

- The date of termination of employment;
- The date the Plan is discontinued;
- The date the Monthly Contribution Employee ceases to meet the requirements of an Employee;
- The date the Monthly Contribution Employee fails to become or remain covered under any coverage available under the Plan for which he/she is eligible; or
- The end of the last period for which any required contribution has been received.

Special Transfer Rules

Under certain circumstances a Monthly Contribution Employee will be allowed to transfer between the available plans as follows:

- **Associated Organization Ceases Operation** - An Employee whose coverage terminates under the Monthly Contribution approach due to an Associated Organization ceasing operation as a business and who becomes employed within thirty (30) days as an Employee of an Associated Organization under any option, may continue coverage by making self-payments for a period of no more than six (6) months or until eligibility is established under this Trust or any other medical insurance, whichever occurs first.
- **Terminated Associated Organizations -** In the event an Associated Organization ceases business operations or files bankruptcy proceedings, Employees employed by the Associated Organization at the time business operations cease or bankruptcy is filed may make self-payments for coverage, provided the Employee has been employed by the Associated Organization or has been an Employee covered by the Plan for a minimum of ten (10) years out of the last fifteen (15) years.

  An Employee whose coverage terminates due to an Associated Organization ceasing operations as a business may continue coverage by electing COBRA continuation coverage for a period of no more than eighteen (18) months. See the COBRA chapter for more details.
- **Associated Organization Changes from the Monthly Contribution Approach to the Hour Bank Approach -** In the event an Associated Organization changes from the Monthly Contribution approach to the Hour Bank approach, the Employee will be loaned an immediate Hour Bank to provide for continuous coverage.
- **Employee Changes Employment to an Associated Organization that Provides Hour Bank Coverage** - In the event an Employee who is covered under the Monthly Contribution approach becomes employed by an Associated Organization that provides coverage under the Hour Bank approach, the Employee may continue coverage in the Plan by making COBRA payments until the initial eligibility under the Hour Bank or the safe harbor rules are satisfied.

Reinstatement for Spouse or Civil Union Partner

A Spouse or Civil Union Partner who is eligible as an Employee under the Hour Bank approach may be reinstated (as a Dependent under the Monthly Contribution Approach) the first day after coverage is lost under the Hour Bank Plan provided the Spouse or Civil Union Partner continues to meet the definition of a Dependent and the request for reinstatement is made to the Administrative Office within thirty-one (31) days after losing eligibility under the Hour Bank approach.

ELIGIBILITY PROVISIONS THAT APPLY TO ALL EMPLOYEES

Dependents' Eligibility:

If you elect coverage for yourself, you are also eligible for coverage for your Eligible Dependents on the later of the day you become eligible for your own medical coverage or the day you acquire an Eligible Dependent, either by marriage, birth, adoption or placement for adoption, but only if you have submitted a completed written enrollment card that can be obtained from the Administrative Office and if that medical coverage is in effect for you on that day and you provide the Plan's required proof of Dependent status and pay any required contribution for coverage of the dependent(s). A Dependent may not be enrolled for coverage unless the Employee is also enrolled. Specific documentation to substantiate Dependent status may be required.

Your Eligible Dependents include your lawful Spouse (including a Common Law Spouse or a Civil Union Partner) and your Dependent Child(ren), as those terms are defined in the Definitions chapter of this document. Anyone who does not qualify as a Dependent Child or Spouse or Civil Union Partner (as those terms are defined by this Plan) has no right to any coverage for Plan benefits or services under this Plan.

Proof of Dependent Status

Proof of dependent status may be requested from time to time by the Board of Trustees. This proof may be requested in the form of marriage records, birth certificates and court approved permanent custody documents, or other applicable documents.

Termination of Dependent's Coverage

The coverage of any Dependent will terminate on the earliest of the following dates:

- The date the Employee's coverage terminates;
- The last day of the month following the date the Dependent ceases to qualify as a Dependent;
- The end of the period for which the last payment was made for coverage under the Plan;
- The date the Spouse or Civil Union Partner enters the Armed Forces on full-time active duty; or
- The date the Plan is discontinued.

Enrollment Procedure

There are three opportunities to enroll for coverage under this Plan: Initial Enrollment, Open Enrollment and Special Enrollment. These opportunities are described further in this chapter.

Procedure to request enrollment: Generally, an individual must make a written request for coverage to the Administrative Office (The address, phone number, and fax number for the Administrative Office is listed on the Quick Reference Chart in the front of this document.) Once enrollment is requested, you will be provided with an enrollment card that must be completed and returned to the Administrative Office. This enrollment card may be returned by mail, fax, or may be signed and submitted electronically in accordance with the instructions noted on the enrollment card.

A person who has not properly enrolled by requesting enrollment in a timely manner, has no right to any coverage for Plan benefits or services under this Plan.

Failure to Provide Proof of Dependent Status: See also the section on Proof of Dependent Status above. Claims for newly added dependents (e.g. Spouse, Civil Union Partner, and children) will not be considered for payment by this Plan until the Administrative Office receives verification/proof of dependent status.

SOCIAL SECURITY NUMBERS NEEDED

To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) of you and your Eligible Dependents for whom you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

Failure to provide the SSN or failure to complete the CMS model form (form is available from the Claims Administrator or http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/RevisedHICNSSNForm081809.pdf) means that **claims for eligible individuals may not be considered a payable claim for the affected individuals.**

INITIAL ENROLLMENT

Initial enrollment is the first time you are eligible to enroll for benefits. You must enroll no later than 31 days after the date on which you are eligible for coverage by submitting a completed written enrollment card (that may be obtained from the Administrative Office). If you want Dependent coverage, you must also authorize any necessary payroll deductions for the Dependent's coverage (and provide necessary proof of Dependent status as required).

Benefits will not be able to be considered for payment until the completed enrollment card is received by the Administrative Office.

Start of Coverage Following Initial Enrollment

Hour Bank Employee: An Hour Bank Employee will become eligible for coverage on the first (1st) day of the second (2nd) calendar month next following any period of not more than four (4) consecutive calendar months during which the Employee works a total of at least three hundred (300) hours with one (1) or more Associated Organizations.

In order to allow sufficient time for the Associated Organization reports to be received and processed by the Administrative Office, a lag month will be used in determining an Employee's monthly eligibility. The lag month is the month between the report period and the month of actual coverage.

Coverage of your eligible Spouse and/or Dependent Child(ren), who are properly enrolled for coverage, begins on the date your coverage begins. **If you do not enroll any of your Eligible Dependents during the Initial Enrollment period**, unless your Eligible Dependent(s) qualify for the Special Enrollment described in the following section of this chapter, you will not be able to enroll them until the next Open Enrollment period.

A Monthly Contribution Employee will become eligible for coverage on the first of the month following any applicable waiting period selected by your Contributing Employer. **If you do not enroll yourself, or if you do not enroll any of your Eligible Dependents during the Initial Enrollment period**, unless you and/or your Eligible Dependent(s) qualify for the Special Enrollment described in the following section of this chapter, you will not be able to enroll yourself and/or them until the next Open Enrollment period.

SPECIAL ENROLLMENT

There are three HIPAA Special enrollment opportunities to enroll in the Plan's benefits mid-year: a) upon gaining (acquiring) a new dependent, b) loss of other coverage, and c) on account of Medicaid or a State Children's Health Insurance Program (CHIP). These opportunities are explained below:

A. **Newly acquired Spouse (including a Civil Union Partner), and/or Dependent Child(ren)** (as these terms are defined under this Plan)

- **If <u>you are enrolled</u> for coverage** under this Plan and if you acquire a Civil Union Partner, Spouse by marriage, or if you acquire any Dependent Child(ren) by birth, adoption or placement for adoption, you may request enrollment for your newly acquired Civil Union Partner, Spouse and/or any Dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption.

- **If <u>you are eligible but not not enrolled</u> for coverage** under this Plan and if you acquire a Civil Union Partner, Spouse by marriage, or if you acquire any Dependent Child(ren) by birth, adoption or placement for adoption, you may request enrollment for yourself and/or your newly acquired Civil Union Partner, Spouse and/or any Dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption. If the Employee is not already enrolled for coverage, he or she must request enrollment for himself or herself in order to enroll a newly acquired Dependent.
- **If you did not enroll your Spouse or Civil Union Partner for coverage** within 31 days of the date on which he or she became eligible for coverage under this Plan, and if you subsequently acquire a Dependent Child(ren) by birth, adoption or placement for adoption, you may request enrollment for your Spouse, Civil Union Partner, and/or your newly acquired Dependent Child(ren) and/or any Dependent Child(ren) no later than 31 days after the date of your newly acquired Dependent Child(ren)'s birth, adoption or placement for adoption. If the Employee is not already enrolled for coverage, he or she must request enrollment for himself or herself in order to enroll a newly acquired Dependent.
- To request Special Enrollment, follow the procedure described under "Enrollment Procedure" in this chapter. To obtain more information about Special Enrollment, contact the Administrative Office at the number listed on the Quick Reference Chart at the beginning of this booklet.

B. Loss of Other Coverage

If you did not request enrollment under this Plan for yourself, your Spouse, Civil Union Partner, and/or any Dependent Child(ren) within **31 days** after the date on which coverage under the Plan was previously offered because you filed a waiver card and you or they had health care coverage under another group health plan or health insurance policy (including COBRA Continuation Coverage, certain types of individual health insurance, Medicare, or other public program) **and** you, your Spouse, Civil Union Partner and/or any Dependent Child(ren) **lose coverage** under that other group health plan or health insurance policy; you may request enrollment for yourself and/or your Spouse, Civil Union Partner and/or any Dependent Child(ren) within **31 days** after the termination of their coverage under that other group health plan or health insurance policy **if** that other coverage terminated because of:

- Loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of Employee to pay premiums on a timely basis, voluntarily dropping other coverage, or termination of the other coverage for cause); or
- Termination of Employer contributions toward that other coverage (an Employer's reduction but not cessation of contributions does not trigger a special enrollment right); or
- The health insurance that was provided under COBRA, and such coverage was **"exhausted;"** or
- Moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or
- The other plan ceasing to offer coverage to a group of similarly situated individuals; or
- The loss of dependent status under the other plan's terms; or
- The termination of a benefit package option under the other plan, unless substitute coverage offered.

COBRA is **"exhausted"** if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with COBRA). Exhaustion of COBRA can also occur if the coverage ceases:

- Due to the failure of the Employer or other responsible entity to remit premiums on a timely basis;
- When the Employer or other responsible entity terminates the Plan and there is no other COBRA coverage available to the individual;
- When the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA coverage available to the individual; or
- Because the 18-month, 29-month or 36-month period of COBRA has expired.

C. **Special Enrollment due to Medicaid or a State Children's Health Insurance Program (CHIP)**

You and your eligible dependents may also enroll in this Plan if you (or your eligible dependents):

- Have coverage through **Medicaid or a State Children's Health Insurance Program (CHIP)** and you (or your dependents) **lose eligibility for that coverage**. However, you must request enrollment in this Plan within **60 days** after the Medicaid or CHIP coverage ends; or
- Become **eligible for a premium assistance program through Medicaid or CHIP**. However, you must request enrollment in this Plan within **60 days** after you (or your dependents) are determined to be eligible for such premium assistance.

Start of Coverage Following Special Enrollment:

Coverage of an individual enrolling because of loss of other coverage or because of marriage: If the individual requests Special Enrollment **within 31 days** of the date of the event that created the Special Enrollment opportunity, (except for a newborn and newly adopted child or on account of Medicaid or a State Children's Health Insurance Program (CHIP), (discussed below)) generally coverage will become effective on the first day of the month following the date the Plan receives the request for special enrollment.

- If the individual requests enrollment **within 60 days** of the date of the Special Enrollment opportunity related to **Medicaid or a State Children's Health Insurance Program (CHIP),** generally coverage will become effective on the first day of the month following the date of the event that allowed this Special Enrollment opportunity.
  - **Coverage of a newborn or newly adopted newborn Dependent Child** who is properly enrolled within 31 days after birth will become effective as of the date of the child's birth. The newborn or newly adopted newborn Dependent Child must be added as a covered Dependent.
  - **Coverage of a newly adopted Dependent Child or Dependent Child Placed for Adoption** who is properly enrolled more than 31 days after birth, but within 31 days after the child is adopted or Placed for Adoption, will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.

Individuals enrolled during Special Enrollment have the same opportunity to select Plan benefit options (when such options exist) at the same costs and the same enrollment requirements as are available to similarly-situated Employees at Initial Enrollment.

Failure to Enroll During Special Enrollment (Very Important Information): If you fail to request enrollment for yourself and/or any of your Eligible Dependents within 31 days (or as applicable 60 days) after the date on which you and/or they first become eligible for Special Enrollment, you will not be able to enroll them until the next Open Enrollment period or any Special Enrollment period.

OPEN ENROLLMENT

Open Enrollment Period: An Employer can have an annual Open Enrollment period for Employees to elect or change Deductible options. The Open Enrollment period cannot occur sooner than November 1st but must end prior to December 15th when such changes are required to be submitted to the Administrative Office for a January 1st effective date.

Elections Available During Open Enrollment: During the Open Enrollment period, you may elect, for yourself and your Eligible Dependents, to **enroll** in one of the plan options offered (and the dental/vision coverage if your Employer has chosen to include) by the Plan, or **add or drop** Eligible Dependents to the coverage, or **change** health plans. Please note that your Employer may choose two of the six Deductible options to offer to its Employees.

Restrictions on Elections During Open Enrollment: No Dependent may be covered unless you the Employee are covered. You and all your covered Eligible Dependents must be enrolled for the same coverage. All relevant parts of the enrollment card must be completed and the form must be submitted before the end of the Open Enrollment period to the Administrative Office along with proof of Dependent status (as requested).

Start of or Changes to Coverage Following Open Enrollment:

- If you or your Spouse, Civil Union Partner or Dependent Child(ren) are enrolled for the first time during an Open Enrollment period, that person's coverage will begin on the first day of the new Calendar Year following the Open Enrollment.
- If you or your Spouse, Civil Union Partner or Dependent Children are changing or discontinuing coverage during Open Enrollment, such changes will become effective on the first day of the new Calendar Year following Open Enrollment.

Caution: Open Enrollment procedures can differ from the process outlined above and if so, the procedure on how to enroll at Open Enrollment time will be announced at the beginning of the Open Enrollment period.

Failure to Enroll During Open Enrollment (Very Important Information): If you fail to enroll yourself and/or any of your Eligible Dependents within the Open Enrollment period (unless your Eligible Dependents qualify for Special Enrollment described in the previous section of this chapter), you will not be able to enroll yourself and/or them until the next Open Enrollment period.

Failure to Provide Proof of Dependent Status: If you fail to provide proof of Dependent status within 31 days of the effective date of coverage, the Plan may deny the Dependent's claims until such proof is provided although, the Plan will begin the required contribution for coverage. Claims related to that Dependent cannot be processed until such proof of dependent status is received by the Plan and determined by the Administrative Office, or its designee, to meet the Plan's definition of Dependent Child and/or Spouse or Civil Union Partner. No refund/reimbursement of premium contributions is made by this Plan if you enroll a dependent for coverage and fail to provide proof of dependent status or such proof does not satisfy the Plan's definition of Dependent Child and/or Spouse or Civil Union Partner. Remember, you may drop dependents from coverage only at Open Enrollment or if you have a mid-year change of status that makes dropping a Dependent consistent with the change of status event.

Newborn Dependent Children (Special Rule for Coverage)

Your newborn Dependent Child(ren) **will automatically be covered** for the first 31 days after birth if either parent is eligible under the Plan on the date of the child's birth (the newborn Dependent Child is added as a covered Dependent as of the date of his or her birth). In order for coverage to continue beyond the first 31 days after birth, you must request enrollment of that newborn Dependent Child for coverage within 60 days after the child's date of birth, submit a completed written enrollment card to the Contributing Employer along with proof of Dependent status (if requested) and pay any required contribution for that Dependent Child's coverage. The Contributing Employer will forward the information to the Administrative Office.

If the addition of the Dependent would increase the contribution rate for the Employee, coverage for the Dependent will continue beyond the thirty-one (31) days only upon submission of the enrollment card and the additional contribution by the Employee. Failure to furnish this additional information will not impact any claim incurred during the original thirty-one (31) day period.

The effective date of coverage is the date of birth for a newborn child and it will not be based upon him or her being discharged from the Hospital.

A newborn Dependent Child may not be enrolled for coverage unless the Employee is also enrolled for coverage. Submitting a claim to the Plan for maternity care/delivery or for care of a newborn child is **not** considered proper enrollment of that child for coverage under this Plan.

Any newborn Dependent Child not enrolled within 31 days will need to enroll during any subsequent Open Enrollment period or Special Enrollment Period.

Adopted Dependent Children (Special Rule for Coverage)

Your adopted Dependent Child will be covered from the date the child is adopted or "Placed for Adoption" with you, whichever is earlier, provided you follow the enrollment procedure of this Plan. A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.

- **A Newborn Child who is Placed for Adoption** with you within 31 days after the child was born will be covered from the date the child was Placed for Adoption if you comply with the Plan's requirements for obtaining coverage for a Newborn Dependent Child, described above in this chapter.

- **A Dependent Child adopted more than 31 days after the child's date of birth** will be covered from the date that child is adopted or "Placed for Adoption" with you, whichever is earlier, if you submit a completed written enrollment card to the Administrative Office and provide of proof of Dependent status (if requested) and pay any required contribution for that Dependent Child's coverage, within 31 days of the child's adoption or placement for adoption.

If the adopted Dependent Child is not properly enrolled in a timely manner, he or she will not be able to enroll until the next Open Enrollment period or Special Enrollment period, if applicable. However, if a child is Placed for Adoption, and if the adoption does not become final, coverage of that child will terminate as of the date the Employee no longer has a legal obligation to support that child. Remember that an adopted Child or a Child Placed for Adoption may not be enrolled for coverage unless the Employee is also enrolled for coverage.

When you and any of your Dependents both work for any Contributing Employer: (Special Rule for Enrollment)

No individual may be covered under this Plan both as an Employee and as a Dependent, nor may any Dependent Child be covered as the Dependent of more than one Employee.

If both you and your Spouse or Civil Union Partner are eligible Employees of any Contributing Employer.

- One of you must be designated as the eligible Employee who can file the medical coverage choices for the entire family, including the other Employee as a Spouse or Civil Union Partner, and all Dependent Children. The Spouse or Civil Union Partner who is **not** designated as the eligible Employee may not make any independent coverage elections under the Plan.
- If the Spouse or Civil Union Partner who selected coverage as an Employee terminates employment or has a reduction in hours that would ordinarily result in a termination of coverage, the benefits-eligible Employee who was covered as Spouse or Civil Union Partner will immediately be deemed to have Employee coverage, and the Employee who had Employee coverage will immediately be deemed to be covered as a Spouse or Civil Union Partner, and all Dependent Children will retain their coverage. Contributions for Dependent coverage will be deducted from the pay of the Employee-Spouse or Civil Union Partner who is now deemed to be the eligible Employee. As a result, neither Employee will sustain a loss of coverage because of termination of employment or reduction in hours.
- The Employee-Spouse or Civil Union Partner who is then deemed to be the eligible Employee will have the option to terminate the coverage of the Spouse or Civil Union Partner or any Dependent Child or otherwise elect any alternative coverage available under the Plan for the family members provided such election is, in the judgment of the Administrative Office or its designee, consistent with the change in the family's circumstances as a result of the termination of employment or reduction in hours.

If, while your family coverage is in effect, any of your Dependent Children becomes an Employee of any Contributing Employer and becomes eligible for coverage as an Employee:

- That child will need to decide whether her or she wants to be covered as a Dependent Child, or as an Employee. If the child elects to be covered as an Employee, coverage as a Dependent Child will terminate as of the date coverage as a benefits-eligible Employee becomes effective.
- If the Employee-child terminates employment or has a reduction in hours that would ordinarily result in a termination of coverage, and still qualifies as a Dependent Child, the Employee-child will immediately be deemed to be covered as a Dependent Child of the Employee-parent. As a result, the Employee-child will not sustain a loss of coverage because of termination of employment or reduction in hours. Contributions for Dependent coverage will be deducted from the pay of the Employee-parent, and will be adjusted as may be required when a Dependent Child becomes an Employee and ceases to have coverage as a Dependent Child, or when the Employee-child ceased to be an Employee and resumes coverage as a Dependent Child.

Qualified Medical Child Support Orders (QMCSO) (Special Rule for Enrollment)

1. This Plan will provide benefits in accordance with a **National Medical Support Notice**. In this document the term QMCSO is used and includes compliance with a National Medical Support Notice. According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. The QMCSO typically requires that the Plan recognize the child as a dependent even though the child may

not meet the Plan's definition of dependent. A QMCSO usually results from a divorce or legal separation and typically:

- Designates one parent to pay for a child's health coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

2. An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any benefit option that the Plan does not otherwise provide, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.
3. If a court or state administrative agency has issued an order with respect to health care coverage for any Dependent Child of the Employee, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the Employee, the other parent, the child, and any other party acting on behalf of the child. The Plan Administrator or its designee will notify the parents and each child if an order is determined to be a QMCSO, and if the Employee is covered by the Plan, and advise them of the procedures to be followed to provide coverage of the Dependent Child(ren).
4. **Enrollment Related to a Valid QMCSO:** If the Plan has determined that an order is a valid QMCSO it will accept enrollment of the alternate recipient as of the earliest possible date following the date the Plan determined the order was valid, without regard to typical enrollment restrictions. **If the Employee is already a Plan Participant**, the QMCSO may require the Plan to provide coverage for the Employee's Dependent Child(ren) and to accept contributions for that coverage from a parent who is not a Plan Participant. The Plan will accept a Special Enrollment of the alternate recipient specified by the QMCSO from either the Employee or the custodial parent. Coverage of the alternate recipient will become effective as of the date specified on the QMCSO or if not specified, the first day of the month after the Special Enrollment request is received. Coverage will be subject to all terms and provisions of the Plan, including limits on selection of provider and requirements for authorization of services, as permitted by applicable law.
5. **Contributions for Coverage:** No coverage will be provided for any alternate recipient under a QMCSO unless the applicable Employee contributions for that alternate recipient's coverage are paid, and all of the Plan's requirements for enrollment and coverage of that alternate recipient have been satisfied. Contributions required for coverage under a QMCSO are the total Employer contributions required for coverage of the Employee and all members of the Employee's family who are enrolled in the Plan, minus the contributions otherwise actually being paid by the Employee.
6. **Termination of Coverage:** Generally, coverage under the Plan terminates for an alternate recipient when the period of coverage required under the QMCSO ends or for the same reasons coverage terminates under the Plan for other Dependent Children. This includes termination of coverage for failure to pay any required contributions. When coverage terminates, alternate recipients may be eligible for COBRA Continuation Coverage. See also the COBRA chapter of this document.
7. **Additional Information:** For additional information (free of charge) regarding the procedures for administration of QMCSOs, contact the Administrative Office.

Payment for Your Coverage

If you are eligible for and wish to be covered, you may be required to make a contribution for coverage. These benefits are Medical coverage, Dental coverage and Vision coverage.

You may be able to pay any contributions for healthcare coverage on a **before-tax** (pre-tax) basis. This means that your payments for this coverage comes from your pay before federal, and in most cases, state taxes are withheld. That way, you should pay less in taxes.

Your Employer pays the difference between the full cost of the entire benefits program and the amount contributed by Employees. As a result, your contributions (if any) pay part of the cost of coverage for yourself and, where applicable, your Dependents.

NOTE: If you elect coverage for a Civil Union Partner (as defined in this Plan), the contributions you make toward the cost of this coverage and any children of the Civil Union Partner may be required to be deducted on an after-tax basis. In addition, the amount your Employer pays toward the cost of your Civil Union Partner coverage and coverage for the children of Civil Union Partner may be imputed as taxable income. Consult with your tax professional if you elect Civil Union Partner coverage.

If you are participating in a cafeteria plan through your Employer, you may have the opportunity to modify your paycheck deduction elections mid-year. Please speak with your Employer for more information.

When Coverage Ends

Employee coverage ends on the earliest of the last day of the month in which:

- Your employment ends (for Monthly Contribution Employees);
- The last day of the calendar month in which the Hour Bank falls below one hundred fifty (150) hours after deduction for the current month's coverage (for Hour Bank Employees) or he or she is not determined to be full-time in accordance with the Look Back Measurement method.
- You enter the Armed Forces (the military) on full-time active duty;
- You are no longer eligible to participate in the Plan;
- You or your Employer cease to make any contributions required for your coverage;
- The date the Plan is discontinued; or
- The date of your death.

Dependent coverage ends on the earliest of the last day of the month in which:

- The Employee's coverage ends; or
- Your covered Spouse or Civil Union Partner or Dependent Child(ren) no longer meet the definition of Spouse or Civil Union Partner or Dependent Child(ren) as provided in the Definitions chapter of this document; or
- You or your Employer cease to make any contributions required for coverage of your Spouse or Civil Union Partner or Dependent Child(ren); or
- The date a Spouse or Civil Union Partner enters the Armed Forces on full-time active duty; or
- The date the Plan is discontinued; or
- The date of the Dependent's death.

Options When Coverage Under This Plan Ends

When coverage under this Plan terminates you may have the option to buy temporary continuation of this group health plan coverage by electing COBRA or you can look into your options to buy an individual insurance policy for health care coverage from the **Health Insurance Marketplace**.

Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a Spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

Notice to the Plan

You, your Spouse, your Civil Union Partner, or any of your Dependent Children **must notify the Plan preferably within 31 days but no later than 60 days** after the date a:

- Spouse or Civil Union Partner ceases to meet the Plan's definition of Spouse or Civil Union Partner (such as in a divorce); or
- Dependent Child ceases to meet the Plan's definition of Dependent (such as the Dependent Child reaches the Plan's limiting age or the Dependent Child ceases to have any physical or mental Disability).

Failure to give this Plan a timely notice (as noted above) will cause your Spouse or Civil Union Partner and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage or will cause the coverage of a Dependent Child to end when it otherwise might continue because of a physical or mental Disability.

When The Plan Can End Your Coverage For Cause

The Plan will not retroactively cancel coverage except when Employer contributions and self-payments are not timely paid or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan

The Plan Administrator or its designee may end your coverage and/or the coverage of any of your covered Dependents for cause 30 days after it gives you written notice of its finding that you or your covered Dependent:

- **Made a fraudulent statement**, a material misrepresentation, or omitted any material information in any enrollment, claim or other form in order to obtain coverage, services or benefits under the Plan; or
- **Allowed anyone else to use the identification card** that entitles you or your covered Dependent to coverage, services or benefits under the Plan; or
- **Altered any prescription** furnished by a Physician or other Health Care Practitioner.

If your coverage is terminated for any of the above reasons, it may be terminated retroactivelyto the date that you or your covered Dependent performed or permitted the acts described above. In addition, your coverage may be suspended during the 30-day notice period. Please note that the Trust may also terminate coverage retroactively due to non-payment of premiums or contributions.

Leave of Absence (Special Circumstances)

Family and/or Medical Leave (FMLA)

The Family Medical Leave Act, 29 USC §2601 et seq. provides that if you work for a Contributing Employer covered by that Act you are entitled to unpaid leave for specified family or medical purposes, such as the birth or adoption of a child, to provide care for a Spouse, child or parent who is seriously ill, or for your own Illness. In general, to be eligible for FMLA, an Employee must have worked for their Employer for at least 12 months, met the 1,250 Hours of Service requirement in the 12 months prior to the leave, and worked at a location where the Employer employed at least 50 employees within 75 miles. If the Employee is eligible for FMLA the Employee is entitled by law to up to 12 weeks each year (in some cases, up to 26 weeks) of unpaid family or medical leave for specified family or medical purposes, such as the birth or adoption of a child, to provide care of a Spouse, child or parent who is seriously ill, or for the Employee's own serious Illness.

If you are taking FMLA leave that has been approved by your Contributing Employer, your Employer is responsible for making contributions to the Plan on your behalf, as if you are working, in order to maintain your eligibility. For Hour Bank Employees, the Contributing Employer is required to make contributions for forty (40) hours per week of leave. To find out more about Family or Medical Leave and the terms on which you may be entitled to it, contact your Employer.

Leave for Military Service/Uniformed Services Employment and Reemployment Rights Act (USERRA)

A Participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

What is USERRA? USERRA provides temporary continuation of coverage when it would otherwise end because the Employee has been called to active duty in the uniformed services. USERRA protects Employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

An Employee's coverage under this Plan will terminate when the Employee enters active duty in the uniformed services.

Duty to Notify the Plan: The Plan will offer the Employee USERRA coverage after the Administrative Office has been notified by the Employee in writing that they have been called to active duty in the uniformed services. The Employee must notify the Administrative Office (contact information is on the Quick Reference Chart in the front of this document) as soon as possible but no later than 60 days after the date on which the Employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Plan Offers Continuation Coverage: Once the Administrative Office receives notice that the Employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the Employee (and any eligible Dependents covered under the Plan on the day the leave started). Unlike COBRA, if the Employee does not elect USERRA for the Dependents, those Dependents cannot elect USERRA separately. Additionally, the Employee (and any eligible Dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Administrative Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

Paying for USERRA Coverage:

If the Employee goes into active military service for up to **31 days**, the Employee (and any eligible Dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the Employee continues to pay the appropriate contributions (if applicable) for that coverage during the period of that leave. If contributions for coverage are not required of an active Employee before a USERRA leave, then an Employee going on military leave cannot be required to make contributions for coverage during the first 31 days of a USERRA leave.

If the Employee elects USERRA temporary continuation coverage, the Employee (and any eligible Dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to **24 months** measured from the date the Employee stopped working. USERRA coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. See the COBRA chapter for more details.

In addition to USERRA or COBRA coverage, an Employee's eligible Dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This Plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this plan's benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces:

When the Employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the Employee returns to work provided the Employee returns to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If the Employee is hospitalized or convalescing from an Injury caused by active duty, these time limits are extended up to two years.

The Employee must notify the Administrative Office in writing within the time periods listed above. Upon reinstatement, the Employee's coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

Questions regarding the Employee's entitlement to USERRA leave and to continuation of health care coverage should be referred to the Administrative Office.

MEDICAL EXPENSE BENEFITS

Eligible Medical Expenses

You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called "eligible medical expenses." Eligible medical expenses are determined by the Administrative Office or its designee, and are limited to those that are:

- **"Medically Necessary**," but only to the extent that the charges are "**Allowed Charges**" (as those terms are defined in the Definitions chapter of this document) The fact that a Physician prescribes or orders the service does not, in itself, make it Medically Necessary or a covered expense; and
- **Not services or supplies that are excluded** from coverage (as provided in the Exclusions chapter of this document); and
- **Ordered by a Physician or Health Care Practitioner for the diagnosis or treatment of an Injury or Illness** (except where wellness/preventive services are payable by the Plan as noted in the Schedule of Medical Benefits in this document); and
- **Expenses incurred while you are covered under this Plan**. An expense is incurred on the date you receive the service or supply for which the charge is made.

Generally, the Plan will not reimburse you for all Eligible Medical Expenses. Usually, you will have to satisfy some Deductibles and pay some Coinsurance, or make some Copays toward the amounts you incur that are Eligible Medical Expenses. However, once you have incurred a maximum Out-of-Pocket cost-sharing each calendar year, Allowed Charges will be reimbursed at 100% for the remainder of that Calendar Year.

Non-Eligible Medical Expenses

The Plan will not reimburse you for any expenses that are not Eligible Medical Expenses. This means you are responsible for paying the full cost of all expenses that are not determined to be Medically Necessary, determined to be in excess of the Allowed Charge, not covered by the Plan, or payable on account of a penalty because of failure to comply with the Plan's Utilization Management requirements as described later in this document.

PPO In-Network Health Care Provider Services

- **In-Network:** If you receive medical services or supplies from a Health Care Provider that is contracted with the Plan's PPO you will be responsible for paying less money out of your pocket. Health Care Providers who are under a contract with the PPO have agreed to accept the discounted amount the Plan pays for covered services, plus any additional Copays, Deductibles or Coinsurance you are responsible for paying, as payment in full, except with respect to claims involving a third party payer, including auto insurance, workers' compensation or other individual insurance. In those cases, the contracts of Health Care Providers with the PPO do not require them to adhere to the discounted amount the Plan pays for covered services, and they may charge in excess of what this Plan considers an Allowed Charge.
- **Out-of-Network:** refers to providers who are not contracted with the PPO Network and who do not generally offer any fee discount to the Plan participant or to the Plan. These Out-of-Network Health Care Providers **may bill a Plan Participant a non-discounted amount** for any balance that may be due **in addition to** the Allowed Charge payable by the Plan, also called Balance Billing. **To avoid Balance Billing, use In-Network providers.** See also the Medical Networks chapter of this document.

Overview of Medical Plan Design

There are six medical options offered with varying Deductibles. A Health Reimbursement Arrangement (HRA) may be used with any of the available options, however Health Savings Accounts (HSAs) are only available alongside qualified High Deductible Health Plans (HDHPs). The Trust3000 and the Trust5000 options (outlined in the Schedule of Medical Benefits) are considered to be the HDHPs compatible with either the Health Reimbursement Arrangement (HRA) or the Health Savings Account (HSA). HRAs and HSAs are programs that can assist in reimbursing you for your Deductible and other out-of-pocket cost-sharing that can be, but do not have to be, combined with your applicable medical plan option.

Cost-Sharing

Cost-sharing refers to how you and the Plan split the cost for covered medical plan benefits. There are three types of cost-sharing under this Medical Plan: Deductibles, Copayments/Copays and Coinsurance. These are explained below in more detail and on the Schedule of Medical Benefits. Cost-sharing does not refer to premiums/contributions for coverage, Balance Billing amounts or non-covered/excluded medical expenses. See also the section on Out-of-Pocket Limit that controls the amount of certain cost-sharing you pay each year.

Deductibles

The annual Deductible is the amount you must pay each Calendar Year before the Plan pays eligible medical expenses. The amount applied to the Deductible is the lesser of billed charges or the amount considered to be an Allowed Charge under this Plan. In-Network and Out-of-Network Deductibles are combined.

Each Calendar Year, you (and **not** the Plan) are responsible for paying all of your eligible expenses until you satisfy the annual Deductible and then the Plan begins to pay benefits. Deductibles are applied to the eligible expenses in the order in which claims are received by the Plan. Deductibles under this Plan are accumulated on a Calendar Year basis. Only eligible expenses can be used to satisfy the Plan's Deductibles. As a result, expenses that are not covered do not count toward the Deductible. Copays do not accumulate to meet the Deductible.

There are two types of Deductibles: Individual and Family.

- The **Individual Deductible** is the maximum amount one covered person has to pay toward eligible expenses before Plan benefits begin. The Plan's Individual Deductible varies depending on the plan option that your Employer selects (and the option that you elect if your Employer allows more than one option).
- The **Family Deductible** is the maximum amount that a family of two or more persons is responsible for paying toward eligible expenses before Plan benefits begin. The Plan's Family Deductible varies depending on the option that your Employer selects.
    * **Please Note:** For families enrolled in a HDHP (Trust3000 or the Trust5000), there is a Family Deductible. However, the Plan will reimburse eligible medical expenses for any individual family member who meets his or her Individual Deductible. Any additional eligible medical expenses from other family members will be applied towards the remaining Family Deductible.

Deductible Rules when Enrolled in the HDHP (Trust3000 or Trust5000): If you are enrolled in a HDHP (Trust3000 or Trust5000), this plan option cannot pay ANY benefits (except as otherwise required under the Affordable Care Act) until either the:

- Family Deductible has been met; or
- An individual family member has met his or her own Individual Deductible.

Our High Deductible Health Plans (the Trust3000 and the Trust5000 plan options) are intended to comply with applicable federal laws and regulations to allow your Employer (when applicable) and eligible Employees to make contributions to a Health Savings Account (HSA). The High Deductible Health Plan has a specific design for the Deductible and Out-of-Pocket Limit and this design is adjusted annually in connection with applicable IRS rules, and as appropriate for Plan administration. Note that per federal regulations, the only time that the Deductible can be waived is if the participant receives preventive care that is required to be covered under the Affordable Care Act. For example, routine nursery care for newborns is not considered to be preventive care under the Affordable Care Act, and, as a result, it is required to be subject to the annual Deductible.

Expenses Not Subject to Deductibles: Certain eligible expenses are not subject to Deductibles. These expenses may be covered 100% by the Plan, or they may be subject to Copays (explained below). See the Schedule of Medical Benefits to determine when eligible expenses are not subject to Deductibles. Please note that for the Trust3000 and the Trust5000, this means the only time that the Deductible is waived is if the Participant receives preventive care that is required to be covered under the Affordable Care Act.

Coinsurance

Coinsurance refers to how you and the Plan will split the cost of certain covered medical expenses. Once you've met your annual Deductible, the Plan generally pays a percentage of the eligible expenses, and you (and **not** the Plan) are responsible for paying the rest. The part you pay is called the patient's share of the Coinsurance. The Schedule of Medical Benefits details the Coinsurance applicable to the medical option.

The percentage of covered services will revert to the appropriate percentage on January 1 of each year if the Participant is not Hospital-confined on that date.

Copayment

A Copayment (or Copay) is a set dollar amount you (and **not** the Plan) are responsible for paying when you incur certain eligible expenses. The Plan's Copays are indicated in the Schedule of Medical Benefits. Copays are not used to satisfy the Deductible.

Maximum Out-of-Pocket Limit on Coinsurance

Each Calendar Year, after an individual (or family) has incurred a maximum Out-of-Pocket limit on Coinsurance (as outlined in the Schedule of Medical Benefits), no further Coinsurance will apply to covered eligible expenses. As a result, the Plan will pay 100% of covered eligible expenses, **except for** the Out-of-Pocket Expenses you always pay, listed below, that are incurred during the remainder of the Calendar Year after the maximum Out-of-Pocket on Coinsurance has been reached.

Out-of-Pocket Expenses That Do Not Accumulate to the Coinsurance Maximum: This Plan rarely pays benefits equal to **all** the medical expenses you may incur. You are **always** responsible for paying for certain expenses for medical services and supplies yourself. Under the Plan, each year, you will be responsible for paying the following expenses out of your own pocket **and** these expenses do not accumulate to meet the Out-of-Pocket limit on Coinsurance.

- Any Plan **Deductible or Copay,** except if enrolled in the HDHP (Trust3000 or Trust5000) in which case Deductibles do accumulate to meet your Out-of-Pocket Maximum (there are no Copays under the Trust3000 or Trust 5000).
- All expenses for medical services or supplies that are **not covered** by the Plan.
- All charges in **excess of the Allowed Charge** determined by the Plan. (See the definitions of Allowed Charge and Balance Billing in the Definitions chapter of this document.)
- Any additional other amounts you have to pay because you **failed to comply with the Utilization Management Program** described in the Utilization Management chapter of this document.
- All expenses for **medical services or supplies in excess of Plan benefits** or that are incurred with respect to Outpatient Prescription Retail and Mail Order Drugs, except outpatient prescription drug expenses do accumulate to the Out-of-Pocket Limit on cost sharing and to meet the Out-of-Pocket Maximum if enrolled in a HDHP (Trust3000 or Trust5000).

NOTE:

- In-Network and Out-of-Network Out-of-Pocket Coinsurance maximums are interchangeable (Trust750, Trust1000, Trust1500 and Trust2500), meaning you may use any portion of an In-Network Out-of-Pocket Maximum to meet an Out-of-Network Out-of-Pocket Maximum and vice versa.
- The Family Out-of-Pocket Maximum is the maximum amount of Coinsurance that a family of two or more persons is responsible for paying toward eligible expenses before the Plan's Out-of-Pocket Maximum is satisfied for that year.
- Non-PPO Emergency Services performed in an emergency room will accumulate to the PPO Out-of-Pocket Maximum on Coinsurance.

Out-of-Pocket Limit (Annual Limit on In-Network Cost Sharing)

This provision applies only to the Trust750, Trust1000, Trust1500 and the Trust2500.

The Trust750, Trust1000, Trust1500 and the Trust2500 plans have an Out-of-Pocket Limit which limits your annual cost-sharing for covered benefits received from In-Network providers related to Medical Plan Deductibles, Coinsurance, and Copayments to the amounts permitted under the Affordable Care Act and implementing regulations. The annual cost-sharing limit includes the Coinsurance Maximum described earlier in this chapter. The Out-of-Pocket Limit on Cost Sharing is accumulated on a Calendar Year basis. Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prohibits the plan from imposing an annual Out-of-Pocket Limit on medical/surgical benefits and a separate annual Out-of-Pocket Limit on mental health and Substance Use Disorder benefits. Expenses for mental health and Substance Use Disorder benefits count toward the Out-of-Pocket Limit in the same manner as those for medical expenses.

Please note: The Trust750, Trust1000, Trust1500 and the Trust2500 plans have a separate Out-of-Pocket Limit on prescription drugs which limits your annual cost-sharing for covered benefits received from In-Network providers related to Coinsurance and Copayments. The Out-of-Pocket Limit on Drugs is accumulated on a Calendar Year basis and covered expenses are applied to the annual Out-of-Pocket Limit on Cost Sharing.

Information about Medicare Part D Prescription Drug Plans for People with Medicare

If you and/or your Dependent(s) are entitled to Medicare Part A or enrolled in Medicare Part B, you are also eligible for Medicare Part D Prescription Drug benefits**. It has been determined that the prescription drug coverage outlined in this document is "creditable."** "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all Plan Participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Because this Plan's prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan in order to avoid a late penalty under Medicare. You may, in the future, enroll in a Medicare Prescription Drug Plan during Medicare's annual enrollment period (October 15th through December 7th of each year).

You can keep your current medical and prescription drug coverage with this Plan and you do not have to enroll in Medicare Part D. If however you keep this Plan coverage and also enroll in a Medicare Part D Prescription Drug Plan you will have dual prescription drug coverage and this Plan will coordinate its drug payments with Medicare. See the Coordination of Benefits chapter for more details on how the Plan coordinates with Medicare. If you enroll in a Medicare Prescription Drug Plan you will need to pay the Medicare Part D premium out of your own pocket.

Note that you may not drop just the prescription drug coverage under this Plan. That is because prescription drug coverage is part of the entire medical Plan. Generally, you may only drop medical Plan coverage at this Plan's next Open Enrollment period.

IMPORTANT NOTE: If you are enrolled in the High Deductible Health (HDHP) Trust3000 or Trust5000 Plan with the Health Savings Account (HSA) **you and your Employer may not continue to make contributions to your HSA** once you are enrolled in Medicare including being enrolled in a Medicare Part D drug plan.

Medicare-eligible people can enroll in a Medicare Prescription Drug Plan at one of the following 3 times:

- When they first become eligible for Medicare; or
    - During Medicare's annual election period (from October 15th through December 7th); or
- For beneficiaries leaving Employer group health coverage, you may be eligible for a Special Enrollment Period in which to sign up for a Medicare Part D Prescription Drug Plan.

If you do not have creditable prescription drug coverage and you do not enroll in a Medicare Prescription Drug Plan you may have a late enrollment fee on the premium you pay for Medicare coverage if and when you do enroll. For more information about creditable coverage or Medicare Part D coverage see the Notice of Creditable Coverage (a copy is available from the Administrative Office. See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

Patient Protection Rights of the Affordable Care Act

The medical plans in this document do not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or Non-Network health care provider; however, payment by the Plan may be less for the use of a Non-Network provider.

You also do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the PPO network at their website listed on the Quick Reference Chart.

Nondiscrimination in Health Care

In accordance with the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or

coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

Schedule of Medical Benefits

A schedule of the Plan's medical benefits, appears on the following pages in a chart format. Each of the Plan's benefits is described in the first column. Explanations and limitations that apply to each of the benefits are shown in the second column. Specific differences in the benefits when they are provided under each of the medical plan options and differences in Plan payment for In-Network (when you use PPO Network Providers) and Out-of-Network (when you use Non-PPO, Non-Network Providers) are shown in the subsequent columns.

The first part of the Schedule of Benefits outlines your Deductible, Coinsurance, and Out-of-Pocket Maximum. After that, Hospital Services (Inpatient) and Physician and Health Care Practitioner Services are listed first because these two categories of benefits apply to most health care services covered by the Plan. They are followed by descriptions, appearing in **alphabetical** order, of all other benefits for specific services and supplies. Unless there is a specific statement in the Schedule of Medical Benefits, all benefits shown are subject to the Plan's Deductibles.

All benefits shown in the Schedule of Medical Benefits are subject to the Plan's Deductibles unless there is a specific statement that the Deductible does not apply.

To determine the extent to which limitations apply to the benefits that are payable for any health care services or supplies you receive, you should also check to see if those services are listed separately in the Schedule of Medical Benefits, even if they seem to be included in Hospital Services or Physician and Health Care Practitioner Services, and you should also check the Exclusions chapter of this document to see if they are excluded.

TIME LIMIT FOR INITIAL FILING OF HEALTH CLAIMS

All medical plan claims must be submitted to the Plan within one year from the date of service. No Plan benefits will be paid for any claim submitted after this period.

See also the Claim Filing and Appeal Information chapter for more information. Also review the section toward the end of that chapter on "Limitation On When A Lawsuit May Be Started."

Your Employer has the option of choosing two of the six available plan options (with varying Deductibles) to offer to Eligible Employees.

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST750, TRUST1000, TRUST1500 AND TRUST2500)

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information.

All benefits are subject to the Deductible except where noted. Benefits for Trust 3000 and Trust 5000 begin on page 61

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust750		Trust1000		Trust1500		Trust2500	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Annual and/or Lifetime Maximum	• The most this Plan will pay for all covered expenses for any person.	Unlimited Annual and/or Lifetime Maximum							
Deductible • In-network and out-of-network Deductibles are combined	• The amount you must pay each Calendar Year before the Plan pays benefits. The amount applied to the Deductible is the lesser of billed charges or the amount considered to be allowed under this Plan. • Deductibles are applied to the Eligible Medical Expenses in the order in which claims are processed by the Plan.	$750 Individual $1,500 Family (In and Out-of-Network combined) All services in this summary are subject to the Deductible unless stated otherwise Copays **do not** accumulate toward the Deductible.		$1,000 Individual $2,000 Family (In and Out-of-Network combined) All services in this summary are subject to the Deductible unless stated otherwise Copays **do not** accumulate toward the Deductible.		$1,500 Individual $3,000 Family (In and Out-of-Network combined) All services in this summary are subject to the Deductible unless stated otherwise Copays **do not** accumulate toward the Deductible.		$2,500 Individual $5,000 Family (In and Out-of-Network combined) All services in this summary are subject to the Deductible unless stated otherwise Copays **do not** accumulate toward the Deductible.	
Coinsurance	• How you and the Plan will split the cost of certain covered medical expenses, after the Deductible is met.	80%	60%	80%	60%	80%	60%	80%	60%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST750, TRUST1000, TRUST1500 AND TRUST2500)

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information.

All benefits are subject to the Deductible except where noted. Benefits for Trust 3000 and Trust 5000 begin on page 61

***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust750		Trust1000		Trust1500		Trust2500	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Out-of-Pocket Limit on Coinsurance • Out-of-Pocket Maximums "cross accumulate" between in-network and out-of-network.	The maximum amount of Coinsurance that you are responsible for paying each Calendar Year before the Plan pays 100% of your covered eligible expenses. The following expenses are not included in the Out-of-Pocket limit on Coinsurance: • Deductibles; • Copayments; • Premium; • Expenses not covered by the Medical Plan; • Charges above the Allowed Charge determined by the Plan which includes balance billed amounts for Non-PPO providers; • Penalties for non-complying with the Utilization Management program; • Expenses for dental plan services; and • Charges in excess of the vision plan's maximum benefits.	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family Out-of-Pocket Maximum does not include Deductible, Copays or drugs	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family Out-of-Pocket Maximum does not include Deductible Copays or drugs	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family Out-of-Pocket Maximum does not include Deductible Copays or drugs	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family Out-of-Pocket Maximum does not include Deductible Copays or drugs
Out-of-Pocket Limit on Drugs	The maximum amount of Coinsurance and Copays that you will pay for prescription drugs each Calendar Year before the plan will pay at 100%.	$1,500 per individual, $3,000 per family	No benefits are payable for prescription drugs purchased at Out-of-Network pharmacies	$1,500 per individual, $3,000 per family	No benefits are payable for prescription drugs purchased at Out-of-Network pharmacies	$1,500 per individual, $3,000 per family	No benefits are payable for prescription drugs purchased at Out-of-Network pharmacies	$1,500 per individual, $3,000 per family	No benefits are payable for prescription drugs purchased at Out-of-Network pharmacies

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST750, TRUST1000, TRUST1500 AND TRUST2500)

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information.
All benefits are subject to the Deductible except where noted. Benefits for Trust 3000 and Trust 5000 begin on page 61
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust750		Trust1000		Trust1500		Trust2500	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Out-of-Pocket Limit on Cost Sharing • There is a limit to the total cost sharing (amount of Deductibles, Copayment and Coinsurance that you have to pay) under the medical plan each Calendar Year. • This Out-of-Pocket Limit on Cost Sharing includes both in-network medical and outpatient drug Coinsurance and Copays.	The following expenses are not included in the Out-of-Pocket limit on Cost Sharing: • Premiums; • Expenses not covered by the Medical Plan; • Cost sharing amounts paid by a drug manufacturer coupon for brand name prescription drugs, including when no Generic equivalent is available • Charges above the Allowed Charge determined by the Plan which includes balance billed amounts for Non-Network providers; • Penalties for non-complying with the Utilization Management program; • Expenses for dental plan services; and • Charges in excess of the vision plan's maximum benefits.	$6,600/ person/year $13,200/ family/year	Unlimited	$6,600/ person/year $13,200/ family/year	Unlimited	$6,600/ person/year $13,200/ family/year	Unlimited	$6,600/ person/year $13,200/ family/year	Unlimited

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST750, TRUST1000, TRUST1500 AND TRUST2500)

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information.
All benefits are subject to the Deductible except where noted. Benefits for Trust 3000 and Trust 5000 begin on page 61
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Hospital Services (Inpatient and Outpatient) • Room & board facility fees in a semiprivate room with general nursing services (including Medically Necessary treatment of Mental Illness and Drug and Alcohol Disorders) • Specialty care units (e.g., intensive care unit, cardiac care unit). • Lab/x-ray/diagnostic services. • Related Medically Necessary Ancillary Services (e.g., prescriptions, supplies). • Newborn care. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a hospital/Health Care Facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters. • See the Emergency Room Facility section of this schedule for an explanation of hospital emergency room (ER) facility benefits	• **Elective Hospitalization is subject to Precertification** (except maternity stays which are less than 48 hours for a normal vaginal delivery or 96 hours for a C-section). See the Utilization Management chapter for details. • A private room is covered only if Medically Necessary or if the facility does not provide semi-private rooms. • Routine Nursery care of a newborn child is **not subject to the Deductible** • Benefits include Hospital charges incurred for dental procedures for Dependent Children if one (1) of the following conditions is present: * The child has a physical, mental or medically compromising condition; or * The child is extremely uncooperative, or unmanageable, anxious or uncommunicative, or an adolescent with dental needs which cannot be deferred; or * The child has sustained orofacial or dental trauma; or * Anesthesia charges if the child requires general Anesthesia due to acute infection, anatomic variations or allergy.	80%	60%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST750, TRUST1000, TRUST1500 AND TRUST2500)

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information.
All benefits are subject to the Deductible except where noted. Benefits for Trust 3000 and Trust 5000 begin on page 61
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO

Physician and Other Health Care Practitioner Services
Benefits are payable for professional fees when provided by a Physician or other covered Health Care Practitioner in an office, hospital, emergency room (ER), Urgent Care Facility or other covered Health Care Facility location (if they are legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice).
• Payable Physicians and Health Care Practitioner professional fees include Surgeon; Assistant Surgeon (if Medically Necessary); Anesthesiologist or Certified Registered Nurse Anesthetists (CRNA) during performance of surgical operation; Hospitalist; Anesthesia provided by operating or assistant Physician; Pathologist; Radiologist; Psychiatrist; Psychologist; Certified Midwife; A certified Physician Assistant who is under the direct supervision of a Physician for the performance of medical services including the prescribing of a non-controlled substance within the guidelines established by the Colorado State Board of Medical Examiners.
	• The Administrative Office or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the definition of "**Surgery"** in the Definitions chapter.
	• Benefits are payable for the administration of Anesthesia by the operating or assistant Physician, but not for local infiltration Anesthesia, up to 50% of the amount that would otherwise be payable.
	• **Assistant Surgeon fees** will be reimbursed only for Medically Necessary services to a **maximum of one of the following:**
	  • 20% of the eligible expenses allowed for the primary surgeon; OR
	  • 10% for a Physician Assistant, surgical assistant or a Registered Nurse (RN).
	• Ancillary charges such as x-ray and laboratory must be billed by the same PPO Physician providing the Office Visit services. Other services performed in the Physician's office at the time of the Office Visit, such as surgical procedures, **will be subject to the Deductible**. Ancillary Services performed outside the Physician's office or by any other provider **will be subject to the Deductible.**
	• Under this Plan, there is no requirement to select a primary care Physician (PCP) or to obtain a referral or prior authorization before visiting an OB/GYN provider.
		Office visits
		Primary Care Physician
		$30 Copay, no Deductible
		Specialist
		$45 Copay, no Deductible
		Urgent Care Facility
		$45 Copay, no Deductible
		Inpatient and Outpatient services
		80%
		Emergency Room (ER)
		80%
			60%
			Emergency Room (ER)
			80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST750, TRUST1000, TRUST1500 AND TRUST2500)

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information.
All benefits are subject to the Deductible except where noted. Benefits for Trust 3000 and Trust 5000 begin on page 61
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Allergy Services • Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast. • Desensitization and hyposensitization (allergy shots given at periodic intervals). • Allergy antigen solution.	• Allergy services are covered only when ordered by a Physician. • No coverage for allergy services considered to be Experimental by the Plan	See the Physician and Other Health Care Practitioner Services section of this schedule for an explanation of how this benefit is covered.	
Ambulance Services • Charges for professional ambulance service by air or ground ambulance to or from the nearest local adequate Hospital or Skilled Nursing Facility.	• Expenses for ambulance services are covered **only** when those services are for an **Emergency** as that term is defined in the Definitions chapter of this document or for Medically Necessary inter-facility transport. • Non-Emergency medical transportation is not covered.	80%	80%
Ambulatory Surgical Center	• See the Outpatient (Ambulatory) Surgery Facility row in this Schedule.	80%	60%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST750, TRUST1000, TRUST1500 AND TRUST2500)

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information.
All benefits are subject to the Deductible except where noted. Benefits for Trust 3000 and Trust 5000 begin on page 61
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Autism Spectrum Treatment Coverage includes the assessment, diagnosis and treatment of Autism Spectrum Disorders for a child from birth through 18 years of age.	A "Treatment Plan" for Autism Spectrum Disorders" may include the following: • Evaluation and assessment services; • Behavior training and behavior management and applied behavior analysis including but not limited to consultations, direct care, supervision, or treatment, or any combination; • Habilitative or rehabilitative care including but not limited to Occupational Therapy, Physical Therapy or Speech Therapy (or any combination of those therapies). Please note that the level of benefits for Occupational Therapy, Physical Therapy, or Speech Therapy may exceed the limit of 20 visits for each therapy if such therapy is Medically Necessary; • Pharmacy care and medication; • Psychiatric care; • Psychological care including family counseling; and • Therapeutic care.	80%	60%
Birthing Center/Facility	• See the Maternity Services row of this Schedule.	80%	60%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST750, TRUST1000, TRUST1500 AND TRUST2500)

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Chemotherapy • Chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.	• Benefits are allowed only for therapeutic services necessary for treatment of malignant diseases and other conditions for which such therapy is standard treatment. Chemotherapy means drug therapy administered as treatment for malignant conditions and diseases of certain body systems. • **Oral anticancer medication:** The Plan will provide coverage for prescribed, orally administered anticancer medication that has been approved by the FDA and is used to kill or slow the growth of cancerous cells. The medication will be payable the same as any other intravenously administered or injected cancer medication. The medication may not be prescribed primarily for the convenience of the patient, Physician, or other Health Care Practitioner.	**Office visits** **Specialist** $45 Copay, no Deductible **Inpatient, Outpatient and Home services** 80%	60%
Chiropractic Services	• See the Spinal Manipulation section of this Schedule of Medical Benefits.		

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST750, TRUST1000, TRUST1500 AND TRUST2500)

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Cleft Lip and Palate For newborn Dependent Children born with cleft lip and/or cleft palate or any condition or Illness which is related to or developed as a result of the cleft lip or cleft palate, covered charges and treatment shall include to the extent Medically Necessary and Reasonable: • Oral and facial Surgery and surgical management; • Follow-up care by plastic surgeons and oral surgeons; • Prosthetic treatment such as obturators, speech appliances and feeding appliances; • Medically Necessary and Reasonable orthodontic and prosthodontic treatment; and • Habilitative Speech Therapy, otolarynogology treatment, and audiological assessments and treatment.		80%	60%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST750, TRUST1000, TRUST1500 AND TRUST2500)

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Clinical Trials The Plan will provide coverage for Routine Patient Care costs (as defined in the Definition section of this document) received during a clinical trial if the Participant suffers from a condition that is disabling, progressive, or life-threatening. • The covered person's treating Physician recommends participation in the clinical trial; • The clinical trial or study is approved under the September 19, 2000, Medicare national coverage decision regarding clinical trials; • The patient care is provided by a certified, registered, or licensed Health Care Provider practicing within the scope of his or her license; and • Prior to participation in the clinical trial or study, the Participant has signed a statement of consent indicating that he or she has been informed of the procedure to be undertaken, alternative methods of treatment, and the general nature and extent of the risks associated with participation in the clinical trial or study.	The following services are **not** covered: • Any portion of the clinical trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry; • Any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device; • Extraneous expenses related to participation in the clinical trial including, but not limited to, travel, housing, and other expenses that Participant or person accompanying a Participant may incur; • An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the Participant; • Costs for the management of research relating to the clinical trial or study; and • Services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded under the Plan.	80%	60%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST750, TRUST1000, TRUST1500 AND TRUST2500)

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Cochlear Implants The Plan will cover a unilateral cochlear implant for a patient with bilateral sensorineural hearing loss if the Plan criteria is met. **For adults 18 or older: when both of the following are met:** • Patient has bilateral, severe to profound sensorineural hearing loss; and • Patient has limited or no benefit from binaural hearing aids. **For children age 12 months to 17 years, 11 months: when all of the following are met:** • Child has profound, bilateral sensorineural hearing loss; • Child has limited benefit from binaural hearing aids; and • A three- to six-month hearing aid trial has been attempted and failed. **For all patients:** • No ear infection; • An accessible cochlear lumen that is structurally suited to implantation; • Freedom from lesions in the auditory nerve and acoustic areas of the central nervous system; • No contraindications to Surgery; and • Device must be used in accordance with FDA approved labeling. **Post Implantation Rehabilitation Program** — patient must undergo an extended program of rehabilitation (20-30 hours in children and 20-25 hours in adults). **Replacements and Upgrades** — Plan will cover upgrades to existing cochlear implant systems already in place if the currently used component is no longer functional, and the component cannot be repaired and the currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living. Plan does **not cover** the replacement of external components with upgraded components when done solely to improve appearance or to treat psychological symptomatology or complaints.		80%	60%

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Corrective Appliances (Prosthetic & Orthotic Devices, other than Dental) • Coverage is provided for Medically Necessary: * Rental (but only up to the allowed purchase price of the device). * Purchase of standard model. * Replacement or repair of any prosthetic device will be allowed only once in a five (5) year period, unless due to pathological changes or normal growth.	• See the exclusions related to Corrective Appliances in the Medical Exclusions chapter. • Benefits are available for the following: prosthetic devices and replacement or repair, including those provided under Medicare such as artificial arms, legs and accessories; artificial eyes; leg braces, including attached shoes, arm braces and back braces and cervical collars. Benefits payable include charges for the fitting and adjusting. • **Foot Orthotics** (orthopedic or corrective shoes and other supportive appliances for the feet) are payable if the Fund determines they are Medically Necessary for individuals with diabetes as follows: • one pair of orthotics is payable every 12 months for adults. • A pair of foot orthotics is payable once in a period of 6 months for children under age 19 when replacement is required due to growth.	80%	60%
Diabetes Treatment and Education	• Benefits are payable for outpatient self-management training and education including medical nutrition therapy prescribed by a Physician. In addition, Plan benefits are payable for glucose monitors and insulin pumps. • Continuous glucose monitors are covered under the Plan if the monitor is certified by a licensed Physician as Medically Necessary for the proper care of the participant.	80%	60%
Dialysis • Hemodialysis or peritoneal dialysis and supplies administered under the direction of a Physician in a Hospital or other inpatient Health Care Facility.	• Benefit payments may vary depending on the location in which the hemodialysis or peritoneal dialysis is performed or received by the patient. • **It is important that individuals with end stage kidney/renal disease promptly apply for Medicare coverage, regardless of age**. See also the Coordination of Benefits chapter that discusses what this Plan pays when you are also Medicare eligible.	80%	60%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST750, TRUST1000, TRUST1500 AND TRUST2500)

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Drugs (Outpatient Prescription Medicines) Covered prescription drugs include: • Federal legend drugs; • Drugs required to be covered under the Affordable Care Act; • Insulin; disposable needles/syringes; • Disposable blood/urine glucose/acetone testing agents (e.g. Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips, and Tes-Tape). • Lancets and devices; • Compounded medication of which at least one (1) ingredient is a federal legend drug; • Injectable drugs; • Any other drug which, under applicable state law, may only be dispensed upon the written prescription of a Physician or other lawful prescriber; • FDA approved contraceptives for females, oral or other, whether medication or device. • Specialty Drugs (injectable or oral medications used to treat chronic conditions such as multiple sclerosis, rheumatoid arthritis and hepatitis C). • Immunosuppressive drugs. • Growth hormone and growth/height promotion drugs when Medically Necessary, if Precertification is obtained.	• See a complete list of the specific exclusions related to Prescription Drugs in the Exclusions chapter. • **Precertification is required for certain medications** such as Specialty drugs, weight management drugs, Compound drugs, and growth hormone/height promotion drugs. See the Utilization Management Chapter for details. • Precertification is not required for the first 5-day supply of an FDA approved drug for the treatment of opioid dependence within a 12-month period. • Note that cost sharing amounts paid by a drug manufacturer coupon for brand name prescription drugs are not counted towards the out-of-pocket limit, including when no Generic equivalent is available • **Inpatient/Outpatient facility Prescription Drugs.** The Plan will reimburse charges for covered, Medically Necessary prescription drugs prescribed and delivered during an inpatient and/or outpatient visit or stay according to the Schedule of Benefits, not to exceed the Allowable Amount as determined by the Plan Administrator in its sole discretion. • Note that if a **Participant selects a brand name drug when a Generic drug is available** and the Physician does not indicate otherwise, the Participant will be required to pay the difference between the cost of the brand name and Generic drug. This differential will be in addition to the Deductible and the Copay amounts specified above. • No charge for FDA approved Generic contraceptives with a prescription (brand name if Generic is not available or if it is medically inappropriate). Prescription contraceptives will be covered for a 3-month supply the first time the prescription contraceptive is dispensed, and subsequent dispenses will be covered for up to a 12-month supply or a supply through the end of the individuals' coverage under the plan, whichever is shorter, regardless of whether the individual was enrolled in the Plan at the time of the first dispensing. A prescription vaginal contraceptive ring intended to last for a 3-month period is also covered.	**Retail Drugs** **Generic Drugs** (up to a 30-day supply) 20% Coinsurance subject to a minimum Copay of $10 **Brand Formulary** (up to a 30-day supply) 30% Coinsurance subject to a minimum Copay of $20 **Brand Non-Formulary** (up to a 30-day supply) 50% Coinsurance subject to a minimum Copay of $40 **Specialty Drugs** Claims up to 30 days - Copay of $75 **Mail Order Drugs** (up to a 90-day supply) **Generic**: $20 **Brand Formulary**: $40 **Brand Non-Formulary**: $80 **No benefits are payable for prescription drugs purchased at Out-of-Network pharmacies**: If a Participant elects to use an Out-of-Network pharmacy, he/she will have to pay for the prescription and will receive no reimbursement by the Plan. Out-of-pocket costs for covered insulin prescriptions shall not exceed $100 for a 30-day supply, pursuant to C.R.S. Section 10-16-151.	

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Drugs (Coverage Of Certain Preventive Care Drugs) Where the information in this document conflicts with newly released the Affordable Care Act regulations affecting the coverage of preventive care drugs, this Plan will comply with the new requirements on the date required.	In accordance with the Affordable Care Act and subject to the US Preventive Task Force recommendations, certain preventive care drugs are covered at no charge if you have a prescription from your Physician, including: • Aspirin for pregnant women who are at high risk for preeclampsia and for adults aged 50 to 59 years with a high cardiovascular risk; • Folic acid supplements for women who may become pregnant; • Fluoride supplements for certain children without fluoride in their water source. • Preparation “prep” Products for a Colon Cancer Screening Test; • All FDA-approved tobacco cessation medications for a 90-day treatment regimen (both prescription and over the counter medications if prescribed by a PPO provider). • Statin preventive medicine (low to moderate dose statins) for adults ages 40-75 at high risk. • Breast cancer preventive medication for women who are at increased risk for breast cancer • FDA-approved contraceptives for all females.	No charge	Not covered
Durable Medical Equipment (DME) Benefits include: • Rental of a wheel chair, hospital bed, and other similar Durable Medical Equipment, including equipment for the treatment of diabetes. • Oxygen and rental of equipment for its administration, and other similar equipment, including a maintenance agreement for the up-keep of such equipment.	• See the exclusions related to Corrective Appliances and Durable Medical Equipment in the Exclusions chapter. • When it is determined that purchase of Durable Medical Equipment would be less expensive than rental, or such equipment is not available for the rental, purchase may be authorized by the Administrative Office. • Replacement of Durable Medical Equipment will be allowed only once in a five (5) year period when the replacement is due to the patient's pathological changes or normal growth. • Monitoring devices and other similar devices, other than pacemakers, which can be permanently implanted are not covered. • For the first 12 months following the birth of a child, coverage is provided for one standard manual or standard electric breast pump, plus necessary breast pump supplies. Rental, purchase and repair is payable. Coverage is available at no cost from PPO providers only. No coverage for Non-PPO providers.	80% **Breast Pump and supplies:** No charge	60% **Breast Pump and supplies:** Not covered

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Early Intervention Services and Supports An Eligible Child means an infant or toddler, from birth through two years of age, who is an eligible Dependent as defined by the Plan and who has significant delays in development or has a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development or who is eligible for services pursuant to C.R.S. Section 27-10.5-102(11)(c) Within ninety (90) days after the Division determines that a child is no longer an Eligible Child, the Division shall notify the Plan that the child is no longer eligible and that the Plan is no longer required to provide the coverage.	• **There is no Deductible applied to these services.** • Annual maximum for Early Intervention Services and Supports is 45 visits. The following services are excluded: • Non-Emergency medical transportation; • Respite care; • Service coordination; and • Assistive technology, unless assistive technology is otherwise covered under this Plan.	80%	60%
Employee Assistance Program (EAP) Services: • The Fund offers professional confidential counseling for personal problems including but not limited to adolescent problems, alcohol abuse, anxiety, codependency, depression, drug abuse, eating disorders, eldercare, family problems, financial/legal problems, grief/loss, HIV-AIDS related concerns, marital problems, relationships, self-esteem, stress, trauma counseling, women's issues and work related concerns. • The phone number for the EAP program is listed on the Quick Reference Chart in the front of this document.	• Some of the areas of concern listed in the column to the left may only be covered under the EAP and may **not be covered** under the medical Plan. • Any care that is transitional from EAP to the medical Plan must be coordinated with the Administrative Office. • It is always a good idea to contact the EAP before receiving any mental health or Substance Abuse treatment.	This Plan offers up to 5 free EAP visits per household member per year.	

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Emergency Room Facility • Hospital emergency room (ER) facility for a medical Emergency (i.e. suspected heart attacks, poisonings, convulsions, etc) provided services and supplies are rendered within 72 hours of onset. • Ancillary charges (such as lab or x-ray) performed **during** the ER or Urgent Care visit. • See also the Ambulance section of this schedule. • See the Urgent Care Facility section of this schedule	• Expenses for Emergency Room services are covered only when those services are for an **Emergency** as that term is defined in the Definitions chapter of this document under the heading of "Emergency Care." • Emergency Room Copay will be waived if subsequent immediate admission to the hospital is required. There is no requirement to precertify (prior authorize) the use of a hospital-based emergency room visit. The Plan will pay a reasonable amount for hospital-based Emergency Services performed Out-of-Network, in compliance with Affordable Care Act regulations. See the definition of Allowed Charge and Emergency Services. • The Out-of-Pocket Maximum for PPO cost sharing includes Non-PPO Emergency Services performed in an emergency room.	$100 Copay, then Deductible and payable at 80%	$100 Copay, then Deductible and payable at 80%
Family Planning, Reproductive, Contraceptive and Fertility Services • Surgical sterilization services (e.g. vasectomy, tubal ligation).Female sterilization procedures are payable at no cost from PPO providers. Normal cost sharing applies to Non-PPO providers. Normal cost sharing applies to PPO and Non-PPO providers for vasectomy services. • With a prescription from your doctor, FDA approved contraceptives for females, oral or other, whether medication or device. • No charge for FDA approved Generic contraceptives with a prescription. • FDA approved contraceptives and counseling for females including devices/injections received during a Physician's visit are payable at no cost from PPO providers. Normal cost-sharing applies to Non-PPO providers. • See also the Preventive Care for Women section of this schedule. • See also the Drugs (Outpatient Prescription Medicines)	There are no benefits available for the following: • Elective abortions are not covered except where life of the mother is endangered if the fetus is carried to full term or where medical complications arise from an abortion. • Expenses incurred for the medical or surgical treatment of infertility, or to reverse surgically induced infertility, in-vitro fertilization, sexual impotency, Genetic Counseling (other than described in row of the Summary of Benefits entitled "Genetic Testing"). • Implantable and/or inflatable prosthesis for augmentation or impotence.	80%	60%

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Gene Therapy • The Plan covers Medically Necessary, non-Experimental, FDA-approved Gene Therapy treatment.	• **Gene Therapy services require Precertification** to avoid non-payment. • See also the definition of Gene Therapy in the Definitions chapter.	80%	60%
Genetic Testing and Counseling Services Medically Necessary genetic testing is payable when ordered by a Physician, and performed by a qualified healthcare provider and provided with regard to a genetic test that is payable by this Plan: • female Participant is age thirty-five (35) or older; and family medical history indicates need for counseling/evaluation including a history of spontaneous abortions; or previous pregnancies resulted in a child with Down's syndrome or equally severe complications or abnormalities. • genetic testing recommended by the American College of Ob/Gyn for pregnant women such as genetic carrier testing for cystic fibrosis; • fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and AFP analysis in covered pregnant women (if Medically Necessary); • state-mandated newborn screening tests for genetic disorders; • tests to determine sensitivity to FDA approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity; • genetic testing (e.g. BRCA) and Genetic Counseling required as a Preventive service in accordance with the Affordable Care Act.	**Precertification is required for genetic testing** for the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered Participants. See the Utilization Management Chapter for details. Certain conditions must be met as follows: • the testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and • the covered individual displays clinical features/symptoms, or is at direct risk (family history or 1st or 2nd degree relative) of developing the genetically linked heritable disease/condition in question (pre-symptomatic); and • the results of the test will directly impact clinical decision-making, outcome or treatment being delivered to the covered individual. • Certain genetic testing is not covered as explained in the Medical Plan Exclusion chapter.	Genetic testing and counseling required as a preventive service under the Affordable Care Act: 100% All other: 80%	Genetic testing and counseling required as a preventive service under the Affordable Care Act: Not covered All other: 60%

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Genetic Metabolism Benefit See row entitled "Medical Foods: for an explanation of this benefit.			
Hearing Aids for Participants under age 18	Coverage is provided for hearing aids for Participants under age 18 who have a hearing loss that has been verified by a Physician and by an Audiologist. Coverage will include the purchase of the following: • Initial hearing aids and replacement hearing aids not more frequently than every five years; • A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the Participant; and • Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.	80%	60%
Hearing Services	• Annual hearing exam • Hearing appliance covered once every 3 years (one appliance each ear) • Please also see the row entitled "Cochlear Implants" for additional information.	100% No Deductible	100% No Deductible

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST750, TRUST1000, TRUST1500 AND TRUST2500)

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Home Health Care and Home Infusion Services Home Health Care is covered only if all of the following conditions are met and subject to the limitations outlined in "explanations and limitations" in the next column: 1. Physician must certify that the patient would require inpatient Hospital or Skilled Nursing Facility care if Home Health Care were not available. Or it is determined by the Board of Trustees or its designee that Home Health Care is Medically Necessary; 2. Must be provided according to a plan of treatment ordered by a Physician; 3. Continuing need must be certified periodically (not more frequently than once every two (2) weeks) by an attending Physician; 4. Provider may not be a person who ordinarily resides with the Participant or is a member of the Participant's family; and 5. Provider may not be a person who owns the private residence where the care is provided or who ordinarily resides there. 6. See also the exclusions related to Home Health Care in the Exclusions chapter.	• Maximum number of days covered per Calendar Year is 100. • Covered charges include only the charges for any of the following medical services and supplies for treatment of a Participant's bodily Injury or disease; • Part-time, intermittent **skilled** professional nursing services; • Services of a home health aide on a part-time or intermittent basis; • Respiratory or Rehabilitation Therapy; and • Medical supplies or services provided, such as intravenous medications and injections which must be performed by the home health agency (other than oral drugs and biologicals).	80%	60%

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		PPO	Non-PPO

Hospice
• Hospice services include inpatient Hospice Care in a private residence (not necessarily the residence of the Participant) and outpatient home hospice when the patient meets the definition of hospice in the Definitions chapter of this document.
	• Covered inpatient Hospice Care includes the charge (not to exceed Hospital Benefits) of Hospice Care for the inpatient confinement of a Participant;
	• The Covered Charges for home Hospice Care include:
	  • Services of a home health aide;
	  • Professional services of a Registered Nurse (R.N.) or licensed practical nurse (L.P.N);
	  • Physical and respiratory therapy;
	  • Nutrition counseling and special meals; and
	  • Services of a licensed or certified social worker not to exceed a maximum of six (6) visits (to evaluate the home). Any mental health counseling will be payable under the mental health benefits of the Plan.
	• Respite Care is limited to eight days per lifetime.
	• Hospice Care that is rendered by volunteers or individuals who do not normally charge for their services is **not covered.**
		80%	60%

Implantable Medical Device • Implantable Medical Devices are items partially or completely inserted into the human body or a natural orifice that are expected to stay in use for 30 days or more, or are used to replace an epithelial surface or the surface of the eye and are expected to stay in use for 30 days or more including, but not limited to, artificial limbs, heart pacemakers, or corrective lenses needed after cataract Surgery.	At the Plan's sole discretion, the Allowed Charge for implantable devices will be the lesser of: • 125% of the actual acquisition cost of the implantable devices; or • 115% of the manufacturer's list price for the implantable device. The Plan will reimburse for a standard model of an implantable device upon receipt of an itemized charge detail, proof of acquisition cost, and verification of utilization for Participants who meet all of the following criteria: • the procedure must be determined to be Medically Necessary according to the Plan's Utilization Management firm; • the implantable device is not Experimental; and • is payable only when provided by In-Network Health Care Providers;	80%	Not Covered

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST750, TRUST1000, TRUST1500 AND TRUST2500)

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All benefits are subject to the Deductible except where noted. Benefits for Trust 3000 and Trust 5000 begin on page 61
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Laboratory Services (Outpatient) • Technical and professional fees. • Includes preadmission testing. • Diagnostic sleep study/sleep test using a full-channel nocturnal polysomnography (NPSG) (Type I device) performed in a healthcare facility. Sleep studies using devices that do not provide a measurement of apnea-hypopnea index (AHI) and oxygen saturation are not payable by this Plan.	• **Precertification is required for diagnostic sleep studies/sleep tests**. See the Utilization Management Chapter for details. • Covered only when ordered by a Physician or Health Care Practitioner. • Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical Benefits. • Some laboratory services are payable under the Preventive Care benefits described in this Schedule.	80%	60%
Maternity Services • Hospital and Birth (Birthing) Center charges and Physician and Midwife fees for Medically Necessary maternity services. • Hospital Length of Stay for Childbirth: This Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a Health Care Practitioner to obtain authorization from the Plan or its UM Program for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending Health Care Practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable). • See Genetic Testing for additional information.	• Lamaze classes are not covered. • A pre-planned home delivery is not covered. • Prenatal/postnatal visits and certain prenatal care and maternity related preventive care obtained from a PPO provider are payable at no cost. Normal cost sharing applies to other maternity related services including ultrasounds and delivery expenses. • When a PPO provider submits a bill with a global CPT code for the combination of prenatal/postnatal visits and delivery expenses, the Claims Administrator will process the claim applying no cost-sharing to 40% of the charges representing the prenatal/postnatal visit expenses, and normal cost- sharing to 60% of the charges representing the delivery expenses. • See the Preventive Care for Women (including pregnant women) section for the government websites listing certain prenatal care/maternity related preventive care expenses payable.	80%	60%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST750, TRUST1000, TRUST1500 AND TRUST2500)

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Medical Foods Covered charges include Medical Foods for home use for which a Physician has issued a prescription. Charges are payable for inherited enzymatic disorders (including severe protein allergic conditions) caused by single gene defects involved in the metabolism of amino, organic, and fatty acids. Such disorders shall include, but not be limited to the following diagnosed conditions: • Phenylketonuria; • Maple syrup urine disease; • Tyrosinemia; • Homocystinuria; • Histidinemia; • Urea cycle disorders; • Hyperlysinemia; • Glutaric acidemias; • Methylmalonic acidemia; • Propionic academia; and • maternal phenylketonuria • immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins • severe food protein induced enterocolitis syndrome • eosinophilic disorders as evidenced by the results of a biopsy • impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.	• "Medical Foods" means prescription metabolic formulas and their modular counterparts and amino acid-based elemental formulas, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for severe allergic conditions, if diagnosed by a board-certified allergist or board-certified gastroenterologist, for which medically standard methods of diagnosis, treatment and monitoring exist. The formulas for severe food allergies contain only singular form elemental amino acids. The formulas are to be consumed or administered enterally either via tube or oral route under the direction of a Physician. • There is no age limit on benefits for inherited enzymatic disorders, except for phenylketonuria. The maximum age to receive benefits for phenylketonuria is twenty-one (21) years of age, except for women who are of child-bearing age the maximum age shall be thirty-five (35) years of age. • There is no coverage for laetrile, enzymes and food supplements, except as prescription formulas for individuals that have one of the inherited enzymatic disorders listed in the column to the left. • Coverage of Medical Foods shall not apply to alternative medicines.	80%	60%

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Mental Health and Substance Abuse Treatment **Also, please see the row entitled "Employee Assistance Program (EAP)" for additional benefits that may be available to you and your covered Dependents.** • **Outpatient visits**: including necessary Psychological (Psychiatric) Testing. • **Other Outpatient Services:** partial day care/partial hospitalization or intensive outpatient program (IOP) care. See the Definitions chapter for the meaning of the term partial day care and intensive outpatient program. • **Inpatient acute hospital admission, or inpatient Residential Treatment Program.** See the Definitions chapter for the meaning of the term residential treatment.	• See the specific exclusions related to Mental Health and Substance Abuse Treatment, in the Exclusions chapter. • Drug testing required by an Employer for employment is not covered. • Treatment for Mental Illness and Substance Abuse are payable the same as any other physical Illness. • Residential Treatment Programs may be covered for individuals needing treatment in a highly structured 24-hour therapeutic environment when care cannot be safely or effectively treated in a less intensive setting. A Residential Treatment Facility must be properly licensed in the state in which the facility operates. • **Please remember:** All inpatient treatment (including residential treatment) requires Precertification. See the Utilization Management chapter for details.	**Office visits** $30 Copay, no Deductible **Other Outpatient Services**: 80% **Inpatient services** 80%	60%
Nondurable Supplies • Coverage is provided for Medically Necessary Nondurable Supplies dispensed and used by a Physician or Health Care Practitioner in conjunction with treatment of the Plan Participant.	• To determine what Nondurable Medical Supplies are covered, see the definition of "Nondurable Supplies" in the Definitions chapter. • Diabetic supplies (e.g., insulin syringes, test strips, lancets, and alcohol swabs) are covered under the Prescription Drug Program.	80%	60%

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Nutritional Counseling • Please also see the rows of this Schedule of Benefits titled "Diabetes Treatment and Education, "Preventive Care", and "Weight Management".	The Plan covers nutritional counseling services that are Medically Necessary for the treatment of an individual diagnosed with a mental health or Substance Abuse condition, such as an eating disorder. Also see the row in this schedule titled "Mental Health and Substance Abuse Treatment"	**Office visits** $30 Copay, no Deductible **Inpatient services** 80%	60%
Outpatient (Ambulatory) Surgery Facility • Ambulatory (Outpatient) in a Hospital-based or free-standing Surgery center (e.g. surgicenter, same day Surgery, outpatient Surgery). • Physician fees payable under the Physician services section of this Schedule of Medical Benefits.	• Admission to an outpatient surgical facility requires Precertification. See the Utilization Management chapter for details. Benefits include charges incurred for dental procedures for Dependent Children if one (1) of the following conditions is present: • The child has a physical, mental or medically compromising condition; or • The child is extremely uncooperative, or unmanageable, anxious or uncommunicative, or an adolescent with dental needs which cannot be deferred; or • The child has sustained orofacial or dental trauma; or • Anesthesia charges if the child requires general Anesthesia due to acute infection, anatomic variations or allergy.	80%	60%

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Preventive Care for Children **Covered Services include but are not limited to:** • Newborn screening lab tests (typically payable as part of hospitalization at birth); • At least 11 Office Visits payable during first 30 months of age, then annual Office Visits are payable from age 3 years through age 18 years; • Hemoglobin and lead blood tests in first year of life; • Screening for hepatitis B virus infection; • Application of fluoride varnish to the primary teeth of all infants and children up to age 5 starting at the age of primary tooth eruption, in primary care practices; • Tuberculosis (TB) skin test in first year of life; • Syphilis screening to adolescents at risk. • Hemoglobin blood test in second year of life; and • CDC recommended immunizations. This benefit also includes all preventive services and immunizations required to be provided in basic and standard health benefit plans pursuant to Colorado Section 10-16-105 for Dependent Children up to age thirteen including but not limited to electrocardiogram, blood work, urinalysis and a chest x-ray. See row titled “Weight Management” for coverage of obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss.		**In-Network Preventive Services** that are required to be covered under the Affordable Care Act will be payable at 100%, no Deductible. For covered immunizations/vaccines received at an In-Network Pharmacy, Plan Participants may send their claim/prescription receipts directly to the Administrative Office for reimbursement. Out-of-Network Preventive services **are not covered.** If there is not an In-Network provider who can provide the preventive care service, then the Plan will cover the service when performed by an Out-of-Network provider without cost sharing. Please see: https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at: http://www.uspreventiveservicestaskforce.org/BrowseRec/Index and http://www.cdc.gov/vaccines/schedules/hcp/index.html See the row titled “Drugs (Coverage Of Certain Preventive Care Drugs)” for information on payment for certain preventive care drugs in compliance with the Affordable Care Act.	

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Preventive Care for Men **Covered Services include but are not limited to:** • Abdominal aortic aneurysm screening; • Tuberculosis screening for adults at increased risk • Colonoscopy, sigmoidoscopy or fecal occult blood test beginning at age 50 (including Anesthesia services, a pre-op consult and a pathology exam on a polyp biopsy provided in connection with the procedure). • Five blood tests for cholesterol/lipid, blood sugar, gonorrhea, syphilis, HIV; • Screening for hepatitis B virus infection; • Tobacco Use screening for all adults and cessation interventions for tobacco users. This includes four (4) tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and • CDC recommended immunizations. See row titled "Weight Management" for coverage of obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss.		**In-Network Preventive Services** that are required to be covered under the Affordable Care Act will be payable at 100%, no Deductible. For covered immunizations/vaccines received at an In-Network Pharmacy, Plan Participants may send their claim/prescription receipts directly to the Administrative Office for reimbursement. Out-of-Network Preventive services **are not covered.** If there is not an In-Network provider who can provide the preventive care service, then the Plan will cover the service when performed by an Out-of-Network provider without cost sharing. Please see: https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at: http://www.uspreventiveservicestaskforce.org/BrowseRec/Index and and http://www.cdc.gov/vaccines/schedules/hcp/index.html See the row titled "Drugs (Coverage Of Certain Preventive Care Drugs)" for information on payment for certain preventive care drugs in compliance with the Affordable Care Act.	

Preventive Care for Women (including pregnant women) **Covered Services include but are not limited to:** • Well women Office Visits; • Blood pressure screening throughout a pregnancy to check for preeclampsia. • Screening for gestational diabetes, Tuberculosis screening for adults at increased risk, HPV testing no more frequently than once every 3 years starting at age 30, counseling on sexually transmitted infections, rental or purchase of breastfeeding equipment and necessary supplies after delivery, lactation support following delivery (for duration of breastfeeding); • depression screening during pregnancy and postpartum period; • Sterilization procedures, patient education and counseling; • Many services necessary for prenatal care; • Screening mammogram for breast cancer; • Pap smear and Chlamydia screening; • Osteoporosis screening x-ray; • Colonoscopy, sigmoidoscopy or fecal occult blood test beginning at age 50 (including anesthesia services, a pre-op consult and a pathology exam on a polyp biopsy provided in connection with the procedure); • Five blood tests for cholesterol/lipid, blood sugar, gonorrhea, syphilis, HIV; Screening for hepatitis B virus infection; • Tobacco use screening, cessation interventions for tobacco users and expanded counseling for pregnant tobacco users. This includes four (4) tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; • BRCA 1 and 2 lab test with family history of breast cancer; and • CDC recommended immunizations (including coverage for cervical cancer vaccines as required by Colorado statute). See row titled “Weight Management” for coverage of obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss.	In-Network Preventive Services that are required to be covered under the Affordable Care Act will be payable at 100%, no Deductible. For covered immunizations/vaccines received at an In-Network Pharmacy, Plan Participants may send their claim/prescription receipts directly to the Administrative Office for reimbursement. Out-of-Network Preventive services are not covered. If there is not an In-Network provider who can provide the preventive care service, then the Plan will cover the service when performed by an Out-of-Network provider without cost sharing. Please see: https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at: http://www.hrsa.gov/womensguidelines/ http://www.uspreventiveservicestaskforce.org/BrowseRec/Index and http://www.cdc.gov/vaccines/schedules/hcp/index.html **Please note:** • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share for the diagnostic or therapeutic services but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, the diagnostic or therapeutic cost share will apply. The diagnosis and procedure codes submitted by the provider determine whether a service is considered preventive. • If an Affordable Care Act preventive service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters. See the row titled “Drugs (Coverage Of Certain Preventive Care Drugs” for information on payment for certain preventive care drugs in compliance with the Affordable Care Act.

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST750, TRUST1000, TRUST1500 AND TRUST2500)

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Prostate Screening (Routine) • Charges for prostate cancer screenings for men over fifty (50) and for men over forty (40) with high risk factors.	• The benefit shall be the lesser of $65 or the cost of the screening.	100%, no Deductible up to a maximum benefit of $65 per screening	
Radiology (X-Ray), Nuclear Medicine and Radiation Therapy Services (Outpatient) • Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy. • Includes pre-admission testing.	• Covered only when ordered by a Physician or Health Care Practitioner. • Some Radiology procedures are covered under the Preventive care benefits described in this Schedule. • Outpatient MRIs, CT scans and PET scans requires Precertification. See the Utilization Management chapter for details.	80%	60%

Reconstructive Services and Breast Reconstruction After Mastectomy
• This Plan complies with the **Women's Health and Cancer Rights Act** (WHCRA). For any Plan Participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including:
  • Reconstruction of the breast on which the mastectomy was performed;
  • Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  • Prostheses and physical complications for all stages of mastectomy, including lymphedemas.
These benefits are covered applying the same cost-sharing as is relevant to other medical/surgical plan benefits.
	• See the exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Exclusions chapter. Most Cosmetic Services are excluded from coverage.	80%	60%

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Rehabilitation Services (Physical, Occupational & Speech Therapy) When prescribed or provided by a Physician, the following types of therapy are covered: • Occupational Therapy performed by a properly accredited Occupational Therapist (OT) or certified Occupational Therapy assistant (COTA); • Physical Therapy performed by a Physician or a registered Physical Therapist; and • Speech Therapy and audio therapy, including audio diagnostic testing, when performed by a qualified therapist. • Aquatic Physical Therapy provided by a licensed Physical Therapist on a one-on-one basis in the pool when the patient's condition is not suitable for traditional land Physical Therapy. • Other rehabilitation services (cardiac and pulmonary rehabilitation) performed by a qualified health care professional in a Hospital outpatient department or other outpatient setting.	• Up to 20 visits per Calendar Year are covered if Medically Necessary. More than 20 visits are covered only if prescribed by a Physician and approved by the agent designated by the Trust. • Maintenance Rehabilitation, are not covered. See the exclusions related to Rehabilitation Services in the exclusions chapter. • Inpatient rehabilitation services are payable for charges incurred as a result of confinement in a Rehabilitation Facility	80%	60%
Rehabilitation Services (Therapies for Congenital Defects and Birth Abnormalities) The Plan will provide, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity, Physical Therapy, Occupational Therapy and Speech Therapy for the care and treatment of congenital defects and birth abnormalities for a Dependent Child from the child's third birthday to the Dependent Child's sixth birthday.	• Up to 20 visits per Calendar Year per type of therapy are allowed for congenital defects and birth abnormalities (not subject to Deductible or Copay).	80%	60%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST750, TRUST1000, TRUST1500 AND TRUST2500)

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Skilled Nursing Facility (SNF) or Subacute Facility • Skilled Nursing Facility (SNF). • Subacute Care Facility, also called Long Term Acute Care (LTAC) Facility.	• Skilled Nursing Facility confinement or Subacute care facility confinement is payable up to 60 days per Calendar Year. • The Plan will allow the semi-private room rate of the Skilled Nursing Facility for the services being rendered. • Private Duty Nurse or Physician is not covered.	80%	60%
Spinal Manipulation Services • Spinal Manipulation Services including related Ancillary Services are subject to the limitations shown in the Explanations and Limitations column.	• There is a maximum of 12 visits per person per Calendar Year for Spinal Manipulation Services rendered by a Chiropractor.	80%	60%
TMJ Services • Accidental Injury to Teeth/Jaw includes medical benefits for dental services and supplies if due to damage to teeth if the damage results from an Accident and the charges are incurred within one (1) year from the date of the Accident without regard to when the individual is enrolled in the Plan. • Temporomandibular Joint (TMJ) dysfunction or syndrome **only** if it is as a direct result of an accidental Injury.		80%	60%

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Transplants (Organ and Tissue) • Transplant services (and pre-transplant workup tests) are subject to Precertification. • Coverage is provided for eligible services directly related to non-Experimental transplants of human organs or tissue including bone marrow, peripheral stem cells, cornea, heart, heart/lung, intestine, islet tissue, kidney, kidney/pancreas, liver, liver/kidney, lung(s), pancreas, bone, tendons or skin, along with the facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies. • Organ/tissue Procurement is payable. Procurement includes expenses to find the donated organ/tissue (donor search fees), tests on the potential organ/tissue for compatibility, Surgery to remove the organ/tissue, preservation of the organ/tissue until it can be transplanted and transportation fees to deliver the organ/tissue to the patient/recipient. • Reasonable and necessary medical expenses incurred by a donor who is not covered by this Plan, are payable but only to the extent the donor is not covered by the donor's own insurance and the recipient is a Participant. • Transplant related travel benefits are available for the patient and one family member or companion, when the approved Transplant must occur more than 100 miles from the patient's residence.	**Transplant Related Travel Benefit:** When preapproved by the Fund, Transplant related travel benefits for medical care received more than 100 miles away from home may be payable (e.g. pre-op work-up, Transplant and post-Transplant treatment). The maximum for Transplant related travel expenses (transportation and lodging) for the patient (and where necessary for the patient's well-being for one family member or travel companion) is $10,000 per Transplant. Reimbursement is at 100%, no Deductible as follows: • Cost for round trip "coach" airfare; • Up to a max of $50/person/day for lodging incurred primarily for and essential to the receipt of medical care (if a parent is traveling with a sick child, up to $100); • Necessary travel expenses related to receiving medical care (taxi, subway, train) will be reimbursed at the face value indicated on the receipt up to $50/day; • Plan will reimburse (a) actual operating expenses incurred when your car is used to obtain medical care or (b) mileage for use of your car for medical care (reimbursement up to the IRS max allowance). **Not covered:** meals, car rentals, telephone calls, personal care items, entertainment/personal pleasure expenses, alcohol/tobacco, souvenirs, expenses for persons other than the patient and his/her designated family member. For Participants who serve as a donor, donor expenses are not payable unless the person who receives the donated organ/tissue is covered by this Plan. **Xenographic Transplants** (organ from animal to human) are not covered. Expenses related to xenographic services are not covered by this Plan, except as determined to be an FDA-approved use of xenographic tissue such as a porcine heart valve.	80%	60%
Urgent Care Facility	See the Physician and Other Health Care Practitioner Services row.	$45 Copay, no Deductible	60%

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Vision Therapy Benefits Benefits are payable by the Plan for the following conditions: • Amblyopia, eccentric fixation, • Accommodation inability (non-presbyopic), • Binocular dysfunction - convergence/divergence insufficiency (heterophorias - esophoria and exophoria), • Strabismus, accommodative (heterophorias - esophoria and exophoria), • Anomalous retinal correspondence, or • Myopia, functional (excessive convergence).	• Up to 48 visits per lifetime are payable. Benefits will **not** be paid for • Vision therapy for diagnoses not listed in the column to the left; • For eyeglasses prescribed as a part of vision therapy; or • For treatment not rendered by an optometrist (O.D.).	$45 Copay, no Deductible if billed for an office visit. If no office visit, 80%	60%

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Benefit Description	Explanations and Limitations	Trust750 / Trust1000 / Trust1500 / Trust2500	
		PPO	Non-PPO
Weight Management Bariatric Surgery (surgical weight management) is payable for individuals who meet the Plan's criteria (noted to the right) including but not limited to gastrointestinal bypass and gastric restrictive procedures like gastric banding. Reversal/revision of gastric stapling or intestinal bypass is payable only if there exists a complication of the original procedure. As a preventive benefit in compliance with the Affordable Care Act, the Plan covers obesity screening and counseling for adults and children in accordance with the US Preventive Task Force recommendations.	**Benefits for bariatric surgical procedures are payable to a maximum of 1 procedure and 1 reoperation per person per lifetime.** Charges for bariatric Surgery may be payable if all the following are met: • the Covered Person is 18 years or older and Morbidly Obese with a Body Mass Index of 40kg/m2, or 35kg/m2 in conjunction with an obesity-related co-morbid condition such as diabetes mellitus, cardiovascular disease, hypertension, or life-threatening cardio-pulmonary problems • evidence of past participation in a weight loss program for at least 6 continuous months in the 2 years prior to Surgery • pre-operative medical and mental health evaluations and clearances • a treatment plan addressing the pre and post-operative needs of an individual undergoing bariatric Surgery Covered services may include: • Prescription drugs (if precertified by the PBM as Medically Necessary); • Education by a Dietician or Nutritionist; and • Preventive screening and intensive behavioral counseling. Non-covered services include: • Surgical treatments for Morbid Obesity (such as intestinal bypass and gastric stapling) are not covered.	**Preventive screening and Counseling:** 100% no deductible 80% for bariatric surgery and other covered services	**Preventive screening and Counseling:** Not covered 60% bariatric surgery and for other covered services

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

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Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Lifetime Maximum	• The most this Plan will pay for all covered expenses for any person.	Unlimited Lifetime Maximum			
Deductible • In-network and out-of-network Deductibles are combined	• The amount you must pay each Calendar Year before the Plan pays benefits. The amount applied to the Deductible is the lesser of billed charges or the amount considered to be allowed under this Plan. • Deductibles are applied to the Eligible Medical Expenses in the order in which claims are processed by the Plan.	$3,000 Individual $6,000 Family (In and Out-of-Network combined) All services in this summary are subject to the Deductible unless stated otherwise All covered In-Network Services are paid at 100% after Deductible is met.		$5,000 Individual $10,000 Family (In and Out-of-Network combined) All services in this summary are subject to the Deductible unless stated otherwise All covered In-Network Services are paid at 100% after Deductible is met.	
Coinsurance	• How you and the Plan will split the cost of certain covered medical expenses, after the Deductible is met.	100%	80%	100%	80%
Out-of-Pocket Limit on Coinsurance • Out-of-Pocket Maximums do not "cross accumulate" between in-network and out-of-network as there is no Out-of-Pocket Maximum for In-Network Services (because the HDHP pays 100% of in-network covered eligible expenses after the Deductible is met).	• The maximum amount of Coinsurance that you are responsible for paying each Calendar Year before the Plan pays 100% of your covered eligible expenses.	$0	$5,950 Individual $11,900 Family Includes Deductible	$0	$5,950 Individual $11,900 Family Includes Deductible

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information.
All benefits are subject to the Deductible except where noted. Benefits for Trust 750, Trust1000, Trust1500 and Trust1500 begin on page 28
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Hospital Services (Inpatient and Outpatient) • Room & board facility fees in a semiprivate room with general nursing services (including Medically Necessary treatment of Mental Illness and Drug and Alcohol Disorders) • Specialty care units (e.g., intensive care unit, cardiac care unit). • Lab/x-ray/diagnostic services. • Related Medically Necessary Ancillary Services (e.g., prescriptions, supplies). • Newborn care. • See the Emergency Room Facility section of this schedule for an explanation of Hospital emergency room (ER) facility benefits. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a Hospital/Health Care Facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	• **Elective Hospitalization is subject to Precertification** (except maternity stays which are less than 48 hours for a normal vaginal delivery or 96 hours for a C-section). See the Utilization Management chapter for details. • A private room is covered only if Medically Necessary or if the facility does not provide semi-private rooms. • A newborn Dependent Child is subject to his or her own individual Deductible. • Benefits include Hospital charges incurred for dental procedures for Dependent Children if one (1) of the following conditions is present: * The child has a physical, mental or medically compromising condition; or * The child is extremely uncooperative, or unmanageable, anxious or uncommunicative, or an adolescent with dental needs which cannot be deferred; or * The child has sustained orofacial or dental trauma; or * Anesthesia charges if the child requires general Anesthesia due to acute infection, anatomic variations or allergy.	100%	80%	100%	80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information.
All benefits are subject to the Deductible except where noted. Benefits for Trust 750, Trust1000, Trust1500 and Trust1500 begin on page 28
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO

Physician and Other Health Care Practitioner Services
Benefits are payable for professional fees when provided by a Physician or other covered Health Care Practitioner in an office, Hospital, emergency room (ER), Urgent Care Facility or other covered Health Care Facility location (If they are legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered and acts within the scope of his or her license and/or scope of practice).
• Payable Physicians and Health Care Practitioner professional fees include:
  • Surgeon;
  • Assistant Surgeon (if Medically Necessary);
  • Anesthesiologist or Certified Registered Nurse Anesthetists (CRNA) during performance of surgical operation; Anesthesia provided by operating or assistant Physician;
  • Hospitalist;
  • Pathologist;
  • Radiologist;
  • Psychiatrist;
  • Psychologist;
  • Certified Midwife;
  • A certified Physician Assistant who is under the direct supervision of a Physician for the performance of medical services including the prescribing of a non-controlled substance within the guidelines established by the Colorado State Board of Medical Examiners.
	• The Administrative Office or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the definition of "**Surgery"** in the Definitions chapter.
	• Benefits are payable for the administration of Anesthesia by the operating or assistant Physician, but not for local infiltration Anesthesia, up to 50% of the amount that would otherwise be payable.
	• **Assistant Surgeon fees** will be reimbursed only for Medically Necessary services to a **maximum of one of the following:**
	  • 20% of the eligible expenses allowed for the primary surgeon; OR
	  • 10% for a Physician Assistant, surgical assistant or a registered nurse (RN).
	  • Office Visit and ancillary charges will be subject to the Deductible.
	• Under this Plan, there is no requirement to select a primary care Physician (PCP) or to obtain a referral or prior authorization before visiting an OB/GYN provider.
		100%	80%	100%	80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Allergy Services • Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast. • Desensitization and hyposensitization (allergy shots given at periodic intervals). • Allergy antigen solution.	• Allergy services are covered only when ordered by a Physician. • No coverage for allergy services considered to be Experimental by the Plan	100%	80%	100%	80%
Ambulance Services • Charges for professional ambulance service by air or ground ambulance to or from the nearest local adequate Hospital or Skilled Nursing Facility.	• Expenses for ambulance services are covered **only** when those services are for an **Emergency** as that term is defined in the Definitions chapter of this document or for Medically Necessary inter-facility transport. • Non-Emergency medical transportation is not covered.	100%	80%	100%	80%
Ambulatory Surgical Center	• See the Outpatient (Ambulatory) Surgery Facility row in this Schedule.	100%	80%	100%	80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

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All benefits are subject to the Deductible except where noted. Benefits for Trust 750, Trust1000, Trust1500 and Trust1500 begin on page 28
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Autism Spectrum Treatment Coverage includes the assessment, diagnosis and treatment of Autism Spectrum Disorders for a child from birth through 18 years of age.	A "Treatment Plan" for Autism Spectrum Disorders" may include the following: • Evaluation and assessment services; • Behavior training and behavior management and applied behavior analysis including but not limited to consultations, direct care, supervision, or treatment, or any combination; • Habilitative or rehabilitative care including but not limited to Occupational Therapy, Physical Therapy or Speech Therapy (or any combination of those therapies). Please note that the level of benefits for Occupational Therapy, Physical Therapy, or Speech Therapy may exceed the limit of 20 visits for each therapy if such therapy is Medically Necessary; • Pharmacy care and medication; • Psychiatric care; • Psychological care including family counseling; and • Therapeutic care.	100%	80%	100%	80%
Birthing Center/Facility	• See the Maternity Services row of this Schedule.	100%	80%	100%	80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Chemotherapy • Chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.	• Benefits are allowed only for therapeutic services necessary for treatment of malignant diseases and other conditions for which such therapy is standard treatment. Chemotherapy means drug therapy administered as treatment for malignant conditions and diseases of certain body systems. • **Oral anticancer medication -** The Plan will provide coverage for prescribed, orally administered anticancer medication that has been approved by the FDA and is used to kill or slow the growth of cancerous cells. The medication will be payable the same as any other intravenously administered or injected cancer medication. The medication may not be prescribed primarily for the convenience of the patient, Physician, or other Health Care Provider.	100%	80%	100%	80%
Chiropractic Services	• See the Spinal Manipulation section of this Schedule of Medical Benefits.				

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Cleft Lip and Palate For newborn Dependent Children born with cleft lip and/or cleft palate or any condition or Illness which is related to or developed as a result of the cleft lip or cleft palate, covered charges and treatment shall include to the extent Medically Necessary and Reasonable: • Oral and facial Surgery and surgical management; • Follow-up care by plastic surgeons and oral surgeons; • Prosthetic treatment such as obturators, speech appliances and feeding appliances; • Medically Necessary and Reasonable orthodontic and prosthodontic treatment; and • Habilitative Speech Therapy, otolarynogology treatment, and audiological assessments and treatment.		100%	80%	100%	80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

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All benefits are subject to the Deductible except where noted. Benefits for Trust 750, Trust1000, Trust1500 and Trust1500 begin on page 28
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Clinical Trials The Plan will provide coverage for Routine Patient Care costs (as defined in the Definition section of this document) received during a clinical trial if the Participant suffers from a condition that is disabling, progressive, or life-threatening. • The covered person's treating Physician recommends participation in the clinical trial; • The clinical trial or study is approved under the September 19, 2000 Medicare national coverage decision regarding clinical trials; • The patient care is provided by a certified, registered, or licensed Health Care Provider practicing within the scope of his or her license; and • Prior to participation in the clinical trial or study, the Participant has signed a statement of consent indicating that he or she has been informed of the procedure to be undertaken, alternative methods of treatment, and the general nature and extent of the risks associated with participation in the clinical trial or study.	The following services are **not** covered: • Any portion of the clinical trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry; • Any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device; • Extraneous expenses related to participation in the clinical trial including, but not limited to, travel, housing, and other expenses that Participant or person accompanying a Participant may incur; • An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the Participant; • Costs for the management of research relating to the clinical trial or study; and • Services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded under the Plan.	100%	80%	100%	80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information.
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***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Cochlear Implants The Plan will cover a unilateral cochlear implant for a patient with bilateral sensorineural hearing loss if the Plan criteria is met. **For adults 18 or older: when both of the following are met:** • Patient has bilateral, severe to profound sensorineural hearing loss; and • Patient has limited or no benefit from binaural hearing aids. **For children age 12 months to 17 years, 11 months: when all of the following are met:** • Child has profound, bilateral sensorineural hearing loss; • Child has limited benefit from binaural hearing aids; and • A three- to six-month hearing aid trial has been attempted and failed. **For all patients:** • No ear infection; • An accessible cochlear lumen that is structurally suited to implantation; • Freedom from lesions in the auditory nerve and acoustic areas of the central nervous system; • No contraindications to Surgery; and • Device must be used in accordance with FDA approved labeling. **Post Implantation Rehabilitation Program** — patient must undergo an extended program of rehabilitation (20-30 hours in children and 20-25 hours in adults). **Replacements and Upgrades** — Plan will cover upgrades to existing cochlear implant systems already in place if the currently used component is no longer functional, and the component cannot be repaired and the currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living. Plan does **not cover** the replacement of external components with upgraded components when done solely to improve appearance or to treat psychological symptomatology or complaints.		100%	80%	100%	80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Corrective Appliances (Prosthetic & Orthotic Devices, other than Dental) • Subject to the limitations shown in the Explanations and Limitations column, coverage is provided for Medically Necessary: * Rental (but only up to the allowed purchase price of the device). * Purchase of standard model. * Replacement or repair of any prosthetic device will be allowed only once in a five (5) year period, unless due to pathological changes or normal growth.	• See the exclusions related to Corrective Appliances in the Medical Exclusions chapter. • Benefits are available for the following: prosthetic devices and replacement or repair, including those provided under Medicare such as artificial arms, legs and accessories; artificial eyes; leg braces, including attached shoes, arm braces and back braces and cervical collars. Benefits payable include charges for the fitting and adjusting. • **Foot Orthotics** (orthopedic or corrective shoes and other supportive appliances for the feet) are payable if the Fund determines they are Medically Necessary for individuals with diabetes as follows: • one pair of orthotics is payable every 12 months for adults. • A pair of foot orthotics is payable once in a period of 6 months for children under age 19 when replacement is required due to growth.	100%	80%	100%	80%
Diabetes Treatment and Education	• Benefits are payable for outpatient self-management training and education including medical nutrition therapy prescribed by a Physician. In addition, Plan benefits are payable for glucose monitors and insulin pumps. • Continuous glucose monitors are covered under the Plan if the monitor is certified by a licensed Physician as Medically Necessary for the proper care of the Participant.	100%	80%	100%	80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

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All benefits are subject to the Deductible except where noted. Benefits for Trust 750, Trust1000, Trust1500 and Trust1500 begin on page 28
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Dialysis • Hemodialysis or peritoneal dialysis and supplies administered under the direction of a Physician in a Hospital or other inpatient Health Care Facility.	• Benefit payments may vary depending on the location in which the hemodialysis or peritoneal dialysis is performed or received by the patient. • **It is important that individuals with end stage kidney/renal disease promptly apply for Medicare coverage, regardless of age**. See also the Coordination of Benefits chapter that discusses what this Plan pays when you are also Medicare eligible.	100%	80%	100%	80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information.
All benefits are subject to the Deductible except where noted. Benefits for Trust 750, Trust1000, Trust1500 and Trust1500 begin on page 28
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Drugs (Outpatient Prescription Medicines) Covered prescription drugs include: • Federal legend drugs; • Insulin; disposable needles/syringes; • Disposable blood/urine glucose/acetone testing agents (e.g. Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips, and Tes-Tape). • Lancets and devices; • Compounded medication of which at least one (1) ingredient is a federal legend drug; • Injectable drugs; • Any other drug which, under applicable state law, may only be dispensed upon the written prescription of a Physician or other lawful prescriber; • FDA approved contraceptives for females, oral or other, whether medication or device. • Specialty Drugs (injectable or oral medications used to treat chronic conditions such as multiple sclerosis, rheumatoid arthritis and hepatitis C). • Immunosuppressive drugs. • Growth hormone and growth/height promotion drugs when Medically Necessary, if Precertification is obtained.	• See a complete list of the specific exclusions related to Prescription Drugs in the Exclusions chapter. • **Precertification is required for certain medications** such as Specialty drugs, weight management drugs, Compound drugs, and growth hormone/height promotion drugs. See the Utilization Management Chapter for details. • Precertification is not required for the first 5-day supply of an FDA approved drug for the treatment of opioid dependence within a 12-month period. • **Inpatient/Outpatient facility Prescription Drugs.** The Plan will reimburse charges for covered, Medically Necessary prescription drugs prescribed and delivered during an inpatient and/or outpatient visit or stay according to the Schedule of Benefits, not to exceed the Allowable Amount, as determined by the Plan Administrator in its sole discretion.	All covered prescription drugs are subject to the Deductible and Coinsurance (except for preventive care drugs that are required to be covered under the Affordable Care Act). Covered prescription drugs are payable at 100% after the Deductible is met. **No benefits are payable for prescription drugs purchased at an Out-of-Network Pharmacy** No charge for FDA approved Generic contraceptives with a prescription (brand name if Generic is not available or if it is medically inappropriate) Prescription contraceptives will be covered for a 3-month supply the first time the prescription contraceptive is dispensed, and subsequent dispenses will be covered for up to a 12-month supply or a supply through the end of the individuals' coverage under the plan, whichever is shorter, regardless of whether the individual was enrolled in the Plan at the time of the first dispensing. A prescription vaginal contraceptive ring intended to last for a 3-month period is also covered.		All covered prescription drugs are subject to the Deductible and Coinsurance (except for preventive care drugs that are required to be covered under the Affordable Care Act). Covered prescription drugs are payable at 100% after the Deductible is met. **No benefits are payable for prescription drugs purchased at an Out-of-Network Pharmacy** No charge for FDA approved Generic contraceptives with a prescription (brand name if Generic is not available or if it is medically inappropriate) Prescription contraceptives will be covered for a 3-month supply the first time the prescription contraceptive is dispensed, and subsequent dispenses will be covered for up to a 12-month supply or a supply through the end of the individuals' coverage under the plan, whichever is shorter, regardless of whether the individual was enrolled in the Plan at the time of the first dispensing. A prescription vaginal contraceptive ring intended to last for a 3-month period is also covered.	

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Drugs (Coverage Of Certain Preventive Care Drugs) Where the information in this document conflicts with newly released Affordable Care Act regulations affecting the coverage of preventive care drugs, this Plan will comply with the new requirements on the date required.	In accordance with the Affordable Care Act and subject to the US Preventive Task Force recommendations, certain preventive care drugs are covered at no charge if you have a prescription from your Physician, including: • Aspirin for pregnant women who are at high risk for preeclampsia (and) for adults aged 50 to 59 years with a high cardiovascular risk. • Folic acid supplements for women who may become pregnant; • Fluoride supplements for certain children without fluoride in their water source; • Preparation “prep” Products for a Colon Cancer Screening Test; • All FDA-approved tobacco cessation medications for a 90-day treatment regimen (both prescription and over the counter medications if prescribed by a PPO provider); • Statin preventive medicine (low to moderate dose statins) for adults ages 40-75 years; • Breast cancer preventive medication for women who are at increased risk for breast cancer • FDA-approved female contraceptives for all females.	No charge	Not covered	No charge	Not covered

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Durable Medical Equipment (DME) Benefits include: • Rental of a wheel chair, Hospital bed, and other similar Durable Medical Equipment, including equipment for the treatment of diabetes. • Oxygen and rental of equipment for its administration, and other similar equipment, including a maintenance agreement for the up-keep of such equipment.	• See the exclusions related to Corrective Appliances and Durable Medical Equipment in the Exclusions chapter. • When it is determined that purchase of Durable Medical Equipment would be less expensive than rental, or such equipment is not available for the rental, purchase may be authorized by the Administrative Office. • Replacement of Durable Medical Equipment will be allowed only once in a five (5) year period when the replacement is due to the patient's pathological changes or normal growth. • Monitoring devices and other similar devices, other than pacemakers, which can be permanently implanted are not covered. • For the first 12 months following the birth of a child, coverage is provided for one standard manual or standard electric breast pump, plus necessary breast pump supplies. Rental, purchase and repair is payable. Coverage is available at no cost from PPO only. No coverage for Non-PPO providers.	Breast Pump and Supplies: No charge 100%	Breast Pump and Supplies: Not covered 80%	Breast Pump and supplies: No charge 100%	Breast Pump and Supplies: Not covered 80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

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Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Early Intervention Services and Supports An Eligible Child means an infant or toddler, from birth through two years of age, who is an eligible Dependent as defined by the Plan and who has significant delays in development or has a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development or who is eligible for services pursuant to C.R.S. Section 27-10.5-102(11)(c) Within ninety (90) days after the Division determines that a child is no longer an Eligible Child, the Division shall notify the Plan that the child is no longer eligible and that the Plan is no longer required to provide the coverage.	• **The Deductible will apply to these services on the Trust3000 and the Trust5000 unless those services are preventive.** Annual maximum for Early Intervention Services and Supports is 45 visits. The following services are excluded: • Non-Emergency medical transportation; • Respite care; • Service coordination; and • Assistive technology, unless assistive technology is otherwise covered under this Plan.	100%	80%	100%	80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

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***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Employee Assistance Program (EAP) Services: • The Fund offers professional confidential counseling for personal problems including but not limited to adolescent problems, alcohol abuse, anxiety, codependency, depression, drug abuse, eating disorders, eldercare, family problems, financial/legal problems, grief/loss, HIV-AIDS related concerns, marital problems, relationships, self-esteem, stress, trauma counseling, women's issues and work related concerns. • The phone number for the EAP program is listed on the Quick Reference Chart in the front of this document.	• Some of the areas of concern listed in the column to the left may only be covered under the EAP and may **not be covered** under the medical Plan. • Any care that is transitional from EAP to the medical Plan must be coordinated with the Administrative Office. • It is always a good idea to contact the EAP before receiving any mental health or Substance Abuse treatment.	This Plan offers up to 5 free EAP visits per household member per year.			
Emergency Room Facility • Hospital emergency room (ER) facility for a medical Emergency (i.e. suspected heart attacks, poisonings, convulsions, etc) provided services and supplies are rendered within 72 hours of onset. • Ancillary charges (such as lab or x-ray) performed **during** the ER or Urgent Care visit. • See also the Ambulance section of this schedule. • See the Urgent Care section of this schedule	• Expenses for Emergency Room services are covered only when those services are for an **Emergency** as that term is defined in the Definitions chapter of this document under the heading of "Emergency Care." • • Emergency Room Copay will be waived if subsequent immediate admission to the Hospital is required.	100%	100%	100%	100%

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Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Family Planning, Reproductive, Contraceptive Fertility Services • Surgical sterilization services (e.g. vasectomy, tubal ligation). Female sterilization procedures are payable at no cost from PPO providers. Normal cost sharing applies to Non-PPO providers. Normal cost sharing applies to PPO and Non-PPO providers for vasectomy services. • With a prescription from your doctor, FDA approved contraceptives for females, oral or other, whether medication or device. • No charge for FDA approved Generic contraceptives with a prescription. • FDA approved contraceptives and counseling for females including devices/injections received during a Physician's visit are payable at no cost from PPO providers. Normal cost-sharing applies to Non-PPO providers. • See also the Preventive Care for Women section of this schedule. • See also the Drugs (Outpatient Prescription Medicines)	There are **no benefits** available for the following: • Elective abortions are not covered except where life of the mother is endangered if the fetus is carried to full term or where medical complications arise from an abortion. • Expenses incurred for the medical or surgical treatment of infertility, or to reverse surgically induced infertility, in-vitro fertilization, sexual impotency, Genetic Counseling (other than described in row of the Summary of Benefits entitled "Genetic Testing"). • Implantable and/or inflatable prosthesis for augmentation or impotence.	100%	80%	100%	80%
Gene Therapy The Plan covers Medically Necessary, non-Experimental, FDA-approved Gene Therapy treatment.	• Gene Therapy services require Precertification to avoid non-payment. • See also the definition of Gene Therapy in the Definitions chapter.	100%	80%	100%	80%

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Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Genetic Testing and Counseling Services Medically Necessary genetic testing is payable when ordered by a Physician, and performed by a qualified healthcare provider and provided with regard to a genetic test that is payable by this Plan: • female Participant is age thirty-five (35) or older; and family medical history indicates need for counseling/evaluation including a history of spontaneous abortions; or previous pregnancies resulted in a child with Down's syndrome or equally severe complications or abnormalities. • genetic testing recommended by the American College of Ob/Gyn for pregnant women such as genetic carrier testing for cystic fibrosis; • fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and AFP analysis in covered pregnant women (if Medically Necessary); • state-mandated newborn screening tests for genetic disorders; • tests to determine sensitivity to FDA approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity; • genetic testing (e.g. BRCA) and Genetic Counseling required as a Preventive service in accordance with the Affordable Care Act.	**Precertification is required for genetic testing** for the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered Participants. See the Utilization Management chapter for details. Certain conditions must be met as follows: • the testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and • the covered individual displays clinical features/symptoms, or is at direct risk (family history or 1st or 2nd degree relative) of developing the genetically linked heritable disease/condition in question (pre-symptomatic); and • the results of the test will directly impact clinical decision-making, outcome or treatment being delivered to the covered individual. • Certain genetic testing is not covered as explained in the Medical Plan Exclusion chapter.	100%	Genetic testing and counseling required as a preventive service under the Affordable Care Act: Not covered All other 80%	100%	Genetic testing and counseling required as a preventive service under the Affordable Care Act: Not covered All other 80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information.
All benefits are subject to the Deductible except where noted. Benefits for Trust 750, Trust1000, Trust1500 and Trust1500 begin on page 28
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Genetic Metabolism Benefit See row entitled "Medical Foods: for an explanation of this benefit.					
Hearing Aids for Participants under age 18	Coverage is provided for hearing aids for Participants under age 18 who have a hearing loss that has been verified by a Physician and by an Audiologist. Coverage will include the purchase of the following: • Initial hearing aids and replacement hearing aids not more frequently than every five years; • A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the Participant, and • Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.	100%	80%	100%	80%
Hearing Services	• Annual hearing exam • Hearing appliance covered once every 3 years (one appliance each ear) • Please also see the row entitled "Cochlear Implants" for additional information.	100%	80%	100%	80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

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Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO

Home Health Care and Home Infusion Services
Home Health Care is covered only if all of the following conditions are met and subject to the limitations outlined in "explanations and limitations" in the next column:
1. Physician must certify that the patient would require inpatient Hospital or Skilled Nursing Facility care if Home Health Care were not available. Or it is determined by the Board of Trustees or its designee that Home Health Care is Medically Necessary;
2. Must be provided according to a plan of treatment ordered by a Physician;
3. Continuing need must be certified periodically (not more frequently than once every two (2) weeks) by an attending Physician;
4. Provider may not be a person who ordinarily resides with the Participant or is a member of the Participant's family; and
5. Provider may not be a person who owns the private residence where the care is provided or who ordinarily resides there.
6. See also the exclusions related to Home Health Care in the Exclusions chapter.
	• Maximum number of days covered per Calendar Year is 100.
	• Covered charges include only the charges for any of the following medical services and supplies for treatment of a Participant's bodily Injury or disease;
	  • Part-time, intermittent **skilled** professional nursing services;
	  • Services of a home health aide on a part-time or intermittent basis;
	  • Respiratory or Rehabilitation Therapy; and
	  • Medical supplies or services provided, such as intravenous medications and injections which must be performed by the home health agency (other than oral drugs and biologicals).
		100%	80%	100%	80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

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Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO

Hospice
• Hospice services include inpatient Hospice Care in a private residence (not necessarily the residence of the Participant) and outpatient home hospice when the patient meets the definition of hospice in the Definitions chapter of this document.
	• Covered inpatient Hospice Care includes the charge (not to exceed Hospital Benefits) of Hospice Care for the inpatient confinement of a Participant;
	• The Covered Charges for home Hospice Care include:
	  • Services of a home health aide;
	  • Professional services of a registered nurse (R.N.) or licensed practical nurse (L.P.N);
	  • Physical and respiratory therapy;
	  • Nutrition counseling and special meals; and
	  • Services of a licensed or certified social worker not to exceed a maximum of six (6) visits (to evaluate the home). Any mental health counseling will be payable under the mental health benefits of the Plan.
	• Respite Care is limited to eight days per lifetime.
	• Hospice Care that is rendered by volunteers or individuals who do not normally charge for their services is **not covered.**
		100%	80%	100%	80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

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Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Implantable Medical Device Implantable Medical Devices are items partially or completely inserted into the human body or a natural orifice that are expected to stay in use for 30 days or more, or are used to replace an epithelial surface or the surface of the eye and are expected to stay in use for 30 days or more including, but not limited to, artificial limbs, heart pacemakers, or corrective lenses needed after cataract Surgery.	At the Plan's sole discretion, the Allowed Charge for implantable devices will be the lesser of: • 125% of the actual acquisition cost of the implantable devices; or • 115% of the manufacturer's list price for the implantable device. The Plan will reimburse for a standard model of an implantable device upon receipt of an itemized charge detail, proof of acquisition cost, and verification of utilization for Participants who meet all of the following criteria: • the procedure must be determined to be Medically Necessary according to the Plan's Utilization Management firm; • the implantable device is not Experimental; and • is payable only when provided by In-Network Health Care Providers;	100%	Not Covered	100%	Not Covered
Laboratory Services (Outpatient) • Technical and professional fees. • Includes pre-admission testing. • Diagnostic sleep study/sleep test using a full-channel nocturnal polysomnography (NPSG) (Type I device) performed in a healthcare facility. Sleep studies using devices that do not provide a measurement of apnea-hypopnea index (AHI) and oxygen saturation are not payable by this Plan.	• Covered only when ordered by a Physician or Health Care Practitioner. • **Precertification is required for diagnostic sleep studies/sleep tests**. See the Utilization Management Chapter for details. • Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical Benefits. • Some laboratory services are payable under the Preventive Care benefits described in this Schedule.	100%	80%	100%	80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

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Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Maternity Services • Hospital and Birth (Birthing) Center charges and Physician and Midwife fees for Medically Necessary maternity services. • Hospital Length of Stay for Childbirth: This Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a Health Care Practitioner to obtain authorization from the Plan or its UM Program for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending Health Care Practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable). See Genetic Testing for additional information.	• Lamaze classes are not covered. • A pre-planned home delivery is not covered. • Prenatal/postnatal visits and certain prenatal care and maternity related preventive care obtained from a PPO provider are payable at no cost. Normal cost sharing applies to other maternity related services including ultrasounds and delivery expenses. • When a PPO provider submits a bill with a global CPT code for the combination of prenatal/postnatal visits and delivery expenses, the Claims Administrator will process the claim applying no cost-sharing to 40% of the charges representing the prenatal/postnatal visit expenses, and normal cost- sharing to 60% of the charges representing the delivery expenses. • See the Preventive Care for Women (including pregnant women) section for the government websites listing certain prenatal care/maternity related preventive care expenses payable.	100%	80%	100%	80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

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Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Medical Foods Covered charges include Medical Foods for home use for which a Physician has issued a prescription. Charges are payable for inherited enzymatic disorders (including severe protein allergic conditions) caused by single gene defects involved in the metabolism of amino, organic, and fatty acids. Such disorders shall include, but not be limited to the following diagnosed conditions: • Phenylketonuria; • Maple syrup urine disease; • Tyrosinemia; • Homocystinuria; • Histidinemia; • Urea cycle disorders; • Hyperlysinemia; • Glutaric acidemias; • Methylmalonic acidemia; • Propionic academia; and • maternal phenylketonuria • immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins • severe food protein induced enterocolitis syndrome • eosinophilic disorders as evidenced by the results of a biopsy • impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.	• "Medical Foods" means prescription metabolic formulas and their modular counterparts and amino acid-based elemental formulas, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for severe allergic conditions, if diagnosed by a board-certified allergist or board-certified gastroenterologist, for which medically standard methods of diagnosis, treatment and monitoring exist. The formulas for severe food allergies contain only singular form elemental amino acids. The formulas are to be consumed or administered enterally either via tube or oral route under the direction of a Physician. • There is no age limit on benefits for inherited enzymatic disorders, except for phenylketonuria. The maximum age to receive benefits for phenylketonuria is twenty-one (21) years of age, except for women who are of child-bearing age the maximum age shall be thirty-five (35) years of age. • There is no coverage for laetrile, enzymes and food supplements, except as prescription formulas for individuals that have one of the inherited enzymatic disorders listed in the column to the left. • Coverage of Medical Foods shall not apply to alternative medicines.	100%	80%	100%	80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

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Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Mental Health and Substance Abuse Treatment **Also, please see the row entitled "Employee Assistance Program (EAP)" for additional benefits that may be available to you and your covered Dependents.** • **Outpatient visits**: including necessary Psychological (Psychiatric) Testing. • **Other Outpatient Services:** partial day care/partial hospitalization or intensive outpatient program (IOP) care. See the Definitions chapter for the meaning of the term partial day care and intensive outpatient program. • **Inpatient acute hospital admission, or inpatient Residential Treatment Program.** See the Definitions chapter for the meaning of the term residential treatment	• See the specific exclusions related to Mental Health and Substance Abuse Treatment, in the Exclusions chapter. • Drug testing required by an Employer for employment is not covered. • Treatment for Mental Illness and Substance Abuse Treatment are payable the same as any other physical Illness. • Residential Treatment Programs may be covered for individuals needing treatment in a highly structured 24-hour therapeutic environment when care cannot be safely or effectively treated in a less intensive setting. A Residential Treatment Facility must be properly licensed in the state in which the facility operates. • **Please remember:** All inpatient treatment (including residential treatment) requires pre-certification.	100%	80%	100%	80%
Nondurable Supplies • Coverage is provided for Medically Necessary Nondurable Supplies dispensed and used by a Physician or Health Care Practitioner in conjunction with treatment of the Plan Participant.	• To determine what Nondurable Medical Supplies are covered, see the definition of "Nondurable Supplies" in the Definitions chapter. • Diabetic supplies (e.g., insulin syringes, test strips, lancets, and alcohol swabs) are covered under the Prescription Drug Program.	100%	80%	100%	80%

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Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Nutritional Counseling • Please also see the rows of this Schedule of Benefits titled "Diabetes Treatment and Education,", "Preventive Care, and "Weight Management"".	The Plan covers nutritional counseling services that are Medically Necessary for the treatment of an individual diagnosed with a mental health or Substance Abuse condition, such as an eating disorder. Also see the row in this schedule titled "Mental Health and Substance Abuse Treatment"	100%	80%	100%	80%
Outpatient (Ambulatory) Surgery Facility • Ambulatory (Outpatient) in a Hospital-based or free-standing Surgery center (e.g. surgicenter or same day Surgery). • Physician fees payable under the Physician services section of this Schedule of Medical Benefits.	• Admission to an outpatient surgical facility requires Precertification. See the Utilization Management chapter for details. Benefits include charges incurred for dental procedures for Dependent Children if one (1) of the following conditions is present: • The child has a physical, mental or medically compromising condition; or • The child is extremely uncooperative, or unmanageable, anxious or uncommunicative, or an adolescent with dental needs which cannot be deferred; or • The child has sustained orofacial or dental trauma; or • Anesthesia charges if the child requires general Anesthesia due to acute infection, anatomic variations or allergy.	100%	80%	100%	80%

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Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Preventive Care for Children **Covered Services include but are not limited to:** • Newborn screening lab tests (typically payable as part of hospitalization at birth); • At least 11 Office Visits payable during first 30 months of age, then annual Office Visits are payable from age 3 years through age 18 years; • Hemoglobin and lead blood tests in first year of life; • Screening for hepatitis B virus infection; • Application of fluoride varnish to the primary teeth of all infants and children up to age 5 starting at the age of primary tooth eruption, in primary care practices; • Tuberculosis (TB) skin test in first year of life; • Syphilis screening to adolescents at risk. • Hemoglobin blood test in second year of life; and • CDC recommended immunizations. This benefit includes all preventive services and immunizations required to be provided in basic and standard health benefit plans pursuant to Colorado Section 10-16-105 for Dependent Children up to age thirteen including but not limited to electrocardiogram, blood work, urinalysis and a chest x-ray. See row titled “Weight Management” for coverage of obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss		**In-Network Preventive Services** that are required to be covered under the Affordable Care Act will be payable at 100%, no Deductible. For covered immunizations/vaccines received at an In-Network Pharmacy, Plan Participants may send their claim/prescription receipts directly to the Administrative Office for reimbursement. Out-of-Network Preventive services **are not covered.** If there is not an In-Network provider who can provide the preventive care service, then the Plan will cover the service when performed by an Out-of-Network provider without cost sharing. Please see the following Government website for a complete description of covered preventive care or call the Administrative Office with any questions you have. Please see: https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at: http://www.uspreventiveservicestaskforce.org/BrowseRec/Index and http://www.cdc.gov/vaccines/schedules/hcp/index.html and http://www.uspreventiveservicestaskforce.org/BrowseRec/Index and http://www.hrsa.gov/womensguidelines/ See the row titled “Drugs (Coverage Of Certain Preventive Care Drugs” for information on payment for certain preventive care drugs in compliance with the Affordable Care Act.		

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

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Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Preventive Care for Men Covered Services include but are not limited to: • Abdominal aortic aneurysm screening; • Colonoscopy, sigmoidoscopy or fecal occult blood test beginning at age 50 (including Anesthesia services, a pre-op consult and a pathology exam on a polyp biopsy provided in connection with the procedure); • Five blood tests for cholesterol/lipid, blood sugar, gonorrhea, syphilis, HIV; • Screening for hepatitis B virus infection; • Tobacco Use screening for all adults and cessation interventions for tobacco users. . This includes four (4) tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and • CDC recommended immunizations. See row titled "Weight Management" for coverage of obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss		**In-Network Preventive Services** that are required to be covered under the Affordable Care Act will be payable at 100%, no Deductible. For covered immunizations/vaccines received at an In-Network Pharmacy, Plan Participants may send their claim/prescription receipts directly to the Administrative Office for reimbursement. Out-of-Network Preventive services **are not covered.** If there is not an In- Network provider who can provide the preventive care service, then the Plan will cover the service when performed by an Out-of-Network provider without cost sharing. Please see the following Government website for a complete description of covered preventive care or call the Administrative Office with any questions you have. Please see: https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at: http://www.uspreventiveservicestaskforce.org/BrowseRec/Indexand http://www.cdc.gov/vaccines/schedules/hcp/index.html and http://www.uspreventiveservicestaskforce.org/BrowseRec/Index See the row titled "Drugs (Coverage Of Certain Preventive Care Drugs" for information on payment for certain preventive care drugs in compliance with the Affordable Care Act.		

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Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Preventive Care for Women (including pregnant women) Covered Services include but are not limited to: • Well women Office Visits; • Blood pressure screening throughout a pregnancy to check for preeclampsia. • Screening for gestational diabetes, Tuberculosis screening for adults at increased risk, HPV testing no more frequently than once every 3 years starting at age 30, counseling on sexually transmitted infections, rental or purchase of breastfeeding equipment and necessary supplies after delivery, lactation support following delivery (for duration of breastfeeding); • depression screening during pregnancy and postpartum period; • Sterilization procedures, patient education and counseling; • Many services necessary for prenatal care; • Screening mammogram for breast cancer; • Pap smear and Chlamydia screening; • Osteoporosis screening x-ray; • Colonoscopy, sigmoidoscopy or fecal occult blood test beginning at age 50 (including Anesthesia services, a pre-op consult and a pathology exam on a polyp biopsy provided in connection with the procedure); • Five blood tests for cholesterol/lipid, blood sugar, gonorrhea, syphilis, HIV; Screening for hepatitis B virus infection; • Tobacco use screening, cessation interventions for tobacco users and expanded counseling for pregnant tobacco users. This includes four (4) tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; • BRCA 1 and 2 lab test with family history of breast cancer; and • CDC recommended immunizations (including coverage for cervical cancer vaccines as required by Colorado statute). See row titled “Weight Management” for coverage of obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss.	**In-Network Preventive Services** that are required to be covered under the Affordable Care Act will be payable at 100%, no Deductible. For covered immunizations/vaccines received at an In-Network Pharmacy, Plan Participants may send their claim/prescription receipts directly to the Administrative Office for reimbursement. Out-of-Network Preventive services **are not covered.** If there is not an In-Network provider who can provide the preventive care service, then the Plan will cover the service when performed by an Out-of-Network provider without cost sharing. Please see the following Government website for a complete description of covered preventive care or call the Administrative Office with any questions you have. Please see: https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at: http://www.uspreventiveservicestaskforce.org/BrowseRec/Index and http://www.cdc.gov/vaccines/schedules/hcp/index.html and http://www.uspreventiveservicestaskforce.org/BrowseRec/Index and http://www.hrsa.gov/womensguidelines/ See the row titled “Drugs (Coverage Of Certain Preventive Care Drugs” for information on payment for certain preventive care drugs in compliance with the Affordable Care Act.			

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Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Routine Prostate Screening • Charges for prostate cancer screenings for men over fifty (50) and for men over forty (40) with high risk factors. • The benefit shall be the lesser of $65 or the cost of the screening.		100%, no Deductible up to a maximum benefit of $65 per screening			
Radiology (X-Ray), Nuclear Medicine and Radiation Therapy Services (Outpatient) • Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy.	• Covered only when ordered by a Physician or Health Care Practitioner. • Some Radiology procedures are covered under the Wellness Programs described in this Schedule. • Outpatient MRIs, CT scans and PET scans requires Precertification. See the Utilization Management chapter for details.	100%	80%	100%	80%

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Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO

Reconstructive Services and Breast Reconstruction After Mastectomy
• This Plan complies with the **Women's Health and Cancer Rights Act** (WHCRA). For any Plan Participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including:
  • Reconstruction of the breast on which the mastectomy was performed;
  • Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  • Prostheses and physical complications for all stages of mastectomy, including lymphedemas.
These benefits are covered applying the same cost-sharing as is relevant to other medical/surgical plan benefits.
	• See the exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Exclusions chapter. Most Cosmetic Services are excluded from coverage.	100%	80%	100%	80%

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Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Rehabilitation Services (Physical, Occupational & Speech Therapy) When prescribed or provided by a Physician, the following types of therapy are covered: • Occupational Therapy performed by a properly accredited Occupational Therapist (OT) or certified Occupational Therapy assistant (COTA); • Physical Therapy performed by a Physician or a registered Physical Therapist; and • Speech Therapy and audio therapy, including audio diagnostic testing, when performed by a qualified therapist. • Aquatic Physical Therapy provided by a licensed Physical Therapist on a one-on-one basis in the pool when the patient's condition is not suitable for traditional land Physical Therapy. • Other rehabilitation services (cardiac and pulmonary rehabilitation) performed by a qualified health care professional in a Hospital outpatient department or other outpatient setting.	• Up to 20 visits per Calendar Year are covered if Medically Necessary. More than 20 visits are covered only if prescribed by a Physician and approved by the agent designated by the Trust. • Maintenance Rehabilitation services are not covered. See the exclusions related to Rehabilitation Services in the exclusions chapter. • Inpatient rehabilitation services are payable for charges incurred as a result of confinement in a Rehabilitation Facility	100%	80%	100%	80%

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Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Rehabilitation Services (Therapies for Congenital Defects and Birth Abnormalities) The Plan will provide, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity, Physical Therapy, Occupational Therapy and Speech Therapy for the care and treatment of congenital defects and birth abnormalities for a Dependent Child from the child's third birthday to the Dependent Child's sixth birthday.	• Up to 20 visits per Calendar Year per type of therapy are allowed for congenital defects and birth abnormalities.	100%	80%	100%	80%
Skilled Nursing Facility (SNF) or Subacute Facility • Skilled Nursing Facility (SNF). • Subacute Care Facility, also called Long Term Acute Care (LTAC) Facility.	• Skilled Nursing Facility confinement or Subacute care facility confinement is payable up to 60 days per Calendar Year. • Plan will allow the semi-private room rate of the Skilled Nursing Facility for the services being rendered. • Private Duty Nurse or Physician is not covered.	100%	80%	100%	80%
Spinal Manipulation Services • Spinal Manipulation Services including related Ancillary Services are subject to the limitations and Annual Maximum Plan Benefit shown in the Explanations and Limitations column.	• There is a maximum of 12 visits per person per Calendar Year for Spinal Manipulation Services rendered by a Chiropractor.	100%	80%	100%	80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information.
All benefits are subject to the Deductible except where noted. Benefits for Trust 750, Trust1000, Trust1500 and Trust1500 begin on page 28
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
TMJ Services • Accidental Injury to Teeth/Jaw includes medical benefits for dental services and supplies if due to damage to teeth if the damage results from an Accident and the charges are incurred within one (1) year from the date of the Accident without regard to when the individual is enrolled in the Plan. • Temporomandibular Joint (TMJ) dysfunction or syndrome **only** if it is as a direct result of an accidental Injury.		100%	80%	100%	80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information.
All benefits are subject to the Deductible except where noted. Benefits for Trust 750, Trust1000, Trust1500 and Trust1500 begin on page 28
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Transplants (Organ and Tissue) • Coverage is provided for eligible services directly related to non-Experimental Transplants of human organs or tissue including bone marrow, peripheral stem cells, cornea, heart, heart/lung, intestine, islet tissue, kidney, kidney/pancreas, liver, liver/kidney, lung(s), pancreas, bone, tendons or skin, along with the facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies. • Organ/tissue Procurement is payable. Procurement includes expenses to find the donated organ/tissue (donor search fees), tests on the potential organ/tissue for compatibility, Surgery to remove the organ/tissue, preservation of the organ/tissue until it can be transplanted and transportation fees to deliver the organ/tissue to the patient/recipient. • Reasonable and necessary medical expenses incurred by a donor who is not covered by this Plan, are payable but only to the extent the donor is not covered by the donor's own insurance and the recipient is a Participant. • Transplant related travel benefits are available for the patient and one family member or companion, when the approved Transplant must occur more than 100 miles from the patient's residence.	• **Transplant services (and pre-Transplant workup tests) are subject to Precertification.** • Transplant Related Travel Benefit: When preapproved by the Fund, Transplant related travel benefits for medical care received more than 100 miles away from home may be payable (e.g. pre-op work-up, Transplant and post-Transplant treatment). The maximum for Transplant related travel expenses (transportation and lodging) for the patient (and where necessary for the patient's well-being for one family member or travel companion) is $10,000 per Transplant. Reimbursement is at 100%, no Deductible as follows: • Cost for round trip "coach" airfare; • Up to a max of $50/person/day for lodging incurred primarily for and essential to the receipt of medical care (if a parent is traveling with a sick child, up to $100); • Necessary travel expenses related to receiving medical care (taxi, subway, train) will be reimbursed at the face value indicated on the receipt up to $50/day; • The Plan will reimburse (a) actual operating expenses incurred when your car is used to obtain medical care or (b) mileage for use of your car for medical care (reimbursement up to the IRS max allowance). • **Not covered:** meals, car rentals, telephone calls, personal care items, entertainment/personal pleasure expenses, alcohol/tobacco, souvenirs, expenses for persons other than the patient and his/her designated family member. For Participants who serve as a donor, donor expenses are not payable unless the person who receives the donated organ/tissue is covered by this Plan. • **Xenographic Transplants** (organ from animal to human) are not covered. Expenses related to xenographic services are not covered by this Plan, except as determined to be an FDA-approved use of xenographic tissue such as a porcine heart valve.	100%	80%	100%	80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information.
All benefits are subject to the Deductible except where noted. Benefits for Trust 750, Trust1000, Trust1500 and Trust1500 begin on page 28
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Urgent Care Facility		100%	80%	100%	80%
Vision Therapy Benefits Benefits are payable by the Plan for the following conditions: • Amblyopia, eccentric fixation, • Accommodation inability (non-presbyopic), • Binocular dysfunction - convergence/divergence insufficiency (heterophorias - esophoria and exophoria), • Strabismus, accommodative (heterophorias - esophoria and exophoria), • Anomalous retinal correspondence, or • Myopia, functional (excessive convergence).	• Up to 48 visits per lifetime are payable. Benefits will **not** be paid for • Vision therapy for diagnoses not listed in the column to the left; • For eyeglasses prescribed as a part of vision therapy; or • For treatment not rendered by an optometrist (O.D.)**.**	100%	80%	100%	80%

SCHEDULE OF MEDICAL BENEFITS (FOR TRUST3000 AND TRUST5000)

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions chapters of this document for important information.
All benefits are subject to the Deductible except where noted. Benefits for Trust 750, Trust1000, Trust1500 and Trust1500 begin on page 28
***IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.**

Benefit Description	Explanations and Limitations	Trust3000		Trust5000	
		PPO	Non-PPO	PPO	Non-PPO
Weight Management Bariatric Surgery (surgical weight management) is payable for individuals who meet the Plan's criteria (noted to the right) including but not limited to gastrointestinal bypass and gastric restrictive procedures like gastric banding. Reversal/revision of gastric stapling or intestinal bypass is payable only if there exists a complication of the original procedure. • As a preventive benefit in compliance with the Affordable Care Act, the Plan covers obesity screening and counseling for adults and children in accordance with the US Preventive Task Force recommendations.	**Benefits for bariatric surgical procedures are payable to a maximum of 1 procedure and 1 reoperation per person per lifetime.** Charges for bariatric Surgery may be payable if all the following are met: • the Covered Person is 18 years or older and Morbidly Obese with a Body Mass Index of 40kg/m2, or 35kg/m2 in conjunction with an obesity-related co-morbid condition such as diabetes mellitus, cardiovascular disease, hypertension, or life-threatening cardio-pulmonary problems • evidence of past participation in a weight loss program for at least 6 continuous months in the 2 years prior to Surgery • pre-operative medical and mental health evaluations and clearances • a treatment plan addressing the pre and post-operative needs of an individual undergoing bariatric Surgery Covered services may include: • Prescription drugs (if precertified by the PBM as Medically Necessary); • Education by a Dietician or Nutritionist; and • Preventive screening and intensive behavioral counseling. Non-covered services include: • Surgical treatments for Morbid Obesity (such as intestinal bypass and gastric stapling) are not covered.	100% (Deductible waived for obesity screening and intensive counseling that is required to be covered by ACA)	Preventive screening and Counseling: Not covered 80% for bariatric Surgery and other covered services	100% (Deductible waived for obesity screening and intensive counseling that is required to be covered by ACA)	Preventive screening and Counseling: Not covered 80% for bariatric Surgery and other covered services

MEDICAL NETWORKS

In-Network and Out-Of-Network Services

In an effort to control health care costs and reduce your out-of-pocket expenses, the Plan has entered into agreements with Preferred Provider Organizations (PPOs). A Plan Participant may select any doctor of your choice when medical care is needed. However, if a Health Care Provider under contract with the PPO is used, costs will be reduced considerably. Additionally, the Health Care Provider cannot charge more than the Plan allows in accordance with the Schedule of Medical Benefits for certain charges.

In-Network Services

In-network Health Care Providers have agreements with the Plan's Preferred Provider Organization (PPO) under which they provide health care services and supplies for a favorable negotiated discount fee for Plan Participants. When a Plan Participant uses the services of an In-Network Health Care Provider, he or she is responsible for paying the applicable Deductible and Coinsurance on the discounted fees or Copay for any Medically Necessary services or supplies, subject to the Plan's limitations and exclusions.

A Participant may also verify whether a Health Care Provider is an In-Network provider by contacting the PPO network listed on the Quick Reference Chart in the front of this document.

Out-Of-Network Services

Out-of-Network (also called Non-Network or Non-PPO) Health Care Providers have no agreements with the PPO network and are generally free to set their own charges for the services or supplies they provide. The Plan will reimburse the Plan Participant for the Allowed Charge (as defined in this document) for any Medically Necessary services or supplies, subject to the Plan's Deductibles, Coinsurance (on non-discounted services), Copays limitations and exclusions. Plan Participants must submit proof of claim before any such reimbursement will be made.

Special Reimbursement Provisions:

- In the event that covered services are rendered by a Non-PPO provider for an Emergency, when such services cannot be rendered by a Preferred Provider, or when it is not medically possible or prudent to obtain service from a Preferred Provider, payments shall be made under the Preferred Provider level of benefits.
- In the event an individual was treated/confined in a PPO facility but an Non-PPO provider (outside the patient's control) performed certain Medically Necessary covered services such as radiology, Anesthesia, Assistant Surgeon, pathology, laboratory, and Emergency room services benefits shall be paid pursuant to the Preferred Provider level of benefits.
- In the event that covered services are rendered by a Non-PPO Provider to a Participant whose Employer's principal place of business is in Pitkin or Garfield Counties, payments will be made under the Preferred Provider level of benefits.

CAUTION: Out-of-Network Health Care Providers may bill the Plan Participant for any balance due in addition to the Allowed Charge payable by the Plan, which is also called Balance Billing. Avoid Balance Billing by using In-Network providers.

Preferred Provider Organization (PPO)

The Plan's Preferred Provider Organization (PPO) is a network of Hospitals, Physicians, laboratories and other Health Care Providers who are located within a service area and who have agreed to provide health care services and supplies for favorable negotiated discount fees applicable only to Plan Participants. If Medically Necessary services or supplies are received from a PPO Provider, the Participant will pay a lower Coinsurance than if the services were received from a Health Care Provider who is not a PPO Provider; **and** the PPO Provider has agreed to accept the Plan's payment (plus any applicable Coinsurance or Copay) as payment in full.

Directories of Network Providers

Physicians and Health Care Providers who participate in the Plan's Network are added and deleted during the year. At any time, Participants can find out if any Health Care Provider is a member of the Network by contacting the PPO at its telephone number or website shown on the Quick Reference Chart in the front of this document.

Remember, because providers are added to and dropped from the PPO network periodically throughout the year it is best to ask the Health Care Provider IF they are still participating with the PPO or contact the network each time BEFORE services are received.

Please note for Preventive Care benefits:

- When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share for the diagnostic or therapeutic services, but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, the diagnostic or therapeutic cost sharing will apply. The diagnosis and procedure codes submitted by the provider determine whether a service is considered preventive.
- If an Affordable Care Act preventive service recommendation or guideline does not specify the frequency, method, treatment or setting for the provision of that service, the plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters.

UTILIZATION MANAGEMENT (UM)

Purpose of the Utilization Management (UM) Program

This Plan is designed to provide Plan Participants with financial protection from significant health care expenses. The development of new drugs, medical technology and procedures and the ever-increasing cost of providing health care may make it difficult for the Trust to afford the cost of maintaining the Plan.

To enable the Plan to provide coverage in a cost-effective way, the Plan has adopted a Utilization Management Program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the Trust is better able to afford to maintain the plan and all its benefits. If a Plan Participant doesn't follow the procedures of the Plan's Utilization Management Program, the Plan provides reduced benefits, resulting in higher out-of-pocket costs to the Plan Participant.

Management of the Utilization Management Program

The Plan's Utilization Management Program is administered by an independent professional Utilization Management Company operating under a contract with the Plan (hereafter referred to as the UM Company). The name, address and telephone number of the UM Company appears in the Quick Reference Chart in the front of this document.

The health care professionals in the UM Company focus their review on the necessity and appropriateness of Hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical or surgical services. In carrying out its responsibilities under the Plan, the UM Company has been given discretionary authority by the Plan Administrator to determine if a course of care or treatment is Medically Necessary with respect to the patient's condition and within the terms and provisions of this Plan.

Elements of the Utilization Management Program

The Plan's Utilization Management Program consists of:

- **Precertification (Preservice) Review**: review of proposed health care services before the services are provided;
- **Concurrent (Continued Stay) Review**: ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a Hospital or Health Care Facility or continued duration of healthcare services;
- **Second and third opinions**: consultations and/or examinations designed to take a second, and, when required, a third look at the need for certain elective health care services;
- **Retrospective (Post-Service) Review**: review of health care services after they have been provided; and
- **Case Management**: a process whereby the patient, the patient's family, Physician and/or other Health Care Providers, and the Administrative Office work together under the guidance of the plan's independent Utilization Management Company to coordinate a quality, timely and cost-effective treatment plan. Case Management services may be particularly helpful for patients who require complex, high-technology medical services and who may therefore benefit from professional assistance to guide them through the maze of choices of health care services, providers and practices.

Restrictions/Limitations of the Utilization Management Program (Very Important Information):

- The fact that a Physician recommends Surgery, Hospitalization, confinement in a Health Care Facility, or that a Physician or other Health Care Provider proposes or provides any other medical services or supplies doesn't mean that the recommended services or supplies will be an eligible expense or be considered Medically Necessary for determining coverage under the Plan.
- The Utilization Management Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. The UM Company's certification that a service is Medically Necessary doesn't mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document.
- All treatment decisions rest with the Plan Participant and the Physician. The patient should follow whatever course of treatment you and your Physician believe to be the most appropriate, even if the UM Company does not certify proposed Surgery/treatment/service or admission as Medically Necessary or as an eligible

expense. However, the benefits payable by the Plan may be affected by the determination of the UM Company.

- With respect to the administration of this Plan, the Administrative Office and the UM Company are not engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by the UM Company as Medically Necessary, or for the results if the patient chooses not to receive health care services that have not been certified by the UM Company as Medically Necessary.
- **Precertification of a service does not guarantee that the Plan will pay benefits for that service** because, other factors, such as ineligibility for coverage on the actual date of service, the information submitted during Precertification varies from the actual services performed on the date of service, and/or the service performed is not a covered benefit, may be a factor in non-payment of a service.

Precertification (Preservice) Review

How Precertification Review Works

Precertification Review is a procedure, administered by the UM Company, to assure that health care services meet or exceed accepted standards of care and that the admission and length of stay in a Hospital or Health Care Facility, Surgery, and other health care services are Medically Necessary. **The following services must be precertified (pre-approved) BEFORE the services are provided:**

SERVICES REQUIRING PRECERTIFICATION BY THE UTILIZATION MANAGEMENT COMPANY:

- All Elective Hospital admissions for medical or surgical care. (Note: for delivery of a child, Precertification is required only for Hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section);
- All outpatient surgeries performed at a Hospital or licensed surgical center;
- Any upcoming Transplant as soon as the Participant is identified as a potential Transplant candidate;
- Any outpatient MRIs, CT scans or Pet Scans.
- An Emergency Hospital admission within two working days after the admission.
- Genetic testing
- Administration of a class of drugs called “survival motor neuron-2 (SMN2)-directed antisense oligonucleotides,” which includes drugs such as Spinraza (nusinersen).
- Any Gene Therapy treatment including but not limited to Kymriah, Yescarta, Luxturna, Zolgensma, etc

Any inpatient hospitalizations for mental health or Substance Abuse (including Residential Treatment Programs) must be precertified by the Behavioral Health Program listed on the Quick Reference Chart.

SERVICES REQUIRING PRECERTIFICATION BY THE PRESCRIPTION DRUG PROGRAM (whose contact information is listed on the Quick Reference Chart in the front of this document):

- Certain medications such as Specialty drugs, weight management drugs, Compound drugs and growth hormone and growth/height promotion drugs require Precertification by contacting the Pharmacy Benefit Manager (PBM). For a current list of prescription drugs that require Precertification, contact the Plan’s PBM as shown on the Quick Reference Chart in the front of this document.

Prior notification does not mean benefits are payable in all cases.

Coverage depends on the services actually provided, your eligibility status at the time service is provided, and any benefit limitations.

There is no requirement to precertify the use of a Hospital-based emergency room visit.

How to Request Precertification (Pre-service Review)

You or your Health Care Provider must call the UM Company or Behavioral Health Program at the telephone number shown in the Quick Reference Chart in the front of this document.

- **Calls for Elective Services should be made at least two weeks prior (when possible) to the expected date of service.**
- The caller should be prepared to provide all of the following information: the Employer's name, Employee's name, patient's name, address, and phone number and social security number; Physician's name, and phone number or address; the name of any Hospital or outpatient facility or any other Health Care Provider that will be providing services; the reason for the health care services or supplies; and the proposed date for performing the services or providing the supplies.
- When calling to precertify, if the preservice review process was not properly followed the caller will be notified as soon as possible but not later than 5 calendar days after your request.
- If additional information is needed, the UM Company will advise the caller. The UM Company will review the information provided, and will let you, your Physician and the Hospital or other Health Care Provider, and the Claims Administrator know whether or not the proposed health care services have been certified as Medically Necessary. The UM Company will usually respond to your treating Physician or other Health Care Provider **by telephone within 3 working days (but not later than 15 calendar days) after it receives the request and any required medical records and/or information**, and its determination will then be confirmed in writing.
- If your admission or service is determined not to be Medically Necessary, you and your Physician will be given recommendations for alternative treatment. You may also pursue an appeal. See the Claim Filing and Appeal Information chapter regarding appealing a UM determination.

Concurrent (Continued Stay) Review

How concurrent (continued stay) review works:

- When you are receiving medical services in a Hospital or other inpatient Health Care Facility, the UM Company will monitor your stay by contacting your Physician or other Health Care Providers to assure that continuation of medical services in the Health Care Facility is Medically Necessary, and to help coordinate your medical care with benefits available under the plan.
- Concurrent Review may include such services as coordinating Home Health Care or Durable Medical Equipment, assisting with discharge plans, determining the need for continued medical services; and/or, advising your Physician or other Health Care Providers of various options and alternatives for your medical care available under this plan.
- If at any point your stay or services are found to NOT be Medically Necessary and that care could be safely and effectively delivered in another environment, such as through Home Health or in another type of Health Care Facility, you and your Physician will be notified. This does not mean that you must leave the Hospital or stop receiving services, but if you choose to stay or continue services, all expenses incurred after the notification will be your responsibility. If it is determined that your Hospital stay or services were not Medically Necessary, no benefits will be paid on any related Hospital, medical or surgical expense.

Emergency Hospitalization

If an Emergency requires hospitalization, there may be no time to contact the UM Company before you are admitted. If this happens, the UM Company must be notified of the Hospital admission within two working days. You, your Physician, the Hospital, a family member or friend can make that phone call. This will enable the UM Company to assist with discharge plans, determining the need for continued medical services, and/or advising

your Physician or other Health Care Providers of the various recommendations, options and alternatives for your medical care.

Pregnancies

Pregnant women should notify the UM Company as soon as possible once they know they are pregnant. This helps to assure that the pregnant woman will receive adequate prenatal care, allow for planning for the upcoming delivery, and enable the plan to provide adequate educational material regarding pregnancy. It also enables the UM Company to work with the treating Physician to monitor for high risk pregnancy factors and to assist the pregnant woman in completing the steps to assure that plan benefits will be available for the newborn child.

Retrospective (Post-Service) Review

All claims for medical services or supplies that have not been reviewed under the Plan's Precertification or Concurrent Review may, at the option of the Administrative Office, be subject to retrospective review to determine if they are Medically Necessary. If the Administrative Office receives a determination from a UM Company or other designated medical review firm that services or supplies were not Medically Necessary, **no benefits will be provided by the Plan for those services or supplies.**

Case Management

How Case Management Works

The Plan will provide medical Case Management Services for the review of certain claims in order to ensure the quality of medical care and maximize benefits under the Plan. The Board of Trustees or its designated agent reserves the right to review alternate methods of medical care or treatment not otherwise listed as a covered service. The Board of Trustees reserves the right to require mandatory medical Case Management for certain claims.

Certain claims will be subject to pre-authorization and Case Management by the agent designated by the Board of Trustees. When determined appropriate by the agent designated by the Board of Trustees, treatment (including Mental Illness and Substance Abuse) will be required to be obtained in the Participant's state of residence. In the event the appropriate care cannot be received in the state of residence, the agent will determine where services will be provided.

In the event that the Participant does not comply with the mandatory Case Management recommendations for treatment, the Plan will have no obligation to pay or recognize any claims that are submitted for non-recommended services, medical care or treatment that are incurred with respect to the particular condition.

Appealing a UM Determination (Appeals Process)

You may request an appeal of any adverse review decision made during the Precertification, Concurrent Review, Retrospective Review, Case Management or second opinion review process described in this chapter. To appeal a denied claim/bill, see the Claim Filing and Appeal Information chapter of this document.

Failure to Follow Required Utilization Management Procedures (Very Important Information)

If you don't follow the Precertification Review, Concurrent (Continued Stay) Review, or Case Management procedures the Administrative Office will request that the UM Company perform a retrospective review to determine if the services performed or received were Medically Necessary.

- If services are retrospectively determined to be not Medically Necessary, **no Plan benefits will be payable for those services.**
- **A Participant who does not obtain Precertification for services will be required to pay an additional amount of $200.**
- **Failure to obtain Precertification for Gene Therapy services will result in non-payment of such services.**
- If the UM Company determines that the services were not Medically Necessary, all benefits will be denied.

- If a confinement extends beyond the number of days certified by the UM Company, the Plan will not provide any benefits for the unapproved days.

Note that the failure to precertify does not apply to failure to timely notify the UM Company of an Emergency admission or an admission for delivery of a baby.

The difference between the amount you would be responsible for paying based on the benefits that would be payable if the review procedure had been followed and the actual benefits payable because the review procedure was not followed will not count toward the Plan's Deductible, Annual Coinsurance maximum, or Annual Out-of-Pocket Maximum.

MEDICAL PLAN EXCLUSIONS

The following is a list of services and supplies or expenses **not covered (excluded) by the Medical Plan**. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. General Exclusions are listed first followed by specific medically related plan exclusion.

General Exclusions (applicable to all medical services and supplies)

- **Concierge/retainer agreements and/or membership fees** or any other type of Health Care Practitioner agreement that requires payment before services are rendered.
- **Medicare:** Any charges incurred through Medicare private contracting arrangements.
- **Costs of Reports, Bills, etc.:** Expenses for preparing forms, medical/dental reports/records or itemized bills.
- **Educational Services:** expenses for learning deficiencies and special education whether or not related to a manifest mental disorder or even if they are required because of an Injury, Illness or Disability of a Participant. The following expenses are not payable by the Plan: educational services, educational materials, supplies or equipment, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, vision therapy except as specifically provided, auditory or speech aids/synthesizers, auxiliary aids such as communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with sign language education for a patient or family members, and implantable medical identification/tracking devices.
- **Expenses Exceeding Allowed Charges:** Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Allowed Charge as defined in the Definitions chapter.
- **Expenses for Which a Third Party Is Responsible:** Expenses for services or supplies for which a third party is required to pay are not covered. See the provisions relating to Third Party Liability in the chapter on Coordination of Benefits in this document. If, with respect to an accidental bodily Injury or sickness, a Participant is entitled, or could have been entitled if proper application had been made, to any medical benefits paid by, reimbursed by or provided by or under the authority of any government or any governmental agency, that benefit will discharge the obligation of this Plan as though and to the extent the benefit had been paid by this Plan, but no claim will be denied solely because treatment or services are rendered in a Hospital owned or operated by a State or a political subdivision.
- **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the Participant became covered under the Plan; or after the date the patient's coverage ends, except under those conditions described in the COBRA chapter of this document.
- **Experimental and/or Investigational Services:** Expenses for any medical services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational as defined in the Definitions chapter of this document.
- **Military service related Injury/Illness**: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related Illness or Injury, benefits are not payable by the Plan.
- **Illegal Act**: Expenses charged for treatment of accidental bodily Injury or sickness resulting from or occurring during the commission of a crime by the Participant unless such Injury or Illness is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor. The Board of Trustee's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Plan Participant (including, without limitation, acquittal, or failure to prosecute) in connection with the acts involved.
- **Medically Unnecessary Services:** Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary as defined in the Definitions chapter of this document, except for certain wellness benefits as outlined in the Schedule of Medical Benefits.

- **Modifications of Homes:** Including but not limited to humidifiers, air conditioners, exercise equipment, whirlpools, health spa or club, or swimming, whether or not prescribed by a Physician.
- **No-Cost Services:** Charges the Participant is not obligated to pay, is not billed or would not have been billed except for the fact that the person was covered under this Plan, unless care is rendered in a Veterans Administration Hospital for a non-military service connected Disability.
- **Non-Emergency Travel and Related Expenses:** Expenses for and related to non-emergency travel or transportation (including lodging, meals, airfare, and related expenses) of a Health Care Provider, Covered Individual or family member of a Covered Individual unless those travel expenses are related to a plan approved Transplant as outlined under Transplantation in the Schedule of Medical Benefits.
- **Occupational Illness, Injury or Conditions Subject to Workers' Compensation**: All expenses incurred for or in connection with any accidental bodily Injury or sickness resulting from and arising out of or occurring in the course of any employment or occupation for wages, compensation or profit.
- **Personal Comfort Items:** Expenses for patient convenience, including, but not limited to, care of family members while the Plan Participant is confined to a Hospital or other Health Care Facility or to bed at home, guest meals, television, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.
- **Relatives Providing Services:** Expenses for services provided by any Physician or other Health Care Practitioner who is the parent, Spouse or Civil Union Partner, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee.
- **Medical Students or Interns:** Expenses for the services of a medical student or intern.
- **Stand-By Physicians or Health Care Practitioners:** Expenses for any Physician or other Health Care Provider who did not directly provide or supervise medical services to the patient, even if the Physician or Health Care Practitioner was available to do so on a stand-by basis.
- **Services Provided Outside the United States:** Expenses incurred outside of the United States or U.S. territories, except when a Participant is a resident of the United States and is traveling outside of the United States or U.S. territories for vacation, business or schooling.
- **Failure to Comply with the mandatory Case Management recommendations**: In the event the Participant does not comply with the mandatory Case Management recommendations for treatment, the Plan will have no obligation to pay or recognize any claims that are submitted for non-recommended services.
- **Telephone Calls:** Telephone consultations are not covered.
- **War or Similar Event:** Charges for treatment of accidental bodily Injury or sickness resulting from any act of war, armed invasion or aggression, except as required by law. This includes any accidental bodily Injury or sickness resulting from any release of nuclear energy, except only when being used solely for medical treatment of a sickness or bodily Injury of the Participant under direction and prescription of a Physician.
- **Self-Inflicted Injury or Attempted Suicide:** Expenses incurred by any Plan Participant arising from an attempt at suicide or from a self-inflicted Injury or Illness, including complications thereof, unless the attempt arises as a result of a physical or mental health condition.
- **Expenses related to complications of a non-covered service.**
- **Surcharges:** Any surcharge fees resulting from state laws (e.g. New York Health Care Reform Act).
- **Expenses for milieu therapy or recreational therapy**.
- **Expenses for non-routine services and supplies associated with a clinical trial**, such as: (1) the investigational items, drugs, devices, or services themselves; (2) items, drugs, devices or services that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, drugs, devices or services inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

Exclusions Applicable to Specific Medical Services and Supplies

A. Allergy/Alternative/Complementary Health Care Services Exclusions

1. Expenses for acupuncture and/or acupressure.
2. Expenses for chelation therapy.

B. Corrective Appliances, Durable Medical Equipment and Nondurable Supplies Exclusions

1. Monitoring devices and other similar devices, other than pacemakers, which can be permanently implanted.
2. Cold therapy machines.
3. Expenses for replacement of lost, missing, or stolen, duplicate or personalized Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment.
4. Expenses for Corrective Appliances and Durable Medical Equipment to the extent they exceed the cost of standard models of such appliances or equipment.
5. Expenses for Nondurable Supplies, except as payable under Nondurable Supplies in the Schedule of Medical Benefits.

C. Cosmetic Services Exclusions

1. Cosmetic, plastic, Reconstructive Surgery (except plastic, Cosmetic or Reconstructive Surgery due to a mastectomy described in the Summary of Benefits or breast reduction Surgery in accordance with the guidelines adopted by the Board of Trustees) for developmental malformations, or as a result of earlier Cosmetic, plastic or Reconstructive Surgery, unless the Surgery is necessary for the repair or alleviation of damage resulting from a Disability caused by bodily injuries sustained by a Participant; or the Surgery is necessary because of congenital defects and birth abnormalities of a Dependent Child (Cosmetic includes, but is not limited to, wrinkles, acne, loss of hair, skin treatment, etc.).

D. Custodial Care Exclusions

1. Custodial Care, medical care or treatment and services or supplies for which charges are made by a nursing home, rest home, convalescent home, or similar establishment.
2. Regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, sitter/companion service.

E. Dental Services Exclusions

1. Any non-accidental treatment or services rendered in connection with disturbances of the Temporomandibular Joint (TMJ dysfunction/pain syndrome).
2. Medical benefits for dental services and supplies, unless for treatment of accidental injuries and damage to teeth if the damage results from an Accident and the charges are incurred within one (1) year from the date of the Accident.
3. Oral cancer screening services/products such as ViziLite, oral brush biopsy.

F. Drugs, Medicines and Nutrition Exclusions

Prescription Drug Benefits are not payable for:

1. Drugs or medications procured or procurable without a Physician's written prescription (over-the-counter);
2. Condoms;
3. Immunization agents, blood or blood plasma;
4. Dermatologicals, hair growth stimulants, Cosmetic hair removal products, anti-wrinkle agents;
5. Therapeutic devices, or appliances, including needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically covered in this booklet;
6. Drugs labeled: "Caution - limited by federal law to investigation use," or Experimental drugs, even though a charge is made to the Participant. Drugs not yet approved by the Food and Drug Administration (FDA) are not covered. New FDA-approved drugs will be covered unless the Plan states otherwise or the class of drug is excluded. See the definition of “Experimental and Investigational” in the Definitions chapter of this booklet;
7. Charges for the administration or injection of any drug;
8. Medication which is to be taken by or administered to the Participant, in whole or in part, while confined on an inpatient or outpatient basis in any facility or institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
9. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the original order of a Physician;
10. Prescription drugs which may be properly received without charge under local, state, or federal programs including Worker's Compensation;
11. Infertility medications;

12. Anorectics (any drug used for the purpose of weight loss);
13. Dietary supplements, except as prescription formulas for individuals that have inherited enzymatic disorders or otherwise covered under the section titled “Medical Foods”;
14. Smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms (e.g. Nicorette, Nicoderm, etc.) if not prescribed by an In-Network Health Care Provider;
15. Tretinoin, all dosage forms (e.g. Retin-A), regardless of intended use;
16. Non-legend drugs other than specifically described in the Summary of Benefits in the row titled “Drugs (Outpatient Prescription Medications)”;
17. Impotence medications;
18. Insulin pumps and blood glucose testing monitors.

G. Durable Medical Equipment Exclusions

See the Exclusions related to Corrective Appliances and DME.

H. Fertility and Infertility Services Exclusions

1. Expenses incurred for the medical or surgical treatment of infertility, or to reverse surgically induced infertility, in-vitro fertilization, sexual impotency, Genetic Counseling except as otherwise outlined in the Summary of Benefits.
2. Elective abortions are not covered except where life of the mother is endangered if the fetus is carried to full term or where medical complications arise from an abortion.

I. Foot Care/Hand Care Exclusions

1. Orthopedic shoes, or supportive devices for the feet, such as arch supports, heel lifts, orthotics, etc. except as otherwise provided in the row titled "Corrective Appliances" in the Summary of Benefits.
2. Callus or corn paring, toenail trimming or excision for toenail trimming, treatment of chronic conditions of the foot (such as weak or fallen arches) flat or pronated foot metatarsalgia, or foot strain.

J. Genetic Testing and Counseling Exclusions

1. The following expenses for genetic tests are not covered, including obtaining a specimen and laboratory analysis to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics. (Certain genetic tests are covered as listed as payable in the Genetic Testing row in the Schedule of Medical Benefits.) Genetic services that are not covered include:
   a. Pre-parental genetic testing (also called carrier testing) intended to determine if an individual (such as a prospective parent) is at risk of passing on a particular genetic mutation (at risk for producing affected children);
   b. Expenses for Pre-implantation Genetic Diagnosis (PGD) where one or more cells are removed from an embryo and genetically analyzed to determine if it is normal in connection with in vitro fertilization;
   c. No coverage of genetic testing of Plan Participants if the testing is performed primarily for the medical management of family members who are not covered under this Plan. Genetic testing costs may be covered for a non-covered family member only if such testing would directly impact the Medically Necessary treatment of a Plan Participant;
   d. Home genetic testing kits/services are not covered.
   e. Genetic testing determined by the Plan Administrator or its designee to be not Medically Necessary or is determined to be Experimental or Investigational.
2. Genetic Counseling: Expenses for Genetic Counseling are not covered, unless these three conditions are met: a) is ordered by a Physician, and b) performed by a qualified Healthcare Provider and c) performed with regard to a genetic test that is payable by this Plan.

K. Hair Exclusions

1. Expenses for and related to wigs or artificial hairpieces (except for alopecia resulting from chemotherapy and radiology up to a maximum $500 per member per Calendar Year).

L. Home Health Care Exclusions

1. A masseur, physical culturist or physical education instructor;
2. Routine housekeeping chores, which are not necessary to prevent or postpone the Participant's hospitalization, or similar services which would materially increase the amount of time required for the visit unnecessarily;

3. Any services rendered to the Participant which could have been provided by any other properly trained person of the household without endangering the Participant's life or seriously impairing his/her condition; or
4. Any service or supply that would be excluded if the Participant were confined as an inpatient in a Hospital or Skilled Nursing Facility.

M. Maternity/Family Planning/Contraceptive Exclusions

1. Contraception: Expenses related to non-FDA approved contraceptive drugs and devices such as condoms.
2. Termination of Pregnancy: Expenses for elective induced abortion unless the attending Physician certifies that the health of the woman would be endangered if the fetus were carried to term or medical complications arise from an abortion.
3. Expenses for Lamaze classes.

N. Mental Health and Substance Abuse Exclusions

1. Drug testing required by an Employer for employment.
2. Court ordered treatment (as a result of contact with the criminal justice or legal system) unless such treatment is Medically Necessary and otherwise covered by the Plan.
3. Marital or family counseling.

O. Miscellaneous Services

1. Non-surgical treatment of hemorrhoids.
2. Massage therapy, self-help and stress management, and exercise stress testing.
3. Expenses related to the treatment of intractable pain due to a cause which cannot be removed and which, in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to evaluation by the attending Physician and one or more Physicians specializing in the treatment of the area, system or organ of the body perceived as the source of the pain.
4. Expenses for services, treatments, supplies or accommodations directly or indirectly related to treatment of growth hormone deficiency.

P. Nursing Care Exclusions

1. Private duty nursing care, medical care or treatment, performance of surgical procedures, or therapies when those services are rendered by a nurse, Physician, or therapist that ordinarily resides in the Participant's home or who is a member of the Participant's immediate family.

Q. Preventive Care for Children, for Men and for Women (including pregnant women) Exclusions

1. Out-of-Network preventive care services are not covered. If there is not an In-Network provider who can provide the covered preventive care service, then the Plan will cover the service when performed by an Out-of-Network provider without cost sharing.

R. Rehabilitation Therapy Exclusions (Inpatient or Outpatient)

1. Expenses for educational, vocational rehabilitation.
2. Massage therapy, self-help and stress management, and exercise stress testing.
3. Occupational Therapy which retrains an individual for a job or career.
4. Occupational Therapy, Physical Therapy (including aquatic Physical Therapy) or Speech Therapy services to maintain function at the level to which it has been restored, or when no further significant practical improvement can be expected.
5. Physical Therapy (including aquatic Physical Therapy) and Occupational Therapy which are prescribed by a Physician in lieu of non-medical treatment (e.g. exercise).
6. Cold therapy machines.

S. Sexual/Erectile Dysfunction Services Exclusions

1. Sex Change Counseling, Therapy and Surgery: Expenses for medical, surgical or prescription drug treatment related to transsexual/gender reassignment (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures.
2. Implantable and/or inflatable prosthesis for augmentation or impotence.
3. Expenses for medical or surgical treatment of sexual impotency.

T. Transplant (Organ and Tissue) Exclusions

1. Expenses for human organ and/or tissue Transplants that are Experimental and/or Investigational, including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, Transplants, postoperative services and drugs/medicines and all complications thereof, except those Transplant Services and their complications that are listed as payable under Transplantation in the Schedule of Medical Benefits.
2. Expenses related to non-human (Xenografted) organ and/or tissue Transplants or implants, except heart valves.
3. Expenses for insertion and maintenance of an artificial heart or other organ or related device including complications thereof. This does not include heart valves, kidney dialysis , and a ventricular assist device (VAD) (that is a mechanical pump used to assist a damaged or weakened heart in pumping blood) when used as a bridge to a heart Transplant or for support of blood circulation post-cardiotomy (following open-heart Surgery), or for destination therapy (permanent mechanical cardiac support only if there is approval from the FDA for that purpose, and the device is used according to the FDA-approved labeling instructions).
4. For Participants who serve as a donor, donor expenses are not payable unless the person who receives the donated organ/tissue is a person covered by this Plan.

U. Vision Care Exclusions

1. Any charges in connection with radial keratotomy.
2. Expenses for diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting and repair of eyeglasses or lenses and associated supplies except as provided by the Vision Plan.
3. Vision therapy (orthoptics) and supplies, except as specifically provided in the row titled “Vision Therapy” in the Summary of Benefits.

V. Weight Management and Physical Fitness Exclusions

1. Weight loss or physical fitness programs or treatment for obesity (including surgical treatments such as intestinal bypass and gastric stapling), except for the medical treatment of obesity as specifically outlined in the Schedule of Benefits. This exclusion does not include preventive screening for obesity and intensive counseling and behavioral interventions to promote sustained weight loss as required under the Affordable Care Act.
2. Expenses for surgical treatment of obesity (bariatric Surgery) using malabsorptive procedures, Bilroth II type of anastomosis (known as a “mini gastric bypass”), minimally invasive endoluminal gastric bypass (such as the use of EndoGastric Stomaphyx or endoscopic sleeve gastroplasty), laparoscopic gastric plication, balloon systems, vagus (or vagal) nerve blocking devices, and endoscopically placed percutaneous aspiration tubes.
3. Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment, or weight training services.

DENTAL BENEFITS (OPTIONAL BY EMPLOYER)

Overview of Dental Plan Options

The dental benefits are optional at the discretion of the Employer and are considered excepted benefits under the Affordable Care Act. If your Employer offers dental benefits, you may have a choice between the Delta Dental plan option (fully insured) and the Alpha Dental plan option (discount plan).

Details about dental benefits, cost-sharing, exclusions and limitations are described in the benefit booklets provided to Plan Participants by the dental plan claims administrator, whose contact information is shown below and in the Quick Reference chart of this document. Where the information in this chapter deviates from the certificate of coverage and summary of benefits produced by the dental plan companies, the dental plan company's documents will prevail.

Contact the dental plan companies for a copy of the complete benefit information.

Benefit Type	Claims Administrator Type of Administration	Source of Benefits and Type of Funding
Delta Dental (optional)	Insurance Administration Delta Dental of Colorado P.O. Box 173803 Denver, CO 80217-3803 303-741-9305 or 1-800-610-0201	Fully Insured
Alpha Dental (optional)	Insurance Administration Beta Health Association, Inc. Carrara Place 6200 South Syracuse Way Suite 460 Greenwood Village, CO 80111 (303) 744-3007 or 1-800-807-0706	Discount Plan

Please note that because the dental coverage options are considered excepted benefits, they are not subject to the requirements of the Affordable Care Act. This means that Calendar Year and lifetime maximums may apply and dependent eligibility rules may differ for dental benefits (e.g. a Dependent Child's dental coverage may terminate upon reaching age 19 rather than 26).

DELTA DENTAL PLAN (OPTIONAL BY EMPLOYER)

Premier Dentist

A Premier dentist means a dentist who is licensed to practice and who has signed an agreement with the Delta Dental Plan. Over 100,000 dentists, or 2 out of 3 dentists nationwide are Premier dentists. Under the terms of a signed agreement with the Delta Dental Plan, Premier dentists agree to render dental care to eligible patients according to requirements established by the Board of Trustees of the Delta Dental Plan Insurance company. Premier dentists agree to:

- Submit claim forms for their patients;
- Accept direct payment from Delta Dental Plan Insurance company;
- May only charge the patient for the portion of the treatment that is not covered by the Delta Dental Plan, i.e., the Deductible and/or any Coinsurance; and
- File a listing of their usual fees, on a confidential basis.

Dental Benefits, Services, and Exclusions

Details about cost-sharing for diagnostic and preventive dental services covered by the Delta Dental Plan are described in the benefit booklets provided to Plan Participants by Delta Dental. The benefit booklets describe the types of benefits, scope of coverage, prerequisites to being covered, limitations and exclusions, and other details regarding the benefits not described within this chapter.

ALPHA DENTAL BENEFITS (OPTIONAL BY EMPLOYER)

Overview of Alpha Dental Plan

This dental program is in no way to be considered insurance. It is a discount fee-for-service dental plan. Fees are subject to change on an as needed basis. Please contact Beta Health at 1-(800) 807-0706 for current fees.

Dental Benefits, Services, and Exclusions

Details about cost-sharing for diagnostic and preventive dental services covered by the Alpha Dental Plan are described in the benefit booklets provided to Plan Participants by Alpha Dental. The benefit booklets describe the types of benefits, scope of coverage, prerequisites to being covered, limitations and exclusions, and other details regarding the benefits not described within this chapter.

How to use the Alpha Dental Plan

You may visit any dentist of your choice. If your dentist is a PPO dentist, the claim form for benefits will be filed by your dentist. You need to complete the top or patient section of the claim form and sign the form to indicate that you authorize release of the information to the Alpha Dental Plan.

The Alpha Dental Plan will not be obligated to pay claims submitted more than 18 months after the date the service was provided.

If the patient or Employee encounters any problems relative to fee differences, possible excessive charges, quality of care or refusal on the part of a PPO or Premier dentist to cooperate with the program, the Employee should write a detailed letter explaining the situation to the Alpha Dental Plan Insurance company at the contact information listed on the Quick Reference Chart. Prompt action can be expected if all the information is submitted in writing.

Benefit Payment

PPO Dentist

Patients must choose a PPO dentist to receive benefits. A PPO dentist is a dentist who is licensed to practice, has met the criteria for the program and has signed a special agreement with the Alpha Dental Plan Insurance company to participate in the PPO program. **There are no benefits for services received at a non-PPO dentist.**

Maximum Benefit

There are no annual or lifetime maximums on benefits under the Alpha Dental Plan.
Schedule of Alpha Dental Benefits

These fees are subject to change on an as needed basis, please contact the Alpha Health Plan at the contact information located in the Quick Reference Chart for a list of current fees and copayments.

The Alpha Dental Plan benefits are not subject to a deductible.

VISION PLAN (OPTIONAL BY EMPLOYER)

Overview of the Vision Plan

The Vision Plan benefits considered excepted benefits under the Affordable Care Act. The Vision Plan is designed to provide for standard vision examinations and eyewear materials such as eyeglasses or contact lenses. The Vision Plan is also useful for individuals who have chronic diseases that can affect the eye such as diabetes, high blood pressure (hypertension), glaucoma, and cataracts.

Vision benefits are fully insured and administered by Davis Vision whose contact information is shown below and in the Quick Reference Chart in the front of this document.

Benefit Type	Claims Administrator Type of Administration	Source of Benefits and Type of Funding
Vision (optional)	Contract Administration Davis Vision P.O. Box 1525 Latham, NY 12110 (877) 923-2347 (Client Code 8975)	Fully Insured

Vision Benefits, Services, and Exclusions

Details about cost-sharing for vision benefits covered by the Vision Plan are described in the benefit booklets provided to Plan Participants by the Davis Vision. The benefit booklets describe the types of benefits, scope of coverage, prerequisites to being covered, limitations and exclusions, and other details regarding the benefits not described within this chapter.

Services from a Davis Vision Provider

When a Participant selects a Davis Vision Provider, the Vision Plan covers a vision examination, and materials (eyeglasses or contact lenses) for a Copay (and subject to any limitations outlined in this section). In addition, low vision therapy is covered subject to the limitations below. Any additional care, service and/or materials not covered by Davis Vision may be arranged between the Participant and the Provider.

Services from a Non-Network Provider

The Participant may receive covered services from any optometrist, ophthalmologist and/or dispensing optician who is not a Davis Vision Provider. He or she will be responsible for paying the provider and then submitting an itemized statement of the charges to Davis Vision, whose contact information is listed on the Quick Reference Chart for reimbursement.

To receive reimbursement for Non-Network provider benefits, the Participant must send a copy of the provider's itemized statement of charges (i.e., invoice) to Davis Vision along with a signed form indicating the patient's name, the Employee's name, the Employee's social security number and the name of your plan (CHT).

Please note that benefits obtained from a Non-Network provider are in lieu of obtaining them from a Davis Vision Provider and are subject to the same Benefit Periods.

How to Obtain Benefits

Vision Care

A Participant may call any Davis Vision Provider to make an appointment. If you need assistance locating a Davis Vision provider call Davis Vision at (877) 923-2347 (Client Code 8975) or log on to the Davis Vision website at www.davisvisioncom and use the “Find a doctor” feature. Please indicate that you have vision coverage through Davis Vision and provide the Employee's name and social security number or the Davis Vision member identification number as well as the name and date of birth of the person needing services. The Davis Vision Provider will contact Davis Vision before the appointment to verify eligibility and Plan coverage. The Davis Vision Provider will also obtain authorization from Davis Vision for services and materials.

Direct Payment To The Davis Vision Provider

When you go for your visit, pay the Davis Vision Provider your Copayment and charges for any costs not covered. Davis Vision will pay the provider directly for the balance of the charges. The Davis Vision Provider will submit a claim to Davis Vision. The provider will be paid directly, according to their agreement with Davis Vision. Naturally, if you seek additional or more expensive services than those provided, the arrangement for the added cost or fee is between you and the provider.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT

Overview of the Life Insurance and Accidental Death and Dismemberment Coverage

This section outlines the fully insured Life Insurance and Accidental Death and Dismemberment (AD&D) coverage; however, where this chapter deviates from the certificate of coverage and summary of benefits produced by the Life Insurance company, the insurance company documents will prevail. Contact the Life Insurance company (whose name is listed on the Quick Reference Chart in the front of this document) for a copy of the Certificate of Coverage.

Please note, you may have to satisfy a waiting period before you are eligible for these benefits. See the Certificate of Coverage or contact the Administrative Office for more information.

Schedule of Benefits

The following is a brief summary of the Life Insurance and AD&D coverage (subject to an age reduction schedule):

SCHEDULE OF BENEFITS	
Employee Life Insurance Benefit	
• All eligible Employees • Accelerated Death Benefit may be available	$10,000
Employee Accidental Death & Dismemberment, issued on a 24 hour basis	$10,000
Dependent Life Insurance	
Spouse or Civil Union Partner	$ 3,000
Child (14 days of age up to age 19 (age 24 if a fulltime student)	$ 1,000

For more information on the age reduction schedule, see the Certificate of Coverage or contact the Administrative Office.

Beneficiary for Life Insurance

The Beneficiary will be the person(s) named in writing to receive any amount of insurance payable due to a death.

The Participant may name or change a Beneficiary by giving written notice to the Life Insurance company listed on the Quick Reference Chart. The change will be effective on the date made, subject to any payment the Life Insurance company may have made before it is received.

If the Participant names more than one Beneficiary, those who survive will share equally unless specified otherwise. If there is no named Beneficiary living at the time of the Participant's death, the Life Insurance company will pay any amount due in the following order:

- To his legal Spouse or Civil Union Partner; or
- To his natural or legally adopted children in equal shares; or
- To his estate.

The Dependent Life Insurance Benefit will be paid to:

- The Participant, if living; or
- The legal Spouse or Civil Union Partner of the Participant, if the Participant is not living; or
- The estate of the Dependent, if the legal Spouse or Civil Union Partner of the Participant is not living.

Notice of Claim for Life Insurance

Written notice of a claim for death must be provided by the Beneficiary within 30 days of the date of death. If it is not possible, written notice must be given as soon as it is reasonably possible to do so.

The claim form is available from the Contributing Employer or the Administrative Office. It can also be requested from the Life Insurance company listed on the Quick Reference Chart. Written proof must show the cause of death. Also, a certified copy of the death certificate must be provided.

Accidental Death and Dismemberment

If the Employee suffers a loss described below, the Life Insurance company will pay the amount of insurance that applies. The Employee (or Beneficiary) must give proof to the Life Insurance company that:

- Injury, as defined in the Certificate of Coverage, occurred while the insurance was in force under this section;
- Loss occurred within 90 days after the Injury, as defined in the Certificate of Coverage; and
- Loss was due to Injury, as defined in the Certificate of Coverage, independent of all other causes.

The full benefit amount is listed in the chart above.

For:	The Benefit Amount is:
Loss of life	100% of the full benefit amount
Loss of both hands or both feet	100% of the full benefit amount
Loss of sight of both eyes	100% of the full benefit amount
Loss of one hand and sight of one eye	100% of the full benefit amount
Loss of one foot and sight of one eye	100% of the full benefit amount
Quadriplegia	100% of the full benefit amount
Paraplegia	50% of the full benefit amount
Hemiplegia	50% of the full benefit amount
Loss of one hand	50% of the full benefit amount
Loss of one foot	50% of the full benefit amount
Loss of sight of one eye	50% of the full benefit amount
Loss of speech	25% of the full benefit amount
Loss of hearing	25% of the full benefit amount

Exclusions applicable to the AD&D Benefit

The Life Insurance company will not pay a benefit for a loss caused directly or indirectly by:

- Disease, bodily or mental infirmity, or medical or surgical treatment of these;
- Suicide or intentionally self-inflicted Injury, as defined in the Certificate of Coverage, while sane or insane;
- Participation in a riot or insurrection, or commission of an assault or felony;
- War or any act of war, declared or undeclared;
- Use of any drug, hallucinogen, controlled substance, or narcotic unless prescribed by a Physician;

- Driving while intoxicated, as defined by the applicable state law where the loss occurred;
- Engaging in the following hazardous activities, including skydiving, hang gliding, auto racing, mountain climbing, Russian Roulette, autoerotic asphyxiation or bungee jumping;
- Injury, as defined in the Certificate of Coverage, arising out of or in the course of any occupation or employment for pay or profit, or any Injury or Sickness, as defined in the Certificate of Coverage, for which the Covered Person is entitled to benefits under any Workers Compensation Law, Employers Liability Law or similar law, unless this insurance is issued on an 24 hour basis as shown in the Schedule of Benefits; or
- Travel or flight in, or descent from any aircraft, unless as a fare-paying passenger on a commercial airline flying between established airports on: a) a scheduled route; or b) a charter flight seating 15 or more people.

Notice of Claim for Accidental Death and Dismemberment

Written notice of a claim for death or Injury, as defined in the Certificate of Coverage, must be provided by the Participant or Beneficiary within 30 days of the date of death or the date of Injury, as defined in the Certificate of Coverage. If it is not possible, written notice must be given as soon as it is reasonably possible to do so.

The claim form is available from the Contributing Employer or the Administrative Office. It can also be requested from the Life Insurance company listed on the Quick Reference Chart. Written proof should establish facts about the claim, such as date of occurrence, nature, and extent of the loss involved.

Termination of Coverage

Please see the Certificate of Coverage or contact the Administrative Office for more information on when your or your Dependent's coverage will terminate, including when ceasing to be Actively at Work may affect your coverage.

CLAIM FILING AND APPEAL INFORMATION

How Benefits are Paid

1. Plan benefits are considered for payment on the receipt of a **written** proof of claim (that includes the social security number), commonly called a bill. Generally, Health Care Providers send their bill to the Claims Administrator directly. Plan benefits for eligible service performed by Health Care or Dental Care Providers will then be paid directly to the provider delivering the services. When Deductibles, Coinsurance or Copay apply, you are responsible for paying your share of these charges.
2. If a health care or dental care provider does not submit their claim directly to the Claim Administrator and instead sends the bill to you, you should follow the steps outlined below in this chapter regarding How to File a Claim. If at the time you submit your claim, you furnish evidence acceptable to the Plan Administrator or its designee that you or your covered dependent paid some or all of those charges, Plan benefits will be paid to you up to the amount allowed by the Plan for those services. In all instances, when Deductibles, Coinsurance or Copayments apply, you are responsible for paying your share of the charges.
3. **For claims incurred outside the U.S. (foreign claims)**, in most cases you will have to pay the provider at the time of service. Then at a later date you can submit the foreign claim and your proof of payment to this Plan for consideration of reimbursement in accordance with Plan rules outlined in this document.

WHEN YOU MUST REPAY PLAN BENEFITS: If it is found that the Plan benefits paid by the Plan are too much because:

1. Some or all of the medical or dental expenses were not paid or payable by you or your covered Dependent; **or**
2. You or your covered Dependent received money to pay some or all of those expenses from a source other than the Plan; **or**
3. You or your covered Dependent achieve any recovery whatsoever, through a legal action or settlement in connection with any sickness or Injury alleged to have been caused by a third party, regardless of whether or not some or all of the amount recovered was specifically for the expenses for which Plan benefits were paid; or
4. The Plan erroneously paid benefits to which you were not entitled under the terms and provisions of the Plan, or
5. The Plan erroneously paid benefits because of false information entered on your enrollment card, claim form or required documentation;
6. Then, the Plan will be entitled to
   - a refund from you or your Health Care Provider for the difference between the amount paid by the Plan for those expenses and the amount of Plan benefits that should have been paid by the Plan for those expenses based on the actual facts;
   - offset future benefits if necessary in order to recover such expenses;
   - its attorney's fees, costs and expenses incurred in recovering monies that were wrongfully paid.

TIME LIMIT FOR INITIAL FILING OF HEALTH CLAIMS
All claims must be submitted to the Plan within ONE YEAR from the date of service.
No Plan benefits will be paid for any claim submitted after this period.

HOW TO FILE A CLAIM FOR PROVIDERS WHO DO NOT BILL THE PLAN DIRECTLY

Most providers will send their bill directly to the Claims Administrator. However, for those providers who do not bill the Plan directly, you may be sent a bill. In that case, follow these steps.

Where to Get Claim Forms: Obtain a claim form from the Administrative Office (see the Quick Reference Chart in the front of this document for details on the address.). Please note that you need to complete a claim form once a year for your family and send it to the Administrative Office.

Where to Send the Claim Form

Send the completed claim form, the bill you received (you keep a copy too) and any other required information to the Administrative Office (or insurance company) whose address is listed on the Quick Reference Chart in the front of this document.

Explanation of Benefits (EOB)

When a claim is processed by the Administrative Office you will be sent a form called an Explanation of Benefits or EOB. The EOB describes how the claim was processed, such as Allowed Amounts, amounts applied to your Deductible, if your Out-of-Pocket Maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, how to appeal a claim, etc.

APPEAL OF CLAIMS DENIED IN WHOLE OR IN PART

- Claims covered by the procedures in this chapter include those claims filed and appeals related to the self-funded Medical Plan(s) (including the Prescription Drug Program and Behavioral Health Program).
- For claims administration and appeals under the insured Davis Vision Plan, Alpha Dental Plan, Delta Dental Plan and Life Insurance and AD&D plan, refer to the official documents and Certificate of Coverages of these insurance companies for details. Claim administration and appeal procedures for the insured plans are not described in this chapter.

If your claim for benefits under the Plan is denied in whole or in part, you have a right to appeal the claim denial. The time for making an initial decision on a claim and the time to appeal a claim decision, depends upon the type of claim.

Definitions

Adverse Benefit Determination. An adverse benefit determination is defined as:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including any such denial, reduction, termination or failure to provide or make a payment that is based on:
  - * A determination of an individual's eligibility to participate in the Plan, or
  - * A determination that a benefit is not a covered benefit, or
- A reduction in a benefit resulting from the application of any utilization review decision, network exclusion of providers or services or other limitation on otherwise covered benefits or a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.
- A rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time,

Adverse Appeal Determination. An adverse appeal determination is defined as a determination of an appeal in which the underlying Adverse Benefit Determination is upheld.

Claim for Benefits. Except for certain urgent claims, any claim for benefits under the Plan must be in writing and made to the Claims Administrator. For urgent claims, you can designate a health care professional or use any expeditious method including fax, phone or electronic means to make an urgent claim or an appeal of any urgent claim denial. If the Claims Administrator receives a communication from a Participant that does not fit the Plan's definition of a claim, but includes the claimant's name, condition and the specific treatment for which approval is requested, the Plan must notify the claimant (within five days for a non-urgent pre-service claim, 24 hours for urgent claim) that the claim was not properly filed, and explain the procedures that need to be followed.

Claims Administrator. The various organizations under contract to the Plan to perform claims adjudication services to administer health claims and/or claim appeals. "Claims Adjudication" refers to the determination of the Plan's payment or financial responsibility, after the Plan Participant's benefits are applied to a claim.

Claims are adjudicated by several different claims administrators depending on which type of benefit is being sought. The organizations that administer each type of health claim (the Appropriate Claims Administrator) are outlined in the chart under the heading "Source of Financing and Type of Administration of the Plan" beginning on page 145.

Concurrent Claims. A concurrent claim is a claim that is reconsidered after an initial approval was made and results in a reduced or terminated benefit. The Plan Administrator must notify a claimant of a reconsideration as soon as possible, but early enough to allow the claimant to have an appeal decided before the benefit is reduced or terminated. For approved Urgent Care treatment, a request to extend treatment must be acted upon by the Plan Administrator within 24 hours after receipt of the claim.

Independent Review Organization or IRO: Means an entity that conducts independent external reviews of adverse benefit determinations in accordance with the Plan's external review provisions and current federal external review regulations.

Pre-Service Claims. Any claim for a benefit under the Plan for which the Plan requires approval before medical care is obtained is a pre-service claim. Even if a benefit requires preauthorization, the benefit cannot be denied for lack of approval under circumstances that would make obtaining such prior approval impossible, or where application of the prior approval process could seriously jeopardize the life or health of the claimant.

Post-Service Claims. A post-service claim is any claim for benefits under the Plan that is not a pre-service claim or a concurrent claim. A claim regarding Rescission of Coverage will be treated as a post service claim.

Rescission of Coverage. A cancellation of discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions. The Plan is permitted to rescind your coverage if you perform an act, practice or omission that constitutes fraud or you make an intentional misrepresentation of material fact that is prohibited by the terms of the Plan.

Urgent Claims. An urgent claim is a claim for medical care or treatment that, if normal pre-service standards are applied, would seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with the knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Summary of Claims and Appeals

The following chart provides a brief outline of the timelines that will be followed during the claims and appeals process:

Claims and Appeals Decision	Urgent Claims	Concurrent Claims	Pre-Service Claims	Post-Service Claims
What is the deadline for the Plan to make an initial claim determination?	72 hours from receipt of the claim	Before the benefit is reduced or treatment terminated	15 days from receipt of the claim	30 days from receipt of the claim
Are there any extensions permitted?	* No	No	Yes: One 15-day extension, if the Plan Administrator determines it is necessary due to matters beyond the control of the Plan and informs the claimant of the extension within the normal deadline	Yes: One 15-day extension, if the Plan Administrator determines it is necessary due to matters beyond the control of the Plan and informs the claimant of the extension within the normal deadline
How long does a Participant have to appeal after the initial claim determination?	180 days	180 days	180 days	180 days
What is the deadline for the Plan to make an appeal determination?	As soon as possible but not later than 72 hours from receipt of the appeal	Before the benefit is reduced or treatment terminated	30 days	60 days
Are there any extensions permitted?	No	No	No	No

Claims and Appeals Decision	Urgent Claims	Concurrent Claims	Pre-Service Claims	Post-Service Claims
Voluntary Level 2 Appeal request must be submitted to the Plan within:	N/A	N/A	N/A	180 days
The Plan will make a level 2 appeal determination:	N/A	N/A	N/A	Within the timeframe for Board meetings

* *Please note there is no formal extension for urgent claims but the law does allow that if a claimant files insufficient information the claimant will be allowed up to 48 hours to provide the information.*

Information Provided Upon Initial Denial

If your claim is denied in part or in whole, you will receive notice of the adverse determination that includes all of the following information:

- Sufficient information to identify the claim involved (including the date of service, the Health Care Provider, the claim amount (if applicable);
- A statement that upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review (when external review is applicable).
- The specific reason(s) for the denial, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the claim;
- The specific Plan provision(s) on which the determination is based;
- contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- A description of any additional information needed to perfect the claim and an explanation of why such added information is necessary;
- An explanation of the Plan's internal appeal procedure and external review processes (when external review is applicable) along with time limits and information regarding how to initiate an appeal;
- Contain a statement that you have the right to bring civil action under ERISA Section 502(a) after the appeal is completed;
- If the denial was based on an internal rule, guideline, protocol or similar criterion, a statement that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
- If the denial was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
- The availability of, and contact information for, any applicable health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist individuals with the internal claims and appeals and external review processes; and
- If the claim is an urgent claim, a description of the expedited appeal review process for urgent claims; and
- If required under applicable law, a non-English sentence detailing how a non-English speaker may obtain assistance in his or her non-English language.

Request for Internal Review - Appeal Procedure

In the event a claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may make a written request for an internal review, which is known as an "appeal." The time for appealing the denial of

a claim depends upon the type of claim. Please refer to the summary chart outlined above to determine the time applicable to your appeal.

This Plan maintains a one-level appeals process for preservice claims, Urgent Care claims, concurrent claims, eligibility claims, clinical post-service medical and mental health/Substance Abuse claims (claims that are denied based on Medical Necessity, clinical appropriateness, or whether services or supplies are Experimental/Investigative) and post-service prescription drug, dental, and vision claims.

The Plan maintains a voluntary second-level appeal process for administrative (non-clinical) post-service medical and mental health/Substance Use Disorder claims that are denied for reasons other than Medical Necessity, clinical appropriateness, or whether services or supplies are Experimental/Investigative.

Appeals must be submitted in writing to the Appropriate Claims Administrator whose contact information is listed in the chart under the heading "Source of Financing and Type of Administration of the Plan" beginning on page 145 in this document. You will be provided with:

- Upon request and without charge, reasonable access to and copies of the claim file, including all relevant documents, records and other information relevant to your claim for benefits.
- The opportunity to submit written comments, documents, records and other information, and to present testimony, relating to the claim for benefits, which will be considered during the Plan's review of the denial;
- A full and fair review that takes into account all comments, documents, records, testimony and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination.
- Automatically and free of charge, any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

  Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.
- If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity. A review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.

In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or not appropriate, the appropriate named fiduciary will:

* Consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
* Provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

The Plan will make a determination on the **appeal of:**

* An **urgent claim appeal** as soon as possible but no later than 72 hours after receipt of the appeal;
* A **concurrent claim appeal** as soon as possible but before the benefit is reduced or treatment is terminated;
* A **pre-service claim appeal** no later than 30 calendar days from receipt of the appeal; and
* A Level 1 **post-service claim appeal** no later than 60 calendar days from receipt of the appeal.
* A voluntary Level 2 **administrative (non-clinical) post-service medical or mental health/Substance Use Disorder claim appea**l:

- If a Level 2 appeal is filed with the Plan more than 30 days before the next Board meeting, the review will occur at the next Board meeting date.
- If a Level 2 appeal is filed with the Plan within 30 days of the next Board meeting, the Board review will occur no later than the second meeting following receipt of the appeal.
- If special circumstances (such as the need to hold a hearing) require a further extension of time, the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary, the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.
- After the Board makes their decision on the appeal, you will be notified of the benefit determination on the appeal no later than 5 calendar days after the benefit determination is made.

- There are no extensions permitted during the Level 1 appeal review process. You will be sent a written (or electronic, as appropriate) notice of the appeal determination.
- You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the appeal.
- Your appeal will be reviewed by a person other than the person who originally denied the claim who is not subordinate to the person who originally denied the claim. To ensure that the persons involved with adjudicating claims and appeals (such as claims adjudicators and medical experts) act independently and impartially, decisions related to the employment status of those persons (such as decisions related to hiring, compensation, promotion, retention, or termination) will not be made on the basis of whether that person is likely to support a denial of benefits.
- If the claim was denied due to Medical Necessity, Experimental treatment, or similar exclusion or limit, the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.
- You will receive a notice of the appeal determination. If that determination is adverse, it will include:
  * Sufficient information to identify the claim involved (including the date of service, the Health Care Provider, the claim amount (if applicable);
  * A statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided; however, a request for this information will not be treated as a request for an internal appeal or an external review.
  * The specific reason(s) for the adverse appeal review decision, 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, and a discussion of the decision;
  * A reference to the specific Plan provision(s) on which the determination is based;
  * A statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
  * A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
  * If the denial was based on an internal rule, guideline, protocol or similar criterion, a statement that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
  * If the denial was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
  * The statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."
  * A disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes;
  * An explanation of the voluntary 2nd level appeal process and external review process, <u>if applicable,</u> along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any and

* If required under applicable law, a non-English sentence detailing how a non-English speaker may obtain assistance in his or her non-English language.

- If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart) to find out if assistance is available.

This concludes the internal appeal process under this Plan.

Voluntary Appeal Option

This Plan offers an additional voluntary claim appeal option after the Level 1 claim appeal process is completed for administrative (non-clinical) post-service medical and mental health/Substance Use Disorder claims that are denied for reasons other than Medical Necessity, clinical appropriateness, or whether services or supplies are Experimental/Investigative. If your claim is eligible for an External Review, **you may proceed to External Review without undertaking this voluntary appeal option**. There is no charge for this voluntary appeal option. Note that this voluntary level of appeal has no effect on your right to any other benefits under the Plan. The voluntary appeal option is described as follows:

a. Submit your written request for the voluntary appeal to the Plan Administrator, whose contact information is listed on the Quick Reference Chart in this document, within 180 days of your receipt of the Level 1 non-clinical claim appeal determination. You should also submit written comments, documents, medical records and other information relating to the claim for benefits.

b. The Plan will make a determination on the voluntary appeal (without the opportunity for an extension) as soon as possible but no later than the Board of Trustee meeting timeline (described in the Request for Internal Review section above) after the Plan's receipt of the request for voluntary appeal.

c. You will be provided with a written notice of the Plan's determination on the voluntary appeal request within 5 days of the date of the Plan's determination on the voluntary appeal.

d. If the determination is adverse, the notice will list the specific reason(s) for the decision and reference the specific Plan provision(s) on which the denial is based.

Request for External Review of Claims

The external review process is intended to comply with the Affordable Care Act external review requirements.

If your appeal of a claim (whether pre-service, post-service or urgent claim) is denied for reasons of medical judgment, you may request further review by an Independent Review Organization ("IRO") as described below. In the normal course, you may only request external review after you have exhausted the internal review and Level 1 appeal process described above. External Review is available for the following claim denials:

- A denial that, in the IRO's determination, involves medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; the Plan's determination that a treatment is Experimental or Investigational; whether treatment by a specialist is appropriate, whether treatment involved "Emergency care" or "Urgent Care," affecting coverage or level of coverage, or the Plan's determination that a medical condition is subject to a Plan limitation.
- A denial that is due to a Rescission of Coverage (retroactive elimination of coverage), regardless of whether the Rescission of Coverage has any effect on any particular benefit at that time unless the Rescission of Coverage is due to a failure to pay premiums.

NOTE that external review is not available if a denial is due to your failure to meet the requirements for eligibility under the terms of the Plan, or is based on a contractual or legal determination, or is due to a failure to pay premiums causing a Rescission of Coverage.

External Review of Standard Claims

This voluntary External Review process is intended to comply with the Affordable Care Act external review requirements. Your request for external review of a standard (not urgent) claim must be made, in writing to the Appropriate Claims Administrator, within four (4) months of the date that you receive notice of an Adverse Benefit

Determination or Adverse Appeal Determination. For convenience, these determinations are referred to below as an "Adverse Determination," unless it is necessary to address them separately.

Because the Plan's internal review and appeals process generally must be exhausted before external review is available, in the normal course, external review of standard claims will only be available for Adverse Appeal Determinations.

Preliminary Review of Request for External Review

Within five (5) business days of the Appropriate Claim Administrator's receipt of your external review request for a standard claim, the Appropriate Claim Administrator will complete a preliminary review of the request to determine whether:

- You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
- The Adverse Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan, or to a denial that is based on a contractual or legal determination, or to a failure to pay premiums causing a Rescission of Coverage;
- You have exhausted the Plan's internal claims and Level 1 appeals process (except, in limited, exceptional circumstances); and
- You have provided all of the information and forms required to process an external review.

Within one (1) business day of completing its preliminary review, the Appropriate Claim Administrator will notify you in writing as to whether your application meets the threshold requirements for external review. If applicable, this notification will inform you:

- If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).
- If your request is not complete, in which case the notice will describe the information or materials needed to make the request complete, and allow you to perfect the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

External Review By Independent Review Organization

If the request is complete and eligible, the Appropriate Claim Administrator will assign the request to an IRO. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Appropriate Claim Administrator may rotate assignment among IROs with which it contracts.

Once the claim is assigned to an IRO, the following procedure will apply:

- The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, such information must be submitted within ten (10) business days).
- Within five (5) business days after the assignment to the IRO, the Appropriate Claim Administrator will provide the IRO with the documents and information it considered in making its Adverse Determination.
- If you submit additional information related to your claim, the assigned IRO must within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (without regard to the Plan's decision on the appeal) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's

requirements for benefits, including the Plan's standards for clinical review criteria, Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating Health Care Providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

- The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.
    - If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
    - If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).
- The assigned IRO's decision notice will contain:
    * A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the Health Care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial);
    * The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
    * References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
    * A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
    * A statement that the determination is binding except to the extent that other remedies may be available to you or the Plan under applicable State or Federal law;
    * A statement that judicial review may be available to you; and
    * Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

Expedited External Review of Claims

You may request an expedited external review if:

- You receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- You receive an Adverse Appeal Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive an Adverse Appeal Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency Services, but you have not yet been discharged from a facility.

Preliminary Review of Request for Expedited External Review

Immediately upon receipt of the request for expedited external review, the Appropriate Claim Administrator will complete a preliminary review of the request to determine whether the requirements for preliminary review set forth above are met. The Appropriate Claim Administrator will immediately notify you as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information described above.

Expedited External Review By Independent Review Organization

Upon a determination that a request is eligible for external review following the preliminary review of the request for the expedited review, the Appropriate Claim Administrator will assign an IRO. The Plan will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the assigned IRO must review the claim *de novo* (without regard to the Plan's decision on the appeal) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

After External Review

If the final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

Limitation on When a Lawsuit may be Started

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, **until after all mandatory administrative procedures have been exhausted** (including this Plan's Level 1 claim appeal review procedures described in this document) **for every issue deemed relevant by the claimant**, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision.

You are not required to exhaust external review or the Level 2 voluntary appeal (if applicable) before seeking judicial remedy.

No lawsuit may be started more than three years after the end of the year in which services were provided.

Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan, to resolve ambiguities and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

There is no liability on the Board of Trustees or any individual entity to provide payment over and beyond the amounts in the Trust collected and available for such purpose.

Non-Assignment

The Plan and the Plan Sponsor categorically prohibit and will not accept in any circumstance any assignment or attempt to assign any benefits claims, right to coverage, or any other type of claims, regardless of the nature of such claims and any attempt to do so will be void and will not apply. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person, including the Plan Participant, a Participant's dependent or creditor of the Plan Participant without the express written permission of the Plan Sponsor; however, a Plan Participant may direct that benefits due to the Participant, be paid to a Health Care Provider in consideration for Hospital, medical, dental and/or vision care services rendered, or to be rendered.

The payment of benefits to a healthcare provider shall be done solely as a convenience and does not constitute an assignment of any right under this Plan or under ERISA, is not authority for such provider to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, is not an assignment of any legal or equitable right to institute any court proceeding against the Plan or the Plan Sponsor, and in no way shall be construed or interpreted as a waiver on the Plan's and Plan Sponsor's prohibition on assignments. The Plan and Plan Sponsor are not responsible for paying healthcare provider invoices that are balance billed to a Plan Participant.

Facility of Payment

If the Plan Administrator or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the Health Care Provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator, Administrative Office nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

Elimination of Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

COORDINATION OF BENEFITS (COB)

How Duplicate Coverage Occurs

This chapter describes the circumstances when you or your covered Dependents may be entitled to health care benefits under This Plan and may also be entitled to recover all or part of your health care expenses from some other source. The COB provisions in this chapter pertain to the Medical Plan(s), Dental Plan(s) and Vision Plan(s).

In this chapter the term “you” references all covered Plan Participants. In many of those cases, either this Plan or the other source (the primary plan or program) pays benefits or provides services first, and the other (the secondary plan or program) pays some or all of the difference between the total cost of those services and payment by the primary plan or program. In other cases, only one plan pays benefits. This can occur if you or a covered Dependent is also covered by:

- Another group health care plan (including but not limited to a plan which provides the Plan Participant with COBRA Continuation Coverage); or
- Medicare; or
- Other government program, such as Medicaid, TRICARE, or a program of the U.S. Department of Veterans Affairs, motor vehicle including but not limited to no-fault, uninsured motorist or underinsured motorist coverage for medical expenses or loss of earnings that is required by law, or any coverage provided by a federal, state or local government or agency; or
- Workers’ compensation.
- Coverage resulting from a judgment at law or settlement.
- Any responsible third party, its insurer, or any other source on behalf of that party.
- Any first party insurance (e.g. medical, personal Injury, no-fault, underinsured motorist or uninsured motorist coverage).
- Any policy from any insurance company or guarantor of a third party.
- Any other source (e.g. crime victim restitution, medical, Disability, school insurance).

This chapter describes the rules that determine which plan pays first (is primary) and which pays second (is secondary), or when one of the plans is responsible for benefits and the other is not. This Plan operates under rules that prevent it from paying benefits which, together with the benefits from another source you possess (as described above), would allow you to recover more than 100% of expenses you incur. In many instances, you may recover less than 100% of those expenses from the duplicate sources of coverage or recovery.

In some instances, this Plan will not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its benefits, but only subject to its right to recover them if and when you or your covered Dependent actually recover some or all of your losses from a third party (see also the Subrogation provisions in this chapter). Duplicate recovery of health care expenses may also occur if there is any other coverage for your health care expenses including third party liability or if you have an Injury or Illness that is caused by negligent or intentionally wrongful action by a third party.

Definitions specific to this Section

Other Plan

“Other Plan” means any plan providing benefits or services for or by reason of Hospital, surgical, medical, major medical benefits, or treatment, which benefits or services are provided in:

- Group, blanket or franchise coverage;
- Group practice and other group prepayment coverage;
- Group service plans; and
- Any coverage under labor management trusteed plans, union welfare plans, Employer organization plans or employee benefit organization plans.

The term "Other Plan" shall not include Medicare or any individual policy or contract.

The term "Other Plan" shall not otherwise include any plan of individual insurance or School Accident Type Coverages, written on either a blanket, group or franchise basis and should not be taken into consideration in Coordination of Benefits. In this context, School Accident Type Coverages are defined to mean coverage covering

grammar school and high school students for Accident only, including athletic injuries, either on a twenty-four (24) hour basis or "to and from school", for which the parent pays the entire premium. The term "Plan" shall be construed separately with respect to each policy, contract or other arrangement for benefits or services and separately with respect to that portion of such policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

This Plan

"This Plan" means that portion of This Plan which provides the benefits that are subject to these provisions. (Any benefits provided under This Plan that are not subject to these provisions constitute another plan.)

Allowable Expense

The term "Allowable Expense" means any necessary, Usual Customary and Reasonable item of expense, at least a portion of which is covered under This Plan. Benefits will be subject to plan maximums and will be equal to This Plan's benefits in the absence of other health insurance. When an "Other Plan" provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

Claim Determination Period

"Claim Determination Period" means a Calendar Year.

Application. These provisions shall apply in determining the benefits as to a Participant under This Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such Participant during such period, the sum of:

- The benefits that would be payable under This Plan in the absence of this section, and
- The benefits that would be payable under all other plans in the absence therein of provisions of similar purpose to this section would exceed such Allowable Expenses.

When and How Coordination of Benefits (COB) Applies

- For the purposes of this Coordination of Benefits chapter, the word "plan" refers to any group medical or dental policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of medical or dental services incurred by the Plan Participant or that provides health care services to the Plan Participant. A "group plan" provides its benefits or services to Employees, retirees or members of a group who are eligible for and have elected coverage (including but not limited to a plan that provides the Plan Participant with COBRA Continuation Coverage).
- Many families have family members covered by more than one medical or dental plan. If this is the case with your family, you must let this Plan and its Claims Administrators know about all medical and dental plan coverages when you submit a claim.
- Coordination of Benefits (or COB, as it is usually called) operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan, (called the secondary plan) may then pay additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the health care expenses incurred. Sometimes, the combined benefits that are paid will be less than the total expenses.

Which Plan Pays First: Order of Benefit Determination Rules

1. The benefits of a Plan which covers the Participant on whose behalf a claim is based, other than as a Dependent, shall be determined before the benefits of a Plan which covers such person as a Dependent, except as otherwise specifically set forth in paragraph 2. below or if the person is also a Medicare beneficiary and as a result of the rule established by Title XVIII of the Social Security Act implementing regulations, Medicare is:

   (a) secondary to the Plan covering the person as a Dependent, and

   (b) primary to the Plan covering the person as other than a Dependent (e.g. a retired Employee),

   then the benefits of the Plan covering that person as a Dependent are determined before those of the plan covering that person as other than a Dependent.

2. When a Participant is covered as a Qualified Beneficiary under This Plan and is also covered under another Plan, benefits shall be determined as follows:

   (a) first, the benefits of a Plan covering the person as an Employee or as the Employee's dependent;

   (b) second, the benefits under the continuation coverage of This Plan.

3. For children, the primary plan is the plan of the parent whose birthday is earlier in the year if:

   (a) The parents are married;

   (b) The parents are not separated (whether or not they ever have been married); or

   (c) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

   If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

   If the parents are not married or are separated (whether or not they ever were married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' Spouses (if any) is:

   (a) The plan of the custodial parent;

   (b) The plan of the Spouse or Civil Union Partner of the custodial parent;

   (c) The plan of the noncustodial parent; and then

   (d) The plan of the Spouse or Civil Union Partner of the noncustodial parent.

   If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's Spouse or Civil Union Partner does, the Spouse's or Civil Union Partner's plan is primary. This subparagraph shall not apply with respect to any claim determination period or Plan Year during which benefits are paid or provided before the entity has actual knowledge.

4. For a Dependent Child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as described in Rule 5 (the longer/shorter length of coverage) and if length of coverage is the same, then the birthday rule (Rule 3) applies between the Dependent Child's parents coverage and the dependent's Spouse's coverage. For example, if a married Dependent Child on this Plan is also covered as a dependent on the group plan of their Spouse, this Plan looks to which plan has the longer length of coverage. If the length of coverage is the same, then the Plan looks to whose birthday is earlier in the year (the Employee-parent covering the dependent or the Employee-Spouse covering the dependent).

5. When rules 1., 2. and 3. do not establish an Order of Benefit Determination, the benefits of a Plan which has covered the individual on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time.

6. The benefits of a Plan which covers the Participant as an Employee who is neither laid off nor retired (or as that Employee's dependent) are determined before those of a Plan which covers that Participant as a laid off or retired Employee (or as that Employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this section will not apply.

Coordination of Benefits with Medicare

- **Entitlement to Medicare Coverage:** Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income benefits is also entitled to Medicare coverage (usually after a waiting period).

- **Medicare Participants May Retain or Cancel Coverage Under This Plan:** If an eligible individual under this Plan becomes covered by Medicare, whether because of end-stage renal disease (ESRD), Disability or age, that individual may either retain or cancel coverage under this Plan. If the eligible individual under this Plan is covered by both this Plan and by Medicare, as long as the Employee remains actively employed, that Employee's medical expense coverage will continue to provide the same benefits and contributions for that coverage will remain the same. In that case, this Plan pays first and Medicare pays second.

  If an eligible individual under this Plan is covered by Medicare and an Employee cancels coverage under this Plan, coverage of his/her Spouse or Civil Union Partner and/or Dependent Child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. If any of the Employee's Dependents are covered by Medicare and the Employee **cancels** that Dependent's coverage under this Plan, that Dependent will **not** be entitled to COBRA Continuation Coverage. The choice of retaining or canceling coverage under this Plan of a Medicare participant is the responsibility of the Employee. Neither this Plan nor the Employee's Employer will provide any consideration, incentive or benefits to encourage cancellation of coverage under this Plan.

If an eligible individual under this Plan is covered by Medicare by virtue of age or Disability and then at a later date elects COBRA, that individual may continue Cobra coverage. However, Medicare pays primary and COBRA (this Plan) pays secondary.

- **Coverage Under Medicare and This Plan for End-Stage Renal Disease:** If, while actively employed, an eligible individual under this Plan becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for **30 months** starting the **earlier** of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second. See also the Dialysis row in the Schedule of Medical Benefits in this document.

  * **Important Note for Individuals Eligible for Medicare Based on End-Stage Renal Disease (ESRD):** For individuals eligible for Medicare based on ESRD, federal law requires this Plan to pay for Plan-covered benefits as a primary payer for a period of time known as the 30-month coordination period. At the end of the 30-month coordination period, Medicare becomes the primary payer (for Medicare-covered claims), and this Plan becomes a secondary payer (for Plan-covered benefits). This Plan will treat someone for whom Medicare would be the primary payer as if the person is enrolled in (and paying any required premiums for) Medicare Parts A and B. In other words, **if a person fails to enroll in and maintain Medicare coverage after the 30-month coordination period is completed (for example, fails to enroll in Part B or to pay the required Medicare Part B premiums), this Plan will nonetheless pay Plan-covered benefits as if the individual had Medicare coverage under Parts A and B. As a result, in order to receive the maximum amount of coverage to which you may be entitled under Medicare, you should consider enrolling in and paying any premiums required for Medicare coverage, including Part B, no later than the end of the 30-month coordination period.**

- **Employee's Entitlement to Coverage Due to Employment Status:** Benefits shall be payable under This Plan without regard to a Participant's entitlement to Medicare provided such individual is:

  * an Employee sixty-five (65) or older;
  * a Dependent age sixty-five (65) or older of an Employee;
  * a Disabled individual who maintains a current employment status with the Employer or a Disabled Dependent of an Employee.

How Much This Plan Pays When It Is Secondary to Medicare

- **When Covered by This Plan and also by Medicare Parts A and B:** When an eligible individual under This Plan is also covered by Medicare Parts A and B and This Plan is secondary to Medicare, This Plan pays the same benefits provided for Employees less any amounts paid by Medicare. Benefits payable by This Plan are based on the fees allowed by Medicare and not on the billed charges of the Health Care Provider.

- **When Covered by This Plan and also by a Medicare Advantage Program (formerly called Medicare + Choice or Part C) without prescription drug benefits:** If an individual is covered by both This Plan and a Medicare Advantage program, and obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services In-Network when the Medicare Advantage program requires it, This Plan will reimburse all applicable Copays and will pay the same benefits provided by This Plan less any amounts paid by the Medicare Advantage program
- **When Covered by This Plan and Eligible for but Not Covered by Medicare:** When the Covered individual is covered by this Plan and is also **eligible for, but is not enrolled in Medicare Parts A, B and/or D**, this Plan pays the same benefits provided for all active Employees.
- **When Covered by This Plan and the Individual also Enters Into a Medicare Private Contract:** Under the law a Medicare beneficiary is entitled to enter into a Medicare private contract with certain Health Care Practitioners (who have opted out of Medicare), under which the individual agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare participant enters into such a contract This Plan will NOT pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to it.
- **When Covered by this Plan and the Individual also has signed an Advance Beneficiary Notice (ABN):** Under the law a Health Care Provider who believes that Medicare may not pay for a particular proposed service is to issue an Advance Beneficiary Notice (ABN) to a Medicare beneficiary (meaning an individual who is determined by the Social Security Administration to be eligible for and has actually enrolled in Medicare benefits). If the Plan receives a claim coded to explain that the Medicare beneficiary has signed an ABN, **this Plan will NOT pay any benefits** for any health care services and/or supplies the Medicare beneficiary receives pursuant to the ABN if Medicare will not pay such services.
- **When Covered by This Plan and also by a Medicare Part D Prescription Drug Plan:** If you have dual coverage under both This Plan and Medicare Part D, for Medicare eligible Employees and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage is secondary.

Coordination with Other Government Programs

If a Participant is covered by both This Plan and another government program, the Participant must provide This Plan's insurance card when receiving health care services.

- **Medicaid**: If an individual is covered by both This Plan and Medicaid or a State Children's Health Insurance Program (CHIP), This Plan pays first and Medicaid or the State Children's Health Insurance Program (CHIP) pays second.
- **TRICARE**: If a Dependent is covered by both This Plan and the TRICARE Program that provides health care services to dependents of active armed services personnel, This Plan pays first and TRICARE pays second. For an Employee called to active duty for more than 30 days who is covered by both TRICARE and This Plan, TRICARE is primary and This plan is secondary for active members of the armed services only. If an eligible individual under This Plan receives services in a Military Medical Hospital or Facility on account of a military service-related Illness or Injury, benefits are not payable by This Plan.
- **Veterans Affairs/Military Medical Facility Services**: If an eligible individual under This Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related Illness or Injury, benefits are not payable by the Plan. If an eligible individual under This Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is **not** a military service-related Illness or Injury, benefits are payable by the Plan to the extent those services are Medically Necessary and the charges are Allowed Charges.
- **Motor Vehicle/Motorcycle Coverage**: Benefits under This Plan will be coordinated with a Participant's automobile and/or motorcycle insurance medical payment coverage. If a Participant's automobile/motorcycle insurance policy provides medical payment coverage, then This Plan will coordinate benefits with those coverages in effect. If a Participant's automobile insurance policy provides uninsured/underinsured motorist coverage, then this Plan will coordinate benefits with those coverages in effect.
- **Indian Health Services (IHS):** If an individual is covered by both This Plan and Indian Health Services, This Plan pays first and Indian Health Services pays second.

- **Other Coverage Provided by State or Federal Law**: If an eligible individual under This Plan is covered by both This Plan and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and This Plan pays second.

Workers' Compensation (Occupational Disease Law)

This Plan **does not provide** benefits if the expenses are covered by workers' compensation or occupational disease law. If the individual's Employer contests the application of workers' compensation law for the Illness or Injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. Before such payment will be made, the individual must execute a Subrogation and reimbursement agreement acceptable to the Plan Administrator or its designee. However, the failure of the individual to sign such an agreement will not constitute a waiver by the Plan, the Plan Administrator, the Board of Trustees or the Administrative Office of their rights to recover any payments that the Plan has advanced.

The benefits provided by This Plan are not in lieu of and do not affect any requirement for coverage by Worker's Compensation Insurance laws or similar legislation.

Subrogation, Reimbursement, and Third Party Responsibility

The Plan does not cover expenses for services or supplies for which a third party pays due to any recovery, whether by settlement, judgment or otherwise, however, the Plan may advance payment of benefits subject to the Plan's right to be subrogated and shall succeed to the individual's rights of recovery from a third party for incurred Hospital, medical, surgical expenses, or other damages regardless of how such suit, settlement or other out of court agreement is otherwise designated. The individual shall pay over to the Plan all sums recovered by suit, settlement or otherwise in an amount equal to such services or benefits which the Plan provided. The Participant shall, upon request, execute and deliver such instrument or papers as may be required and do whatever else is necessary to carry out this provision.

If a Participant is injured or becomes ill due to or as a result of the act or omission of any other person and if Hospital, medical or surgical benefits are provided to or on behalf of the Participant by This Plan due to or as a result of such Injury or Illness, then to the extent that the Participant recovers either similar medical expenses or other damages as a result of the Injury or Illness from any responsible third party or the third party's insurance carrier, This Plan shall be entitled to receive a refund from the Participant in an amount equal to such services or benefits which This Plan provided. Further, if legal action is necessary to enforce a Participant's obligations, then the Plan shall also be entitled to recovery of all of its legal fees and costs. This Plan may file a lien for such payment. The Participant shall, upon request, execute and deliver such instrument or papers as may be required and do whatever else is necessary to carry out this provision.

The Plan shall be entitled to reimbursement (up to the amount of benefits paid hereunder in connection with any Injury, sickness, Accident or condition to which the claim relates) of the proceeds of any settlement or judgment that results in a recovery from a third party, whether such recovery occurs before or after the payments are made by the Plan; whether or not the Participant is made whole by such recovery, and whether or not such recovery allocates or specifies the amount paid for medical expenses or otherwise. The Plan's right to reimbursement shall apply to all sources of compensation to which the Participant was entitled or will become entitled, regardless of whether the recovery was legal or equitable in nature, and the Plan's right to reimbursement shall take priority over a Participant's right to be made whole. The Plan shall have no obligation to pay or reimburse any portion of a Participant's attorney's fee or litigation costs. The Plan's Subrogation interest shall not be settled or compromised without the Plan's express written consent. Any monies received by a Participant will be required to reimburse the Plan out of any monies the Participant receives from the other person as a result of judgment, settlement, or otherwise, without regard as to whether the recovery has been apportioned between medical and other damages, and without regard as to whether full or complete recovery of damages has occurred.
Failure to execute a Subrogation assignment agreement upon request by This Plan may result in non-payment of any related claims. If requested in writing, by the Board of Trustees or its designee, the Participant shall take, through any representative designated by the Board, such action as may be necessary or appropriate to recover payments made by This Plan from any person, organization or other entity and shall hold any money recovered from such person, organization or other entity in trust for the benefit of This Plan to be paid to This Plan immediately upon recovery thereof. The Participant shall not do anything to release, discharge or prejudice the rights referred to in this section to which the claim relates, and the Participant shall assist and cooperate with representatives designated by the Plan to recover damages, and shall do everything that may be necessary to

enable the Plan to effectively bring suit pursuant to the Subrogation herein. Failure by the Participant to comply with a request by the Board of Trustees or its designee under this section may lead to termination of benefits in connection with any Accident or Illness in relation to which such request was made. For the purposes of this provision, “third party” means the responsible or liable party; any liability or other insurance covering the responsible or liable party; you or your covered Dependent’s own uninsured motorist insurance or under insured motorist insurance; any medical payment, no fault or school insurance coverage.

Non-Reversion and Employer Refunds

In no event shall any of the corpus or assets of This Plan revert to the credit of the Contributing Employers or be subject to any claims of any kind or nature by the Contributing Employers or Employees, except for Employee benefits made available to Employees under This Plan. If This Plan is terminated, assets in This Plan which represent Employer contributions may be returned to the Employers to be held for the exclusive benefit of Participants, in accordance with the provisions of the Trust, and any assets in This Plan which represent Participant contributions shall be returned to the contributing Participants, to the extent administratively practicable.

Notwithstanding the foregoing provisions of this section, contributions made by a Contributing Employer by mistake of fact or law (other than a mistake relating to whether the Plan is described in Section 501(c)(9) of the Internal Revenue Code) may be returned to such Contributing Employer within one (1) year after the Plan Administrator determines that the contribution was made by such a mistake.

Non-Sufficient Funds

Any Associated Organization or Self-Pay Participant whose contribution is returned due to non-sufficient funds must pay a late check penalty established by the Board of Trustees and replace such payment, within the original payment due date, with guaranteed funds (money order, cashier’s check, etc.) and all contributions for the next six (6) months must also be made by guaranteed funds.

In the event contributions are returned after any payment grace period allowed by the Trust, payment will be deemed as not received on a timely basis and participation will be terminated effective retroactive to the first day of the month for which payment was not received.

COBRA: TEMPORARY CONTINUATION OF COVERAGE

CONTINUATION OF COVERAGE (COBRA)

Entitlement to COBRA Continuation Coverage

In compliance with a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (commonly called COBRA), eligible Employees, and their covered Dependents (called "Qualified Beneficiaries") will have the opportunity to elect a temporary continuation of their group health coverage under the Plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law).

NOTE: Civil Union Partners (as defined in this Plan) **are not eligible** for COBRA continuation of benefits when coverage ends (as described in this chapter). Civil Union Partners are not considered Qualified Beneficiaries and therefore do not have the federally protected rights afforded to a Qualified Beneficiary.

Alternatives to COBRA: Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace**. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a Spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

Qualified Beneficiaries who elect COBRA must pay for it at their own expense.

This Plan provides no greater COBRA rights than what is required by law and nothing in this chapter is intended to expand a person's COBRA rights.

COBRA Administrator

Please direct any questions about COBRA to the Administrative Office whose name, address and telephone number is shown in the Quick Reference Chart in the front of this document.

IMPORTANT:

This chapter summarizes your rights and obligations under the COBRA law. It is provided to all covered Employees and their covered Spouses and is intended to inform them (and their covered Dependents, if any) in a summary fashion about COBRA, when it may become available and what needs to be done to protect the right to receive COBRA. Since this is only a summary, actual rights will be governed by the provisions of the COBRA law itself. It is important that you and your Spouse take the time to read this chapter carefully and be familiar with its contents.

Who Is Entitled to COBRA Continuation Coverage, When and For How Long

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered Employees may elect COBRA on behalf of their Spouses and covered parents/legal guardians may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other Plan Participants, including Special Enrollment.

- "**Qualified Beneficiary**": Under the law, a Qualified Beneficiary is any Employee or the Spouse or Dependent Child of an Employee who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA coverage is also a Qualified Beneficiary.
    * A child of the covered Employee who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the Employee's period of employment, is entitled to the same rights under COBRA as an eligible Dependent Child.
    * A person who becomes the new Spouse of an existing COBRA participant during a period of COBRA may be added to the COBRA coverage of the existing COBRA participant but is not a "Qualified

Beneficiary." This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.

- **"Qualifying Event"**: Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the Plan Participant LOSES health care coverage under this Plan**. If a Plan Participant has a Qualifying Event but, as a result, **does not lose** their health care coverage under this Plan, (*e. g.* Employee continues working even though entitled to Medicare) then COBRA is not available.

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries[1]		
	Employee	Spouse	Dependent Child(ren)
Employee terminated (for other than gross misconduct), including retirement	18 months	18 months	18 months
Employee reduction in hours worked (making Employee ineligible for health care coverage, or eligible but not at the same required premiums/contributions)	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes divorced or legally separated.	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months
Associated Organization ceases operations as a business	18 months	18 months	18 months

When a covered Employee's Qualifying Event (e.g. termination of employment or reduction in hours) occurs within the 18-month period after the Employee becomes entitled to Medicare (entitlement means the Employee is eligible for and enrolled in Medicare), the Employee's covered Spouse and Dependent Children who are Qualified Beneficiaries (but not the Employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.

Terminated Associated Organizations

An Employee whose coverage terminates due to an Associated Organization ceasing operations as a business may continue coverage by electing COBRA continuation coverage. Each self-payment is due by the first of the month for which coverage is intended, and shall be considered timely if received prior to or on the last day of the month for which coverage is intended. Coverage may be continued for a period of no more than eighteen (18) months or until the earliest of the following dates:

- The date the individual becomes covered under any other group medical coverage as an Employee or dependent. In the event such other group medical coverage has a pre-existing condition clause or limitation, continuation coverage will not terminate until exhaustion of the maximum period continuation coverage is allowed or until the pre-existing condition clause or limitation has been satisfied;
- The end of the period for which the last payment was made for coverage in a timely manner;
- The maximum continuation period has been exhausted;
- The date the Plan is discontinued;
- The date the Associated Organization ceases to provide any group health plan.

Such Self-Pay Employees may continue coverage under the Monthly Contribution approach.

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the date the Qualifying Event occurs. The 18-month period of COBRA may be extended

for up to 11 months under certain circumstances (described in another section of this chapter). The maximum period of COBRA may be cut short for the reasons described in the section on "Early Termination of COBRA" that appears later in this chapter.

Medicare Entitlement

- A person becomes entitled to Medicare on the first day of the month in which he or she attains age 65, but only if he or she submits the required application for Social Security retirement benefits within the time period prescribed by law; or
- Generally a person becomes entitled to Medicare on the first day of the 30th month after the date on which he or she was determined by the Social Security Administration to be Totally and Permanently Disabled so as to be entitled to Social Security Disability income benefits.

Special Enrollment Rights

You have special enrollment rights under federal law that allow you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's Employer) within 30 days (or as applicable 60 days) after your group health coverage ends because of the Qualifying Events listed in this chapter. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Procedure for Notifying the Plan of a Qualifying Event (Very Important Information)

In order to have the chance to elect COBRA after a loss of coverage due to these events: a divorce, legal separation, or a child ceasing to be a "Dependent Child" under the Plan, **you and/or a family member must inform the Plan in writing of that event no later than 60 days after that event occurs.**

That written notice should be sent to the Administrative Office whose address is listed on the Quick Reference Chart in the front of this document. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

NOTE: If such a notice is not received by the Administrative Office within the 60-day period, the Qualified Beneficiary will not be entitled to choose COBRA Continuation Coverage.

Officials of the Employee's own Employer should notify the Administrative Office of an Employee's death, termination of employment, reduction in hours, or entitlement to Medicare. However, **you or your family should also promptly notify the Administrative Office in writing** if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

Notices Related to COBRA

When:

- **Your Employer notifies the Plan** that your health care coverage has ended because your employment terminated, your hours are reduced so that you are no longer entitled to coverage under the Plan, you died, have become entitled to Medicare, or
- **You notify the Administrative Office** that a Dependent Child lost Dependent status, you divorced or have become legally separated,

then the Administrative Office will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA. Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice, to elect COBRA.

NOTE: If you and/or any of your covered Dependents do not choose COBRA within 60 days after receiving notice, you and/or they will have no group health coverage from this Plan after the date coverage ends.

The COBRA Continuation Coverage That Will Be Provided

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on Paying for COBRA that appears later in this chapter for information about how much COBRA will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active Employees and their families, that same change will apply to your COBRA coverage.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

Any person who elects COBRA Continuation Coverage must pay the full cost of the COBRA. The Trust is permitted to charge the full cost of coverage for similarly situated active Employees and families (including both the Trust's and Employee's share), plus an additional 2%. If the 18-month period of COBRA is extended because of Disability, the Trust may add an additional 50% applicable to the COBRA family unit (but only if the Disabled person is covered) during the 11-month additional COBRA period.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

IMPORTANT

You are responsible for making sure that timely COBRA premium payments are made to the COBRA Administrator. The Plan will send out monthly receipts for your payment; however, not receiving a receipt will not extend the due date of your payment.

Grace Periods

The initial payment for COBRA is due to the Administrative Office **no later than 45 days** after COBRA is elected. If this payment is not made when due, COBRA will not take effect. After the initial COBRA payment, subsequent payments are due on the first day of each month, but there will be a 30-day grace period to make those payments. If payments are not made within the time indicated in this paragraph, COBRA coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

Confirmation of Coverage Before Election or Payment of the Cost of COBRA

If a Health Care Provider requests confirmation of coverage and you, your Spouse or Dependent Child(ren) have elected COBRA and the amount required for COBRA has not been paid while the grace period is still in effect **or** you, your Spouse or Dependent Child(ren) are within the COBRA election period but have not yet elected COBRA, COBRA coverage will be confirmed, but with notice to the Health Care Provider that the cost of the COBRA has not been paid, that no claims will be paid until the amounts due have been received, and that COBRA will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

HIPAA Special Enrollment and COBRA

- **Addition of Newly Acquired Dependents:** If, while you (the Employee) are enrolled for COBRA, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that Spouse or child for coverage for the balance of the period of COBRA if you do so within 31 days after the marriage, birth, adoption, or placement for adoption. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA. Contact the Administrative Office to add a Dependent.
- **Loss of Other Group Health Plan Coverage:** If, while you (the Employee) are enrolled for COBRA your Spouse or Dependent Child loses coverage under another group health plan, you may enroll the Spouse or Dependent Child for coverage for the balance of the period of COBRA. The Spouse or Dependent Child must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA healthcare plan and declined, the Spouse or Dependent Child must have been covered under another group health plan or had other health insurance coverage. The loss of coverage must be due to exhaustion of COBRA under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of Employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or Participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the

Spouse or Dependent Child within 31 days after the termination of the other coverage. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the Administrative Office an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Employees whose coverage is terminated due to an Associated Organization's termination of participation in the Trust are **not** entitled to COBRA continuation coverage unless they incur a Qualifying Event prior to the date of withdrawal of the Associated Organization. Continuation of coverage under this section will be terminated under this Trust for Qualified Beneficiaries of Associated Organizations on the date of termination of participation in the Trust by the Associated Organization.

However, when withdrawal is a result of an Associated Organization ceasing business operations or filing for bankruptcy the Employee may be eligible for COBRA as outlined in this section.

The Trust constitutes a multiple Employer welfare arrangement as defined in section 3(40) of the Employee Retirement Income Security Act of 1974 (ERISA), and is providing continuation coverage for all Associated Organizations subject to the health care continuation requirements of Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Tax Reform Act of 1986 and the Omnibus Budget Reconciliation Act (OBRA '89).

Extended COBRA Continuation Coverage When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period

A Spouse and Dependent Child who already have COBRA coverage, and then experience a second qualifying event, may be entitled to extend their COBRA from 18 or 29 months, to a total of 36 months of COBRA coverage. Second qualifying events may include the death of the covered Employee, divorce [or legal separation] from the covered Employee, the covered Employee becoming entitled* to Medicare benefits (under Part A, Part B or both), or a Dependent Child ceasing to be eligible for coverage as a dependent under the group health plan.

NOTE: Medicare entitlement is not a Qualifying Event under this Plan and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for Spouses and dependents who are Qualified Beneficiaries.

Notifying the Plan: To extend COBRA when a second Qualifying Event occurs, you must notify the Administrative Office in writing within 60 days of a second Qualifying Event. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the second Qualifying Event, the date of the second Qualifying Event, and appropriate documentation in support of the second Qualifying Event, such as your divorce documents.

This extended period of COBRA Continuation Coverage is not available to anyone who became your Spouse after the termination of employment or reduction in hours. This extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by or Placed for Adoption with you (the covered Employee) during the 18-month period of COBRA Continuation Coverage.

In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of Disability as described in the following section). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA may not be extended beyond 18 months from the initial Qualifying Event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

Extended COBRA Coverage in Certain Cases of Disability During an 18-Month COBRA Continuation Period

If, prior to the Qualifying Event or during the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse or Dependent Child is Totally and Permanently Disabled so as to be entitled to Social Security Disability Income benefits (SSDI), the Disabled person and any covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the Disabled person becomes entitled to Medicare or ceases to be Disabled (whichever is sooner).

- This extension is available only if:
  * the Social Security Administration determines that the individual's Disability began at some time before the 60th day of COBRA Continuation Coverage; **and**
  * the Disability lasts until at least the end of the 18-month period of COBRA Continuation Coverage.

  Notifying the Plan: You or another family member follow this procedure (to notify the Plan) by sending a written notification to the Administrative Office of the Social Security Administration determination within 60 days after that determination was received by you or another covered family member. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the request for extension of COBRA due to a Disability, the date the Disability began and appropriate documentation in support of the Disability including a copy of the written Social Security Administration Disability award documentation, **and** that notice must be received by the Administrative Office before the end of the 18-month COBRA Continuation period.
- The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage will be 50% higher than the cost for coverage during the first 18-month period.
- The Administrative Office must also be notified within 30 days of the determination by the Social Security Administration that you are no longer Disabled.

Early Termination of COBRA Continuation Coverage

Once COBRA Continuation Coverage has been elected, it may be terminated early on the occurrence of any of the following events:

- The date the covered Employee's last Employer withdraws from the Trust;
- The date the Qualified Beneficiary becomes covered under any other group health that does not contain any exclusions or limitations with respect to pre-existing conditions.
- The date the amount due for COBRA coverage is not paid in full within the Grace Period;
- In the event funds remitted for the premium payment are insufficient by an insignificant amount as determined by the guidelines established by the Board of Trustees, the Administrative Office will notify the Qualified Beneficiary of the amount of the insufficiency. The Qualified Beneficiary must remit a payment equal to the amount of the insufficiency to the Administrative Office within thirty (30) days after the date such notice is received by the Qualified Beneficiary. The Qualified Beneficiary will be deemed to remit a payment on the date that the Qualified Beneficiary has proof that the payment was sent. If the payment is not remitted timely, coverage will automatically terminate.
- The date the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA;
- During an extension of the maximum COBRA coverage period to 29 months due to the Disability of the Qualified Beneficiary, the Disabled beneficiary is determined by the Social Security Administration to no longer be Disabled;
- The date the Plan has determined that the Qualified Beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA participants under the Plan).

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion

coverage. The notice will be provided as soon as practicable after the Administrative Office determines that COBRA coverage will terminate early. Once COBRA coverage terminates early it cannot be reinstated.

No Entitlement to Convert to an Individual Health Plan after COBRA Ends

There is no opportunity to convert to an individual health plan after COBRA ends under this Plan.

GENERAL PROVISIONS AND INFORMATION REQUIRED BY ERISA

Name of the Plan

Contractors Health Trust (CHT)

The medical Plan is a self-funded group health plan and is administered by a Board of five trustees. Three trustees are appointed by the President of the Colorado Contractors Association and two trustees are appointed by the President of the Associated General Contractors, Building Chapter, Inc.

Name and Address of Employer's Maintaining the Plan

A complete list of the Employers and Employee organizations sponsoring the Plan may be obtained by Participants upon written request to the Plan Administrator, and is available for examination by Plan Participants.

Name and Address of the Person Designated as Agent for the Service of Legal Process

Stephen A. Weinstein
Spencer Fane LLP
1700 Lincoln Street, Suite 2000
Denver, CO 80203

Service of legal process may also be served on any Plan trustee.

Name and Address of the Plan Administrator

The Trustees (as Plan Administrator) have engaged the independent third-party administrators named on the Quick Reference Chart at the beginning of this document to perform the routine administration of the Trust. If you need to contact a trustee or have any questions regarding the administration of the Fund you may contact the Administrative Office at the following address:

Contractors Health Trust
2380 S. Tejon St.
Englewood, CO 80110
Telephone: (303) 935-2475 or 1-888-221-2201

Names, Titles, and Addresses of any Trustee or Trustees

David Bowman
Bowman Construction Supply Inc.
2310 South Syracuse Way
Denver, Colorado 80231-3716

Steve McWilliams, Chairman
New Design Construction
2350 East 70th Avenue
Denver, Colorado 80229

Brad Marsh
Saunders Construction Company
86 Inverness Place North
Englewood, CO 80112

Scott Lawrence
Lawrence Construction Company
9002 Moore Road
Littleton, Colorado 80125

Nicole Frank
Hyder Construction
543 Sante Fe Drive
Denver, CO 80204

The Internal Revenue Plan Identification Number

84-6067792

Type of Plan and Plan Number

Plan 501

Plan Year

The Plan's fiscal records are kept on a Calendar Year basis beginning on January 1 and ending on December 31.

Plan Sponsor

The Board of Trustees

Source of Financing and Type of Administration of the Plan

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered Participants and defraying administrative expenses.

All of the types of employee welfare benefits provided by the Plan are set forth in this Plan Document/Summary Plan Description. Some benefits are provided directly under a group insurance policy or contract with an insurance company, Administrative Office or claims processing company. The following chart explains whether a particular benefit is provided directly by the trust or another entity, the name and address of any claims administrator or insurance company.

Benefit Type	Claims Administrator Type of Administration	Source of Benefits and Type of Funding
Comprehensive Medical Benefits Welfare group health plan	Contract Administration for medical claims and Level 1 medical appeals Anthem Blue Cross and Blue Shield P.O. Box 5747 Denver, Colorado 80217-5747	Self-funded from Trust assets and Participant self-payments
Comprehensive Medical Benefits Voluntary Level 2 Appeals Welfare group health plan	Self-Administration Contractors Health Trust 2380 S. Tejon St. Englewood, CO 80110 (303) 935-2475 or (833) 935-2475	Self-funded from Trust assets and Participant self-payments
Delta Dental (optional)	Insurance Administration Delta Dental of Colorado P.O. Box 173803 Denver, CO 80217-3803 303-741-9305 or 1-800-610-0201	Fully Insured
Alpha Dental (optional)	Insurance Administration Beta Health Association, Inc. Carrara Place 6200 South Syracuse Way Suite 460 Greenwood Village, CO 80111 (303) 744-3007 or 1-800-807-0706	Discount Plan

Benefit Type	Claims Administrator Type of Administration	Source of Benefits and Type of Funding
Vision (optional)	Contract Administration DavisVision P.O. Box 1525 Latham, NY 12110 1-877-923-2347 (Client Code 8975)	Fully Insured
Employee Life Insurance, Dependent Life Insurance, Accidental Death and Dismemberment Policy Number: 301347	Insurance Administration UnitedHealthcare Specialty Benefits 6300 Olson Memorial Highway Golden Valley, MN 55427 1-866-837-7478	Fully Insured
Prescription Drug	Contract Administration Express Scripts 1-877-551-8811	Self-funded from Trust assets and Participant self-payments
Employee Assistance Program	Contract Administration Mines and Associates, P.C. 10367 W. Centennial Road Littleton, CO 80127 303-832-1068	Self-funded from Trust assets and Participant self-payments

Contribution Source

The Employer/Plan Sponsor and the Employees may share the cost of contributions for the benefits provided by this plan. A portion of the contributions related to health care benefits may be made by the Employer/Plan Sponsor pursuant to salary reduction agreements between Plan Participants and the Employer/Plan Sponsor. The remainder of the contributions related to health care benefits are made by the Employer.

Authority to Interpret and Amend the Plan

The Board of Trustees reserves the right to amend, modify or discontinue all or part of this Plan, for any or all Participants, at any time. The Board of Trustees has the complete authority and sole and absolute discretion to interpret the Plan and determine the right of any Participant to a benefit under the Plan.

Newborn and Maternity

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, in consultation with the mother, from discharging the mother or her newborn earlier than 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 the length of stay not in excess of 48 hours (or 96 hours).

Qualified Medical Child Support Orders (QMCSO)

Benefits under this Plan are subject to the provisions of Qualified Medical Child Support Orders (QMCSO). Participants and beneficiaries can obtain, without charge, a copy of the procedures governing QMCSOs from the Administrative Office.

Rights of Plan Participants

As a Participant in the Contractors Health Trust you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About your Plan and Benefits

Examine, without charge, at the Administrative office and at other specified locations, such as worksites, all documents governing the Plan including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The administrator may make reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Coverage

Continue health care coverage for yourself, Spouse or Dependent Children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Spouse or Dependent Children may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With your Questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about

your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ADMINISTRATIVE OFFICE

General Information, Eligibility, Hospital-Medical Benefits, call or write to the Administrative Office at the phone number and/or address listed below.

Contractors Health Trust
P.O. Box 21240
Denver, Colorado 80221-0240
Telephone: (303) 935-2475
(833) 935-2475

Plan Amendments of Termination of the Plan

The Board of Trustees reserves the right to amend or terminate this Plan, or any part of it, at any time without advance notice to Participants. This includes the discretionary right to interpret, revise, supplement or rescind any or all portions of the Plan including but not limited to the following actions:

- terminate or amend either the amount or condition with respect to any benefit for which services have not been incurred, and
- alter or postpone the method of payment of any benefit for which services have not been incurred; and
- amend or rescind any other provisions of the Restated Plan document/Summary Plan Description;
- change the required contribution by the Associated Organization or Participant;
- change the providers for any portion of the plan of benefits; and
- terminate the plan of benefits in its entirety or terminate portions of the plan of benefits.

Amendments to the Plan may be made in writing designated officers and become effective on the written approval from the Board of Trustees, or on such other date as may be specified in the document amending the Plan.

The Plan or any coverage under it may be terminated by the Board of Trustees, and new coverage may be added by the Board of Trustees. Upon termination, discontinuance or revocation of participation in the Plan, all elections and reductions in compensation related to the Plan will terminate.

Allocation and Disposition of Assets Upon Termination

In order for the Fund to carry out its obligation to provide the maximum possible benefits to all Participants within the limits of its resources, the Board of Trustees has the right to take any of the following actions, even if claims that have already accrued are affected:

- To terminate any benefits provided by these Plan Rules.
- To alter or postpone the method of payment of any benefit.
- To amend or rescind any provision of these Plan Rules.

In addition, the Trust may be terminated by the Board of Trustees, provided that the termination is not effective until 60 days after the mailing of such notice. In the event the Plan terminates, the Trustees, by unanimous agreement and in their full discretion, will determine the disposition of any assets remaining after all expenses of the Trust have been paid; provided that any such distribution will be made only for the benefit of former Participants and for the purposes set forth in the Plan. Upon termination of the Plan, the Trustees (with full power) will continue in such capacity for the purpose of dissolution of the Plan.

Use and Disclosure of Protected Health Information (PHI)

The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

1. determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and Copays as determined for an individual's claim);
2. coordination of benefits;
3. adjudication of health benefit claims (including appeals and other payment disputes);
4. Subrogation of health benefit claims;
5. establishing Employee contributions;
6. risk adjusting amounts due based on enrollee health status and demographic characteristics;
7. billing, collection activities and related health care data processing;
8. claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;
9. obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
10. Medical Necessity reviews or reviews of appropriateness of care or justification of charges;
11. utilization review, including Precertification, preauthorization, Concurrent Review and retrospective review;
12. disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, social Security number, payment history, account number and name and address of the provider and/or health plan); and
13. reimbursement to the plan.

Health Care Operations

Health Care Operations include, but are not limited to, the following activities:

1. quality assessment;
2. population-based activities relating to improving health or reducing health care costs, protocol development, Case Management and care coordination, disease management, contacting Health Care Providers and patients with information about treatment alternatives and related functions;
3. rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
4. underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
5. conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
6. business planning and development, such as conducting cost-management and planning related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
7. business management and general administrative activities of the Plan, including, but not limited to:
   (a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
   (b) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
8. resolution of internal grievances; and
9. due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

The Plan Will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary

With an authorization, the Plan will disclose PHI to another benefit plan for purposes related to administration ofthese plans.

For Purposes of This Section the Board of Trustees Is the Plan Sponsor

The Plan shall disclose PHI to the Plan Sponsor for the purpose of deciding health claim appeals. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions.

With Respect to PHI, the Plan Sponsor Agrees to Certain Conditions

The Sponsor agrees to:

1. not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
2. ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
4. not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
5. report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. make PHI available to an individual in accordance with HIPAA's access requirements;
7. make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. make available the information required to provide an accounting of disclosures;
9. make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
10. if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).
11. Notify you if a breach of your unsecured protected health information (PHI) occurs.

Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained

In accordance with HIPAA, only the Board of Trustees, other Plan contracted Covered Entities and Business Associates may be given access to PHI.

Limitations of PHI Access and Disclosure

The persons described above may only have access to and use and disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan. If the persons described above do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Security Rule Compliance

The Plan Sponsor will:

1. implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan.
2. ensure that the adequate separation discussed in f. above, specific to electronic PHI, is supported by reasonable and appropriate security measures.
3. ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
4. report to the Plan any security incident of which it becomes aware concerning electronic PHI.

Section 6056 Employer Reporting

If an Employer chooses to receive Protected Health Information ("PHI") for purposes of assisting the Employer with his or her Reporting requirements, the Employer will safeguard and protect the confidentiality of any PHI it receives and will comply with the following requirements:

- the Employer will not use or disclose PHI it receives from CHT, other than as permitted or required by the Trust Agreement or as required by law.
- the Employer will ensure that its subcontractors or agents to whom it provides PHI agree to these same restrictions.
- the Employer will not use or disclose PHI it receives from CHT for employment-related actions.
- the Employer will report to CHT any use or disclosure of PHI that is inconsistent with the Trust Agreement or with the HIPAA Privacy Rule.
- the Employer will permit individuals access to their own PHI and will permit individuals to amend their own PHI..
- the Employer will assist CHT in providing an accounting of disclosures as required by the Privacy Ru1e.
- the Employer will make its practices, books, and records regarding its use of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining CHT's compliance with HIPAA and its Privacy Rule.
- the Employer will return to CHT or to destroy, if feasible, all PHI received from CHT when it is no longer needed.
- the Employer will establish appropriate "firewalls" between itself and CHT, ensuring that only those Employees and agents of Employer who require access to PHI in order to perform their plan administration functions are permitted such access.

Additionally, the Employer has signed a Certification attesting that:

- PHI disclosed to the Employer by CHT shall only be used for purposes of payment or health care operations, as those terms are defined by the Privacy Rule.
- PHI disclosed to an Employer by CHT shall not be used for employment-related functions or for other functions related to other employee benefits plans or other benefits provided by the Employer.
- Only those Employees and agents of an Employer who need access to PHI to perform job-related functions that constitute payment or health care operations shall have access to such information. Each Employer shall identify those Employees and agents, by name, class, or function, in this Certification below.

All issues of non-compliance with this Certification will be brought to the attention of and addressed by CHT's Privacy Officer. Upon being advised of an instance of noncompliance, the Privacy Officer shall, together with legal counsel, determine the extent to which an investigation is appropriate and the nature of any remedial actions to be taken, including CHT's discontinuation of further PHI disclosures to the non-compliant Employer absent obtaining individual authorizations for such disclosures.

Headings, Font and Style do not Modify Plan Provisions

The headings of chapters and subchapters and text appearing in **bold** or CAPITAL LETTERS and font and size of sections, paragraphs and subparagraphs are included for the sole purpose of generally identifying the subject matter of the substantive text for the convenience of the reader. The headings are **not** part of the substantive text of any provision, and they **should not be construed to modify the text of any substantive provision in any way**.

DEFINITIONS

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Accident: A sudden and unforeseen event as a result of an external or extrinsic source, that is not work-related.

Administration Period for Full-time Employees: For full-time employees to be eligible for coverage under the Plan there is an orientation period that is an additional substantive eligibility condition that must be met. This orientation period for training, guidance and oversight will not exceed a 30-day period. For more information about the Orientation Period contact the Administrative Office.

Administrative Office: Administrative Office means the individual or entity designated and engaged by the Board of Trustees to administer the Plan and process benefit claims.

Affordable Care Act: a comprehensive federal health care reform law enacted in March 2010 (sometimes known as ACA, PPACA, Health Reform, or "Obamacare"). The law has two parts: the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (the Reconciliation Act). The Affordable Care Act (ACA) includes requirements for coverage of certain health care services that impact medical plans.

Allowed Charge/Allowed Amount/Allowable Charge: means the amount this Plan allows as payment for eligible Medically Necessary services or supplies. The Allowed Charge amount is determined by the Plan Administrator or its designee to be the **lowest** of:

- **With respect to a network provider** (PPO network Health Care or Dental Care provider/facility), the negotiated fee/rate set forth in the agreement between the participating network Health Care or Dental Care Provider/facility and the PPO network or the Plan; **or**
- **With respect to a Non-Network provider**, Allowed Charge amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary services or supplies performed by Non-Network providers. The Plan's Allowed Charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. See also the definition of Balance Billing in this chapter; **or**
- For an In-Network Health Care Provider/facility whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third party payer, including but not limited to auto insurance, workers' compensation or other individual insurance, or where this Plan may be a secondary payer, the Allowed Charge amount under this Plan is the negotiated fee/rate that would have been payable by the Plan had the claim been processed as an In-Network claim; **or**
- The Health Care or Dental Care Provider's/facility's actual billed charge.

In accordance with federal law, with respect to Emergency Services performed in a Non-Network Emergency Room (ER), the Plan's allowance for ER visit facility fees is to pay the greater of:

- the negotiated amount for In-Network providers, or
- 100% of the Plan's usual payment (Allowed Charge) formula (reduced for cost-sharing) or
- (when such database is available), the amount that Medicare Parts A or B would pay (reduced for cost-sharing).

The Plan will not always pay benefits equal to or based on the Health Care or Dental Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible and Coinsurance. This is because the Plan covers only the "Allowed Charge" amount for health care services or supplies.

Any amount in excess of the "Allowed Charge" amount does not count toward the Plan's annual Out-of-Pocket Maximums. Participants are responsible for amounts that exceed "Allowed Charge" amounts by this Plan.

Ambulatory Surgical Center: "Ambulatory Surgical Center" means a place which maintains and operates facilities for Surgery and surgical diagnosis and treatment on an open panel basis by persons licensed to practice medicine and Surgery in all its branches, licensed to practice podiatry or licensed to practice dentistry or oral

Surgery, which shall have an attending medical staff consisting of one (1) or more anesthesiologists or a nurse anesthetist under the supervision of a licensed Physician or surgeon. This term shall not mean a Hospital, nursing or convalescent home, home for the needy, home for the nursing and domiciliary care of children of pre-school age, infirmary or orphanage, private sanitarium, private office or clinic of licensed health care professionals, maternity home for pre-natal or post-natal care, mental health facilities, home or institutions, or any other facility which exists for the purpose of providing health care services.

Ancillary Services: Services provided by a Hospital or other Health Care Facility other than room and board, including but not limited to, use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g. general Anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g. regional or local Anesthesia). Anesthetics are commonly administered by injection or inhalation.

Appropriate: See the definition of Medically Necessary for the definition of Appropriate as it applies to medical services that are Medically Necessary.

Assistant Surgeon: An Assistant Surgeon is also referred to as an assistant at Surgery or first assistant. A person who functions as an Assistant Surgeon actively assists the Physician in charge of a surgical case (the surgeon) in performing a surgical procedure. This Plan allows payment of an Assistant Surgeon under the following conditions:

- the individual functioning as an Assistant Surgeon is properly licensed but not an Employee of a Hospital or surgical facility or a medical student, intern or other trainee; and
- the use of an Assistant Surgeon(s) is determined by the Plan Administrator or its designee to be Medically Necessary; and
- the Assistant Surgeon actively participated in the surgical procedure (was not stand-by).

Associated Organization or Contributing Employer: Means the Colorado Contractors Association, Inc., the Associated General Contractors of Colorado, Building Chapter, Inc. and any type of member of each such associations, whether individual, firm or corporation, who becomes a party to the Contractors Health Trust by agreeing to be bound by the Trust Agreement, and by agreeing to comply with its provisions by executing such instrument as the Trustees may require evidencing agreement to be bound by the Trust Agreement. Any Associated Organization or Contributing Employer must maintain the highest membership classification for which it is eligible in either the Colorado Contractors Association, Inc., or the Associated General Contractors of Colorado, Building Chapter, Inc. and must also remain an active participant in the industry, as determined by the Trust, to remain eligible to participate. For example, an Associated Organization or Contributing Employer who is qualified to be a general contractor member of either the Colorado Contractors Association, Inc., or the Associated General Contractors of Colorado, Building Chapter, Inc., shall hold such classification in the respective association for participation in Colorado Health Trust, and will be ineligible to participate in the Trust as a subcontractor or specialty contractor member of the other association. However, maintaining the highest membership classification does not automatically constitute active participation in the industry.

Autism services provider: “Autism services provider" means any person who meets the requirements of C.R.S. Section 10-16-104 (1.4)(a)(II), as amended.

Autism Spectrum Disorders: "Autism Spectrum Disorders" or "ASD," consistent with C.R.S. 10-16-104 (1.4)(a)(III) as amended, includes the following disorders: Autistic disorder, Asperger's disorder, and atypical autism as a diagnosis within pervasive developmental disorder not otherwise specified, as defined in the most recent edition of the diagnostic and statistical manual of mental disorders, at the time of the diagnosis.

Autism Treatment Plan: “Treatment plan" includes assessment, diagnosis and treatment of Autism Spectrum Disorder means a plan developed for an individual by an Autism Services Provider and prescribed by a licensed Physician or a licensed psychologist pursuant to a comprehensive evaluation or reevaluation for an individual consisting of the individual's diagnosis; proposed treatment by type, frequency, and anticipated treatment; the anticipated outcomes stated as goals; and the frequency by which the treatment plan will be updated. The treatment plan shall be developed in accordance with the patient-centered medical home as defined in C.R.S. Section 25.5-1-103 (5.5).

Balance Billing: A bill from a Health Care Provider to a patient for the difference (or balance) between this Plan’s Allowed Charges and what the provider actually charged (the billed charges). Amounts associated with Balance

Billing **are not covered** by this Plan, even if the Plan's Out-of-Pocket Maximum limits are reached. See also the provisions related to the Plan's Out-of-Pocket Expenses and the Plan's definition of Allowed Charge. Remember, amounts exceeding the Allowed Charge do not count toward the Plan's Out-of-Pocket Maximum and may result in Balance Billing to you. **Out-of-Network Health Care Providers commonly engage in Balance Billing a Plan Participant for any balance that may be due in addition to the amount payable by the Plan.** Typically, In-Network providers do not balance bill except in situations of third party liability claims. **Generally, you can avoid Balance Billing by using In-Network providers.**

Behavioral Health Disorder: Behavioral Health is an umbrella term that refers to mental health and/or Substance Abuse/Substance Use Disorder. A Behavioral Health Disorder is any Illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Certain Behavioral Health Disorders, conditions and diseases are specifically excluded from coverage as noted in the Medical Plan Exclusions chapter of this document..

Birth (or Birthing) Center: A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy. It must be licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.

Board of Trustees: "Board of Trustees" means the Board of Trustees as established by the Trust Agreement or its successor or successors. The Board of Trustees is the plan administrator.

Calendar Year: The 12-month period beginning January 1 and ending December 31.

Case Management Services: "Case Management Services" means the following as it relates to Early Intervention Services and Supports:

- The determination of eligibility for Early Intervention Services and Supports;
- Early Intervention Services and Supports coordination; and
- The monitoring of all Early Intervention Services and Supports delivered pursuant to the individualized plan, and the evaluation of results identified in the individualized plan.

Case Manager: "Case Manager" means an individual who assists with Case Management Services and supports for persons with developmental disabilities.

Child(ren): See the definition of Dependent Child(ren).

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC); and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column (vertebrae); and acts within the scope of his or her license.

Civil Union Partner: The term Civil Union Partner means an adult who has established a civil union with an Employee pursuant to the provisions of the "Colorado Civil Union Act", Colorado Revised Statutes §§ 14-15-101 et seq.

COBRA: means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. and refers to temporary continuation of health care coverage.

Coinsurance: That portion of Eligible Health Care Expenses for which the covered person has financial responsibility to pay. In most instances, the Plan Participant is responsible for paying a fixed percentage of covered expenses after the Plan's Deductible has been met. Coinsurance amounts are listed in the Schedule of Medical Benefits.

Community Centered Board: "Community Centered Board" means a private corporation, for profit or not for profit, that, when designated pursuant to C.R.S Section 27-10.5-105 provides Case Management Services to persons with developmental disabilities, is authorized to determine eligibility of those persons within a specified geographical area, serves as the single point of entry for persons to receive Early Intervention Services and Supports, and provides authorized services and supports to those persons either directly or by purchasing services and supports from service agencies.

Concurrent Review: "Concurrent Review" means the review of the confinement while a Participant is confined as an inpatient. The review of the continued stay in the facility is coordinated with the Physician, the facility and

the review coordinator for determining Medically Necessary and Reasonable care. The review is designed to eliminate unnecessary treatment or unneeded, prolonged confinements. Also called Continued Stay Review.

Coordination of Benefits (COB): The rules and procedures applicable to determination of how Plan benefits are payable when a person is covered by two or more health care plans.

Copay: The fixed dollar amount you are responsible for paying when you incur an Eligible Medical Expense for certain services. The services with a Copay are listed on the Schedule of Medical Benefits in this document.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic). To determine the category of any particular item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic Appliance (or Device).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical/surgical treatment, prescription drugs and dental treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Cost-Efficient: See the definition of Medically Necessary for the definition of Cost-Efficient as it applies to medical services that are Medically Necessary.

Custodial Care: "Custodial Care" means care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel.

Deductible: The amount of Eligible Medical Expenses you are responsible for paying before the Plan begins to pay benefits. The amount of Deductibles is discussed in the Medical Expense Coverage chapters of this document.

Department: “Department” as it relates to Early Intervention Services and Supports means the department of human services for the state of Colorado.

Dependent: Any of the following individuals: Dependent Child(ren) or Spouse or Civil Union Partner as those terms are defined in this document. See also the definition of Eligible Dependent. Note that the daughter-in-law or son-in-law or grandchild of an eligible Employee or Spouse or Civil Union Partner is not an eligible Dependent under this Plan.

Dependent Child(ren): For the purposes of this Plan, a Dependent Child is any of the Employee’s children listed below who are under the age of 26 (whether married or unmarried):

- Son or daughter (proof of relationship and age may be required);
- Stepson or stepdaughter (proof of relationship and age may be required);
- Legally adopted child or child Placed for Adoption with the Employee (proof of adoption or placement for adoption and age may be required);
- A child named as an “alternate recipient” under a Qualified Medical Child Support Order (QMCSO).

A Spouse of a Dependent Child and a child of a Dependent Child are not eligible for coverage under the Plan.

Additional Dependent Children

In addition to the Dependent Children defined above, the following individuals are eligible for coverage under the Plan:

- A child for whom permanent custody has been awarded by a court order of any court of competent jurisdiction (proof of relationship and age may be required), and who is eligible for tax-free health coverage as a “qualifying child” or “qualifying relative” under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively;
- An unmarried Dependent Child (as defined above) age 26 or older who is incapable of self-sustaining employment by reason of a medically certified mental or physical Disability that existed prior to age 26 and who is eligible for tax-free health coverage as a “qualifying child” or “qualifying relative” under the applicable

requirements of Internal Revenue Code Section 152(c) or 152(d), respectively. The Plan may require initial and periodic proof of Disability. Such incapacitated Dependent Child will be covered for medical and prescription drugs only.

A mental Disability is defined as significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

With the exception of a Dependent Child who is permanently and totally Disabled prior to age 26, coverage shall terminate at the end of the month of the individual's 26th birthday.

Dietician: A Registered Dietician or Nutritionist is a professional who is qualified by training and examination to evaluate people's nutritional health and needs. The Dietician or Nutritionist must be legally licensed where state licensure is required.

Disabled/Disability: The inability of a person to be self-sufficient as the result of a physically or mentally disabling Injury, Illness, or condition (such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, or psychosis), **and** the person is permanently and totally Disabled in that they are unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months and the condition was diagnosed by a Physician, and accepted by the Plan Administrator or its designee, as a permanent and continuing condition. See also the definition of Totally Disabled.

Division: "Division" as it relates to Early Intervention Services and Supports means the unit within the department of human services for the state of Colorado that is responsible for developmental disabilities services.

Durable Medical Equipment: Equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an Injury or Illness; and is not disposable or non-durable and is appropriate for the patient's home (such as a wheel chair).

Early Intervention Services and Supports: "Early Intervention Services and Supports" means education, training, and assistance in child development, parent education, therapies, and other activities for infants and toddlers and their families that are designed to meet the developmental needs of infants and toddlers including, but not limited to, cognition, speech, communication, physical, motor, vision, hearing, social-emotional, and self-help skills.

Elective Hospital Admission, Service or Procedure: Any non-Emergency Hospital admission, service or procedure that can be scheduled or performed at the patient's or Physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Emergency: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman of her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

Emergency services: means a medical screening examination and medical treatment necessary to stabilize the person (in other words, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the person from the facility).

Employee: See the definition of an Hour Bank Employee and Monthly Contribution Employee.

Employer: See the definition of "Associated Organization or Contributing Employer."

Exhausted (in reference to COBRA Continuation Coverage): For the definition of Exhausted in connection with COBRA Continuation Coverage as it relates to entitlement to Special Enrollment for coverage, see the section on Special Enrollment in the Eligibility chapter.

Experimental or Investigational: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational. This includes any drug, device, medical treatment or procedures which are Experimental or Investigative. A drug, device, medical treatment or procedure is Experimental or investigative if:

1. the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
3. reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, Experimental, study or Investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis. Please note the Plan will not exclude services for Routine Patient Care Costs related to a clinical trial in compliance with Colorado state mandates. Please refer to the row titled "Clinical Trials" in the Summary of Benefits for an explanation of covered services.
4. reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

   Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol(s) used by the treatment facility or the protocol(s) utilized by other facilities studying substantially the same drug, device, medical treatment or procedure; or the written informed consent document used by the treating facility or by other facilities studying substantially the same drug, device, medical treatment or procedure.

In compliance with Colorado state mandates, the Plan will not exclude coverage for any drug approved by the FDA for use in the treatment of cancer on the basis that the drug has not been approved by the FDA for the specific type of cancer for which the drug is prescribed if:

- the drug is recognized for treatment of that cancer in the authoritative reference compendia as identified by the secretary of the United States Department of Health and Human Services; and
- the treatment is for a covered condition.

Note that under this medical plan, Experimental, Investigational or unproven **does not include routine costs associated with a certain "approved clinical trial" related to cancer or other life-threatening Illnesses.** The routine costs that are covered by this Plan are discussed below:

- "**Routine costs**" means services and supplies incurred by an eligible individual during participation in a clinical trial if such expenses would be covered for a Participant or beneficiary who is not enrolled in a clinical trial. However, the plan does not cover non-routine services and supplies, such as: (1) the Investigational items, devices, services or drugs being studied as part of the approved clinical trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.
- An "**approved clinical trial**" means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial's study or investigation must be (1) federally-funded; (2) conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements. "Federally funded" clinical trials include those approved or funded by one or more of: the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHCRQ), the Centers for Medicare and Medicaid Services (CMS), a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), the Department of Veterans Affairs (VA); a qualified non-governmental research entity identified by NIH guidelines for grants; or the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- A Participant or beneficiary covered under a group health plan is eligible to participate in a clinical trial and receive benefits from a group health plan for routine services if: (1) the individual satisfies the eligibility requirements of the protocol of an approved clinical trial; and (2) either the individual's referring Physician is a participating Health Care Provider in the plan who has determined that the individual's participation in the

approved clinical trial is medically appropriate, or the individual provides the plan with medical and scientific information establishing that participation in the trial would be medically appropriate.

- The plan may require that an eligible individual use an in-network provider as long as the provider will accept the patient. This plan is only required to cover out-of-network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient's state of residence.
- The plan may rely on its Utilization Management Company or other medical review firm to determine, during a review process, if the clinical trial is related to cancer or a life-threatening condition, as well as to help determine if a person's routine costs are associated with an "approved clinical trial." During the review process, the person or their attending Physician may be asked to present medical and scientific information that establishes the appropriateness and eligibility for the clinical trial for his/her condition. The Plan (at no cost to the patient) reserves the right to have the opinion of a medical review firm regarding the information collected during the review process. Additionally, external review is available for an adverse determination related to coverage of routine costs in a clinical trial.

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain Prescription Drugs and other medical services and supplies to be lawfully marketed.

Generic (drug): A Generic drug is a copy of an FDA approved brand-name drug that contains the same active ingredients as the brand-name drug and is the same in terms of dosage, safety, purity, strength, how it is taken, quality, performance and intended use. Generic drugs work in the same way and in the same amount of time as brand-name drugs. Generic drugs typically provide substantial dollar savings as compared to brand name drugs.

Gene Therapy: is a technique that uses human genes to treat or prevent disease in humans. Gene therapy involves introducing human DNA into an individual to treat a genetic disease (genetically altering the patient's own cells to fight their disease). The new DNA usually contains a functioning gene to correct the effects of a disease-causing mutation. The technique can allow doctors to treat a disorder by inserting a gene into an individual's cells instead of using drugs or Surgery. There are several approaches to Gene Therapy, including:

a) Replacing a mutated "faulty" gene that causes disease with a healthy copy of the gene.

b) Inactivating, or "knocking out," a mutated "faulty" gene that is not functioning properly.

c) Introducing a new gene into the body to help fight a disease or cure the disease.

Most often, human Gene Therapy works by introducing a healthy copy of a defective gene into the patient's cells. There have been rapid advancements in techniques that make it easier than ever to edit the human genome. Genome editing techniques, such as CRISPR/Cas9, allow editing of the genome, by removing, replacing, or adding to parts of the DNA sequence.

Genetic Counseling: Counseling services provided before Genetic Testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of Genetic Testing; and provided after Genetic Testing to explain to the patient and their family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman to allow the patient to make an informed decision.

Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from Genetic Testing or that may be inferred from a person's family medical history.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations.

Habilitative/Habilitation: Health care services, such as Physical Therapy, Occupational Therapy, and/or speech-language pathology, provided to individuals with developmental delays that have never acquired normal functional abilities. Examples of Habilitative services includes Physician-prescribed therapy for a child who is not walking or talking at the expected age.

Health Care Facilities: For the purposes of this Plan, Health Care Facilities include Outpatient Ambulatory Surgical Facilities, Mental Health and Substance Abuse Treatment Facilities, Residential Treatment Facilities, Birthing Centers, Hospices, Skilled Nursing Facilities, and Subacute Care Facilities, all of whom are legally licensed and/or legally authorized to provide certain health care services in that facility under the laws of the state or jurisdiction where the services are rendered. Many of these facility terms are separately defined in this chapter.

Health Care Practitioner: A Physician, Mental Health Practitioner, Chiropractor, Dentist, Nurse (RN, LVN, LPN), Licensed Midwife, Physician Assistant, Podiatrist, or Occupational, Physical, or Speech Therapist, Optometrist, Optician, Registered Dietitian who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered, and acts within the scope of his or her license and/or scope of practice; and is not the patient or the parent, Spouse, Civil Union Partner, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered Employee.

Health Care Provider: A Health Care Practitioner as defined above, or a Hospital, Ambulatory Surgical Facility, Mental Health or Substance Abuse Treatment Facility, Birthing Center, Home Health Care Agency, Hospice or Skilled Nursing Facility.

Home Health Care: "Home Health Care" means services rendered to a Participant in a private residence by or through an organization or agency which meets the requirements for participation as a home health agency under Medicare.

Hospice Benefit Period: "Hospice Benefit Period" means the period that begins on the date the Physician certifies that the Participant is a Terminally Ill Patient and ends six (6) months after it began or on the death of the Participant, if sooner. If the Hospice Benefit Period ends before the death of the Participant, a new Hospice Benefit Period may begin if the Physician again certifies that the Participant is a Terminally Ill Patient.

Hospice Care: "Hospice Care" means palliative and supportive medical, health care and other services provided to Terminally Ill Patients to meet special physical and emotional needs as part of dying so that a hospice patient may remain at home, to the maximum extent possible, with home-like inpatient care utilized only if and while it is necessary. A hospice agency must be licensed by the State of its situs and meet the certification requirements of a hospice agency as required by Medicare.

Hospital: "Hospital" means an institution operated pursuant to law which is primarily engaged in providing, for compensation from its patients, medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an inpatient basis, and which provide such facilities under the supervision of the staff of Physicians and with twenty-four (24) hours a day nursing service by registered graduate nurses. In no event, however, shall such term include any institution or part thereof which is used principally as a rest facility, nursing facility, convalescent facility or facility for the aged.

The term "Hospital" shall include a free standing facility, operated pursuant to applicable laws, regulations and/or certification requirements which is primarily engaged in providing diagnostic radiology and/or pathology services. To the extent that benefits are provided, a facility approved under the laws of the governing jurisdiction of this Plan for the treatment of diagnostic radiology and/or imaging, the treatment of Mental Illness or the treatment of Drug and Alcohol Disorders will be considered a "Hospital" under this Plan with respect to benefits for such treatment.

Hour Bank Employee: Under the Hour Bank approach, an “Employee” means all field or shop personnel who are paid solely by the hours worked and who become eligible in accordance with the Eligibility section beginning on page 7 of this document. In addition, if an Associated Organization so elects, superintendents and foremen who are not Owner-Employees of an Associated Organization, may participate hereunder if the Associated Organization pays on a basis of one hundred seventy-three (173) hours per month.

Hour(s) of Service: means (1) each hour for which an Employee is paid, or entitled to payment, for the performance of duties for an Employer; and (2) each hour for which an Employee is paid, or entitled to payment by an Employer on account of a period of time during which no duties are performed due to vacation, holiday, Illness, incapacity (including Disability), layoff, jury duty, military duty or leave of absence. An hour of service does not include any hour of service performed as a bona fide volunteer, as part of a Federal Work-Study Program (or a substantially similar program of a State or political subdivision thereof) or (according to the final Shared Responsibility regulations) to the extent the compensation for services performed constitutes “income from sources without the United States”.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition. **Pregnancy will be considered to be an Illness only for the purpose of coverage under this Plan.** However, **infertility is not an Illness** for the purpose of coverage under this Plan.

Individualized Family Service Plan. "Individualized Family Service Plan" or "IFSP" means a written plan developed pursuant to 20 U.S.C. sec. 1436 and 34 CFR 303.340 that authorizes the provision of Early Intervention Services and Supports to an Eligible Child and the child's family. An IFSP shall serve as the individualized plan, pursuant to C.R.S. Section 27-10.5-102 (20)(c) for a child from birth through two years of age.

Injury: Any damage to a body part resulting from trauma from an external source.

In-Network Services: Services provided by a Health Care Provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from Out-of-Network Services that are provided by a Health Care Provider that is **not** a member of the PPO.

Inpatient Services: Services provided in a Hospital or other Health Care Facility during the period when charges are made for room and board.

Investigational: See the definition of Experimental and/or Investigational.

Look-Back Measurement Method: Under the look-back measurement method, the Employer measures the Hours of Service of its Employees over a measurement period and then offers coverage during an associated stability period to Employees who worked full-time during the measurement period. Certain new Employees may be measured during an initial measurement period during which their status as full-time or not is unknown and they do not have to be offered coverage. Ongoing Employees are measured during a standard measurement period.

- **New Employee:** An Employee who been employed by the Employer for less than one complete standard measurement period.
- **Part-Time Employee:** A part-time Employee is a new Employee who is expected to average less than 130 Hours of Service per month during the initial measurement period, based on the facts and circumstances at the employee's start date.
- **Variable Hour Employee:** A variable hour Employee is a new Employee whose hours are expected to vary or otherwise be uncertain, and for this reason, the Employer cannot determine whether the new Employee is reasonably expected to average at least 30 Hours of Service per week during the initial measurement period. This classification must be based on the facts and circumstances at the Employee's start date.
- **Seasonal Employees:** A seasonal Employee is one who is hired into a position for which the customary annual employment is six months or less and occurs around the same time each year.
- **Full-time Employee:** an Employee who averages at least 30 Hours of Service per week (130 Hours of Service per month) with an Employer.
- **Initial measurement period:** means a period selected by an Employer of at least 3 but not more than 12 consecutive months used by the Employer as part of the look-back measurement method.
- **Ongoing Employee:** An "ongoing Employee" is generally an Employee who has been employed by the Employer for at least one complete standard measurement period.
- **Standard measurement period:** means a period of at least 3 but not more than 12 consecutive months that is used by an Employer as part of the look-back measurement method.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Medical Foods: "Medical Foods" means prescription metabolic formulas and their modular counterparts and amino acid-based elemental formulas, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and severe allergic conditions, if diagnosed by a board-certified allergist or board-certified gastroenterologist, for which medically standard methods of diagnosis, treatment and monitoring exist. The formulas for severe food allergies contain only singular form elemental amino acids. The formulas are to be consumed or administered enterally either via tube or oral route under the direction of a Physician.

Medically Necessary /Medical Necessity: "Medically Necessary" means a service or supply which is appropriate and consistent with the diagnosis of a particular condition and shall include due consideration of whether services are:

- appropriate and necessary for the symptoms (i.e., diagnosis or treatment of a medical condition);
- provided for the diagnosis or direct care and treatment of a medical condition;
- within standards of good medical practice within the organized medical community;
- not primarily for the convenience of the patient, the attending or consulting Physician, or any other Health Care Provider; and
- the most appropriate level of services or supplies which can be safely provided.

Medicare: "Medicare" means the benefits provided under Title XVIII of the Social Security Act of 1965, and as amended from time to time. A person who is eligible for Medicare will be deemed to have all the coverages for which he or she is so eligible.

Mental Illness: Mental Illness treatment includes outpatient visits and Inpatient Services (including room and board) for a mental disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). At a minimum, Mental Illnesses covered by this Plan include, but are not limited to, those set forth and as defined in C.R.S. Section 10-16-104 (5.5) (a) (IV) (A) and (B) as “biologically based Mental Illness” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder, and “mental disorder” meaning posttraumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, anorexia nervosa, bulimia nervosa, general anxiety disorder, and Autism Spectrum Disorders as defined in C.R.S. 10-16-104 (1.4) (a)(III).

Midwife, licensed Nurse Midwife: A person legally licensed as a Midwife to manage the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care who acts within the scope of his or her license. A Midwife may **not** independently manage moderate or high-risk mothers, admit to a Hospital, or prescribe all types of medications.

Monthly Contribution Employee: In the Monthly Contribution approach, an "Employee" means any Employee who is employed by an Associated Organization on a full-time basis averaging thirty (30) Hours of Service per week at a regularly scheduled place of employment; and

- An Employee who is receiving constant weekly or monthly salary, regardless of hours worked; or
- All office workers of all Contributing Employers, regardless of the basis on which they are paid; or
- All Owner-Employees of an Associated Organization (as defined in the Definition’s section of this document); or
- Subject to Board approval, non-seasonal hourly Employees performing substantial regular services at the Associated Organization’s principal place of business; or
- All field or shop personnel paid solely by the hours worked (and superintendents and foremen regardless of how they are paid) if the Contributing Employer has not elected to provide Hour Bank coverage.

Owner-Employee shall include any person who:

- is a sole proprietor; or
- performs services for, and is a greater than ten percent (10%) owner of, any Associated Organization which is an entity described in Title 7 of Colorado Revised Statutes, including, but not limited to, corporations, partnerships, and limited liability companies.

Ownership is determined with reference to the type of entity present, including the following specific tests:

- for a corporation, an ownership is based on the percentage of total value of all classes of stock or the percentage of total voting power for all classes of stock with voting rights, whichever is greater;
- for a partnership or limited liability company, ownership is a percentage of capital interests or profits interests, whichever is greater. Ownership interests for the purposes of the ten percent limitation shall include any ownership interests held by a person's Spouse and/or children.

Morbidly Obese, Morbid Obesity: Under this Plan, the term means the presence of Morbid Obesity when the condition is determined to be endogenous and the person is considered to be Morbidly Obese according to the following Body Mass Index (BMI) scale.

The BMI scale takes into account both a person's height and weight in determining the severity of a person's weight and how much of a health risk it poses. To calculate BMI, divide a person's weight in kilograms by his or her height in meters squared; or multiply the person's weight in pounds by 704 and divide that amount by his or her height in inches squared. The scale to determine the degree of obesity is as follows:

Classification	BMI Score
Normal	19-24
Overweight	25-29
Obese	30-39
Morbid (or Extreme) Obesity	40 and above

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic appliance (or Device) and Prosthetic Appliance (or Device). Only those Nondurable Supplies identified in the Schedule of Medical Benefits are covered by this Plan. All others are not.

Non-Network: See Out-of-Network.

Nurse: A person legally licensed as a registered nurse (R.N.), a licensed practical nurse (L.P.N.) or a licensed vocational nurse (L.V.N.), on a part-time or intermittent basis.

Occupational Therapist: A person legally licensed as a professional Occupational Therapist who acts within the scope of their license and acts under the direction of a Physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living (such as eating, bathing, dressing) and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills in order to regain independence.

Occupational Therapy: "Occupational Therapy" means the use of educational, vocational, and rehabilitative techniques to improve a patient's functional ability to live independently.

Office Visit: A direct personal contact between a Physician or other Health Care Practitioner and a patient in the Health Care Practitioner's office for diagnosis or treatment associated with the use of the appropriate Office Visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association or the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirement of such CPT or CDT coding. The following are not considered to be an Office Visit: a telephone discussion with a Physician or other Health Care Practitioner, internet/virtual Office Visit, a visit to a Health Care Practitioner's office where no Office Visit code is billed or a visit to a Health Care Practitioner's office for blood drawing, leaving a specimen, or receiving a routine injection.

Ongoing Variable Employee: an Employee who has been continuously employed by a Participating Employer for a full 12-month Standard measurement period or an Employee who terminates employment with a Participating Employer and is subsequently re-hired (or hired by another Participating Employer) with a break in service of less than 4 calendar months.

Out-of-Network Services (Non-Network): Services provided by a Health Care Provider that is **not** a member of the Plan's Preferred Provider Organization (PPO), as distinguished from In-Network Services that are provided by a Health Care Provider that is a member of the PPO.

Out-of-State Services: "Out-of-State Services" means covered charges which are received by a Participant outside the State of Colorado, or the state of the Participant's primary residence.

Out-of-Pocket Maximum (also called Out-of-Pocket Limit): The maximum amount of Coinsurance each covered person or family is responsible for paying during a Calendar Year before the Coinsurance required by the Plan ceases to apply. When the Out-of-Pocket Maximum is reached, the Plan will pay 100% of additional Coinsurance related to most covered expenses for the remainder of the Calendar Year.

Participant: "Participant" includes each eligible Hour Bank or Monthly Contribution Employee, each eligible Dependent, each eligible Qualified Beneficiary and each Self-Pay Participant.

Part-time Employee: means the Employee is reasonably expected to work less than 30 Hours of Service/week (less than 130 Hours of Service/month)

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical Therapist: A person legally licensed as a professional Physical Therapist who acts within the scope of their license and acts under the direction of a Physician to perform Physical Therapy services.

Physical Therapy: "Physical Therapy" means the use of physical agents to treat a Disability resulting from disease or Injury. Physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet radiation, massage, aquatic therapy, and therapeutic exercises.

Physician: "Physician" means a Physician and surgeon (M.D. or D.O.) licensed to practice medicine in the state or jurisdiction in which he/she practices and who acts within the scope of the their license or certification . See also the definition of Health Care Practitioner.

Physician Assistant: "Physician Assistant" means an individual who is qualified by academic and clinical training to provide patient services under the supervision and responsibility of a Physician, and certified by the state as a Physician Assistant.

Placed for Adoption: For the definition of Placed for Adoption as it relates to coverage of adopted Dependent Children, see the definition in the section on Adopted Dependent Children in the Eligibility chapter.

Plan or Fund: "Plan" or "Fund" mean the Contractors Health Trust established by the Trust Agreement.

Plan Participant: Any Employee, and that person's eligible Spouse or Civil Union Partner or Dependent Child (as these terms are defined in the Plan) who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan.

Plan Sponsor: The Board of Trustees of Contractors Health Trust.

Plan Year: "Plan Year" means the Plan's fiscal year which begins March 1 and ends the final day of February of the next year. Benefits under the Plan are provided on a Calendar Year basis, beginning January 1 and ending December 31 of each year.

Podiatrist: A person legally licensed as a Doctor of Podiatric Medicine (DPM) who acts within the scope of his or her license and who is authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered.

Precertification: Precertification is a review procedure performed by the Utilization Management Company **before** services are rendered, to assure that health care services meet or exceed accepted standards of care and that the service, admission and/or length of stay in a Health Care Facility is appropriate and Medically Necessary. Precertification is also referred to as pre-service review, prior authorization, precert, prior auth or preapproval.

Preferred Provider: "Preferred Provider" means any provider who has contracted with the Plan to provide covered services to Participants. The Board of Trustees shall have full discretion regarding the level of benefits payable under the Plan to any Preferred Provider. In the event a contracted provider is reimbursed at a benefit level less than the Preferred Provider level such benefit level shall be agreed to by the parties and designated in writing.

Preferred Provider Organization (PPO): An independent group or network of Health Care Providers (*e.g.* Hospitals, Physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted/reduced rates.

Prescription Drugs: For the purposes of this Plan, Prescription Drugs include:

a. **Federal Legend Drug:** Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
b. **Compound Drug:** Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.
c. **Brand drug:** means a drug that has been approved by the U.S. Food and Drug Administration (FDA) and that drug has been granted a 20-year patent, which means that no other company can make it for the entire duration of the patent period. This patent protection means that only the company who holds the patent has the right to sell that Brand drug. A Brand drug cannot have competition from a Generic drug until after the brand-name patent or other marketing exclusivities have expired and the FDA grants approval for a Generic version.

d. **Generic drug**: means a Generic version of a brand-name drug. The Generic drug must be the same (or bio-equivalent) in several respects: the active ingredients (those ingredients that are responsible for the drug's effects), the dosage amount, the way in which the drug is taken must be the same as the brand name drug, the safety must be the same and the amount of time the Generic drug takes to be absorbed into the body must be the same as the brand name drug. A Generic drug has been approved by the U.S. Food and Drug Administration (FDA), and is basically a "copy" of a brand name drug. Generic drugs can have different names, shapes, colors and inactive ingredients than the original brand name drug.
e. **Specialty drug**: see the separate definition of Specialty drug in this chapter.

Prosthetic Appliance (or Device): A prosthetic device for purposes of this plan is an artificial device to replace, in whole or in part, an arm or leg.

Qualified Medical Child Support Order (QMCSO): A court order that complies with requirements of federal law requiring an Employee to provide health care coverage for a Dependent Child, and requiring that benefits payable on account of that Dependent Child be paid directly to the Health Care Provider who rendered the services or to the custodial parent of the Dependent Child. See also the Eligibility chapter of this document.

Reconstructive Surgery: A Medically Necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental Injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy.

Rehabilitation Facility: "Rehabilitation Facility" means a facility that is recognized by the Plan and licensed or certified to perform rehabilitative health care services by the state or jurisdiction where services are provided. Services of such a facility must also be among those covered by the Plan.

Rehabilitation Therapy: Physical, occupational, or Speech Therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of Illness, Injury or Surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the Injury, Illness or Surgery, and that is performed by a licensed therapist acting within the scope of his or her license.

Residential Treatment Program/Facility/Care: is a non-acute Hospital, intermediate inpatient setting with 24-hour level of care that operates 7 days a week, for people with Behavioral Health Disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders that are unable to be safely and effectively managed in outpatient care. To be payable by this Plan, a facility must be licensed as a Residential Treatment Facility (licensure requirements for this residential level of care may vary by state).

Respite Care: "Respite Care" means care that is furnished to a Terminally Ill Patient when confined as an inpatient so that the family unit may have relief from the stress of the care of the Terminally Ill Patient.

Restatement Effective Date: "Restatement Effective Date" means January 1, 2011. This Plan document has been amended and restated to incorporate all amendments and to update the wording of this Plan Document. This Plan Document/Summary Plan Description replaces all previously issued Plan Documents, Rules and Regulations, Summary Plan Descriptions and amendments.

Routine Patient Care Cost: "Routine patient care cost" (as related to the coverage of clinical trials) means all items and services that would be covered under the Trust if the Participant was not involved in either the Experimental or the control arms of a clinical trial. ; except the investigational item or service, itself; 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; items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; routine costs in clinical trials that include items or services that are typically provided absent a clinical trial; items or services required solely for the provision of the investigational items or services, the clinically appropriate monitoring of the effects of the item of service, or the prevention of complications; and items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

Seasonal Employee: means an Employee hired for a position in which the customary annual employment is 6 months or less.

Skilled Nursing Facility: "Skilled Nursing Facility" means a lawfully operated institution for the care and treatment of persons convalescing from an accidental bodily Injury or sickness which provides room and board and twenty-four (24) hour nursing service by licensed nurses and is under the full time supervision of a legally qualified Physician or a registered nurse (R.N.).

Specialty Drugs: Injectable oral medications that are used to treat chronic conditions such as multiple sclerosis, rheumatoid arthritis and hepatitis C. These drugs often require temperature controlled packaging or other special handling. See the Drug row of the Schedule of Medical Benefits for more information.

Speech Therapist: A person legally licensed as a professional speech therapist who acts within the scope of their license and acts under the direction of a Physician to perform Speech Therapy services including the application of principles, methods and procedures for the measurement, testing, evaluation, prediction, counseling, instruction, or rehabilitation related to disorders of speech, voice, language, swallowing or feeding.

Speech Therapy: "Speech Therapy" means services used for diagnosis and treatment of speech and language disorders.

Spinal Manipulation: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column. Spinal Manipulation is commonly performed by Chiropractors, but it can be performed by Physicians.

Spouse: Employee's lawful Spouse as defined under federal law. This includes a licensed marriage, a Civil Union or a common law marriage if the Employee completes an affidavit of common law marriage and submits evidence satisfactory to the Board of Trustees that the Employee and Spouse have satisfied all the elements required to establish a common law marriage prior to the time of the accrual of any benefits under the Plan. Lawful Spouse does not include a divorced Spouse or legally separated Spouse.

Subrogation: This is a technical legal term for the right of one party to be substituted in place of another party in a lawsuit. See the Third Party Liability subchapter in the chapter on Coordination of Benefits for an explanation of how the Plan may use the right of Subrogation to be substituted in place of a Plan Participant in that person's claim against a third party who wrongfully caused that person's Injury or Illness, so that the Plan may recover medical and/or dental benefits paid if the Plan Participant recovers any amount from the third party either by way of a settlement or judgment in a lawsuit.

Substance Abuse/Substance Use Disorder: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definition of Behavioral Health Disorders.

Supplemental Coverage Months: Months of coverage for hour bank Employees who have not earned eligibility in a given month under the existing hour bank rules but do earn eligibility under the ACA Look Back Measurement Period.

Surgery: Any operative or diagnostic procedure performed in the treatment of an Injury or Illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits. When multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed at the same operative session, the total amount payable shall be for the major procedure plus 50% of the amount for the lesser procedure(s).

When an incidental procedure (e.g., incidental appendectomy, lysis of adhesions, excision of previous scar, puncture of ovarian cyst) is performed through the same incision, the amount payable will be that of the major procedure only;

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome: TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including, but not limited to, masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking), myofacial pain (pain in the muscles of the face), headaches, earaches, limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment.

Terminally Ill Patient: "Terminally Ill Patient" means a patient whose Physician certifies that such patient is terminally ill and who is expected to live six (6) months or less.

Totally and Permanently Disabled: "Totally and Permanently Disabled" means complete inability due solely to accidental bodily Injury or sickness of the Employee to perform his/her regular and customary work, and a

Dependent's complete inability due solely to accidental bodily Injury or sickness to engage in the activities of a person of the same sex and age.

An Employee will be deemed Totally and Permanently Disabled upon determination by the Social Security Administration that he is entitled to a Social Security Disability Award. The Board of Trustees may at any time require evidence of continued entitlement to such Social Security Disability benefit.

The Board of Trustees may from time to time request evidence of an Employee's or Dependent's being continually Totally and Permanently Disabled. Any expense incurred as a result of such a request shall be the responsibility of the Employee.

Transplant, Transplantation: The transfer of whole or partial organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, peripheral stem cells, cornea, skin, tendon or bone) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient.

- **Autologous** refers to Transplants of organs, tissues or cells from one part of the body to another. Bone marrow, peripheral stem cells and skin Transplants are often autologous.
- **Allogenic** refers to Transplants of organs, tissues or cells from one person to another person. Heart Transplants are allogenic.
- **Xenographic/xenotransplant** refers to Transplantation, implantation or infusion of organs, tissues or cells from one species to another (for example, the Transplant of an organ from an animal to a human). Expenses related to xenographic services are **not** covered by this Plan, except as determined to be an FDA-approved use of xenographic tissue such as a porcine heart valve.

See the Schedule of Medical Benefits and the Exclusions chapter for additional information regarding Transplants. See also the Utilization Management chapter of this document for information about Precertification requirements for Transplantation services.

Trust Agreement: "Trust Agreement" or "Trust" means the Agreement and Declaration of Trust establishing the Contractors Health Trust, as modified or amended.

Urgent Care: Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate even though health and life is **not** in jeopardy. Examples of medical conditions that may be appropriate for Urgent Care include, but are not limited to, fever, sprains, bone or joint injuries, continuing diarrhea or vomiting, or bladder infections.

Urgent Care Facility: A public or private Hospital-based or free-standing facility that is licensed or legally operating as an Urgent Care Facility, that primarily provides minor Emergency and episodic medical care, in which one or more Physicians, Nurses, and x-ray technicians are in attendance at all times when the facility is open, and that includes x-ray and laboratory equipment and a life support system.

Utilization Management (UM): A managed care procedure to determine the Medical Necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include, but is not limited to Precertification and/or preauthorization; Concurrent and/or continued stay review; Discharge planning; Retrospective review; Case Management; Hospital or other Health Care Provider bill audits; and Health Care Provider fee negotiation. Utilization Management services (sometimes referred to as UM services, UM program, Utilization Review services, UR services, Utilization Management and Review services, or UMR services) are provided by licensed health care professionals employed by the Utilization Management Company operating under a contract with the Plan.

Utilization Management Company: The independent utilization management organization, staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer the Plan’s Utilization Management services.

Variable Hour Employee: Variable Hour Employee means an Employee not designated as “full-time”, and not expected to average 130 hours or more per month during a 12-month period. Hours include all hours for which the Employee is paid by a participating Employer. In addition, hours must be counted if reported by the participating Employer for unpaid leave subject to FMLA, USERRA, or jury duty. These unpaid hours are counted by calculating the average total hours paid by a participating Employer during the weeks in the stability period

when the Employee is not on unpaid leave and using this average as the weekly unpaid hours during the unpaid leave.

Vocational Rehabilitation: "Vocational Rehabilitation" means teaching and training which allows an individual to resume his previous job or to train for a new job.

You, Your: When used in this document, these words refer to the Employee who is covered by the Plan. They do **not** refer to any Dependent of the Employee.

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